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FALL 2007 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 9 NO. 4

Understanding and Treating Bipolar Disorder

The National Institute of Mental Health (NIMH)

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance, and even suicide. But there is good news: bipolar disorder can be treated, and people with this illness can lead full and productive lives.

About 5.7 million American adults or about 2.6 percent of the population age 18 and older in any given year,[1] have bipolar disorder. Bipolar disorder typically develops in late adolescence or early adulthood. However, some people have their first symptoms during childhood, and some develop them late in life. It is often not recognized as an illness, and people may suffer for years before it is properly diagnosed and treated. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life.

What Are the Symptoms of Bipolar Disorder?

Bipolar disorder causes dramatic mood swings—from overly "high" and/or irritable to sad and hopeless, and then back again, often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood. The periods of highs and lows are called *episodes* of mania and depression.

The signs and symptoms of mania (or a manic episode) include: increased energy, activity, and restlessness; excessively "high," overly good, euphoric mood; extreme irritability; racing thoughts and talking very fast, jumping from one idea to another; distractibility, can't concentrate well ; little sleep needed; unrealistic beliefs in one's abilities and powers; poor judgment; spending sprees; a lasting period of behavior that is different from usual; increased sexual drive; abuse of drugs, particularly cocaine, alcohol, and sleeping medications; provocative, intrusive, or aggressive behavior; and denial that anything is wrong.

A manic episode is diagnosed if elevated mood occurs with three or more of the other symptoms most of the day, nearly every day, for 1 week or longer. If the mood is irritable, four additional symptoms must be present.

Signs and symptoms of depression (or a depressive episode) include: lasting sad, anxious, or empty mood; feelings of hopelessness or pessimism; feelings of guilt, worthlessness, or helplessness; loss of interest or pleasure in activities once enjoyed, including sex; decreased energy, a feeling of fatigue or of being "slowed down;" difficulty concentrating, remembering, making decisions; restlessness or irritability; sleeping too much, or can't sleep; change in appetite and/or unintended

see Bipolar Disorder on page 36

Working with Medications:
So Many Medications for Bipolar Disorder ~ A Good Problem to Have

By Richard H. McCarthy, MD, CM, PhD
Research Psychiatrist

This issue of Mental Health News focuses on "Understanding and Treating Bipolar Disorder". Even though I am writing this column before seeing any of the other articles in this edition, I know that the articles will create a problem for the reader. Specifically, in any article that discusses Bipolar Disorder's treatment, a wide variety of medications will be mentioned. With so many medications, how does anyone decide what to take? This is a good problem to have, and a relatively recent problem. It was not so long ago that Bipolar Disorder was not considered to be medically treatable at all. At that time, patients could be institutionalized patients and wait for their illnesses to fade, but there was nothing that could help them otherwise. All that changed dramatically when lithium was approved by the FDA for the treatment of Mania in 1970. So, for the past 37 years, every physician trained in the United States has been taught that Mania can and does respond to treatment. Mania had moved from an untreatable illness to a responsive one. Even better, in the past 20 years, the number of agents that effectively treat Bipolar Disorder continues to expand. With all of this good news and so many new agents, how is one to choose which agent is best. This choice has something to do with the specific form of bipolar disorder that a person has.

Some Definitions

Bipolar Disorder is characterized by two different phases which, to some degree, are mirror images of each other, Mania and Depression. The highs of Mania with its elevated energy, mood and extreme pleasure seeking stands in sharp contrast to the lows and misery of depression and its complete lack of energy. Bipolar patients typically, and somewhat unpredictably cycle between mania and normal mood and then from normal mood into depression. Different forms of the bipolar illnesses move through different combinations of these symptoms. Bipolar 1 patients have episodes of both mania and depression. It only takes a single episode of mania in one's lifetime to be classified as Bipolar 1. Bipolar 2 patients have episodes of depression and at least one episode of hypomania (a truncated and less intense version of mania), but never have full blown manic episodes. If a patient has elements of both mania and depression at the same time, the illness is referred to as Bipolar Mixed. While symptoms of irritability can be found in mania and depression, they are almost always found in Mixed States. If a person is only depressed and has never had either mania or hypomania, they are said to be Unipolar Depressed. Psychosis can show up in any form of bipolar disorder. When it is present it severely complicates treatment.

Unfortunately, for people with Bipolar Disorder 1 or 2 or Bipolar Mixed, more time is spent depressed than either manic or hypomanic. In addition, it is the presence of mania or hypomania that distinguishes these illnesses from each other and from Unipolar depression. Taking a very good history is critical in arriving at the proper diagnosis and frequently a history of manic symptoms is not discovered because the patient does not recognize that an episode of feeling "too good" might have been a problem. Hence, patients do not tell the doctor about their manic or hypomanic episodes.

see Medications on page 34

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Summer 2008 Issue: "Employment for People With Mental Illness"
Deadline: May 1, 2008

Fall 2008 Issue: "The Interrelationship Between Physical & Mental Health"
Deadline: August 1, 2008

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www.mhnews.org

From The Publisher

Concerns About our Health: Mental and Physical

By Ira H. Minot, LMSW
Founder and Executive Director
Mental Health News

This issue of *Mental Health News* focuses on "Understanding and Treating Bipolar Disorder." A serious and long-term mental illnesses, Bipolar Disorder affects about 5.7 million American adults or about 2.6 percent of the population age 18 and older in any given year. A recent NIMH funded study (see page 25) published in the May 2007 issue of Archives of General Psychiatry suggests that Bipolar Disorder may be more accurately characterized as a spectrum disorder. The study contends that many people with the illness are not being properly diagnosed into one of the three sub-types of Bipolar Disorder (I, II and BP-NOS) and are therefore not receiving more accurately targeted and appropriate treatment.

For those of us who have struggled with mental illness, such a study is most welcome, but does not come as a great surprise. I know I am not alone in having experienced prolonged years of searching for the right diagnosis and treatment. Such delays often equate to many years of undo suffering and putting some in life or death situations. What is frustrating, is why more funding isn't provided so that studies like these can more quickly improve the lives of people with mental illness.

It is for this reason that the educational mission of *Mental Health News* continues to be a vital cornerstone of our mental health delivery system. Consumers, family members, clinicians, services providers and decision makers must continually keep pace with the latest information.

Ira H. Minot, LMSW

The Physical Health of People with Mental Illness

I hope you're as concerned as I am to learn that people with serious mental illness (SMI) are now dying 25 years earlier than the general population.

This alarming statistic is stated in a comprehensive report entitled "Morbidity and Mortality in People with Serious Mental Illness," published in October of 2006 by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (www.nasmhpd.org)

The report states that "It has been known for several years that persons with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity (illness) and mortality (death) in this population has accelerated. Their increased morbidity and mortality are largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care."

I am pleased to note that Dr. Michael Hogan, Commissioner of the New York State Office of Mental Health, was President of the NASMHPD from 2003-2005, and he served on the committee which published the Morbidity and Mortality Report when he was then Director of the Ohio Department of Mental Health.

I recommend that everyone go to the NASMHPD website I just mentioned and read this report. It is over 80 pages and contains an enormous amount of vital information and urgent recommendations. For instance, the report recommends three steps that should be taken on the national level including:

1. Designate the population with SMI as a health disparities population.
2. Adopt ongoing surveillance methods.
3. Support education and advocacy.

It is for this reason that I have chosen this topic for the next in our series of themes for *Mental Health News*. If you turn to page three you will see that I have listed "The Interrelationship Between Physical & Mental Health" as our theme for the fall 2008 issue. I wish to invite Dr. Hogan, the organizations working in this area, and our entire readership to help us bring this vital topic to the forefront.

I have come a long way since my ten year battle with depression, but I don't for one minute forget what those horrible years were like. There's an old proverb that says "walk a mile in another man's shoes." Unless you have had an SMI yourself, it's hard to understand how a person's mental ability, feelings and thought processes become altered with illnesses such as bipolar disorder, schizophrenia or depression. However, there's another side to understand, that involves loosing your friends, your means of employment, your home, and your employee health insurance which then causes your medical *and* dental health to deteriorate.

The NASMHPD Report states "It is challenging for people with Medicaid or no insurance to find primary care and specialty physicians who will see them. *Lack of health care coverage represents an enormous barrier to addressing the health care needs of the uninsured population with SMI."*

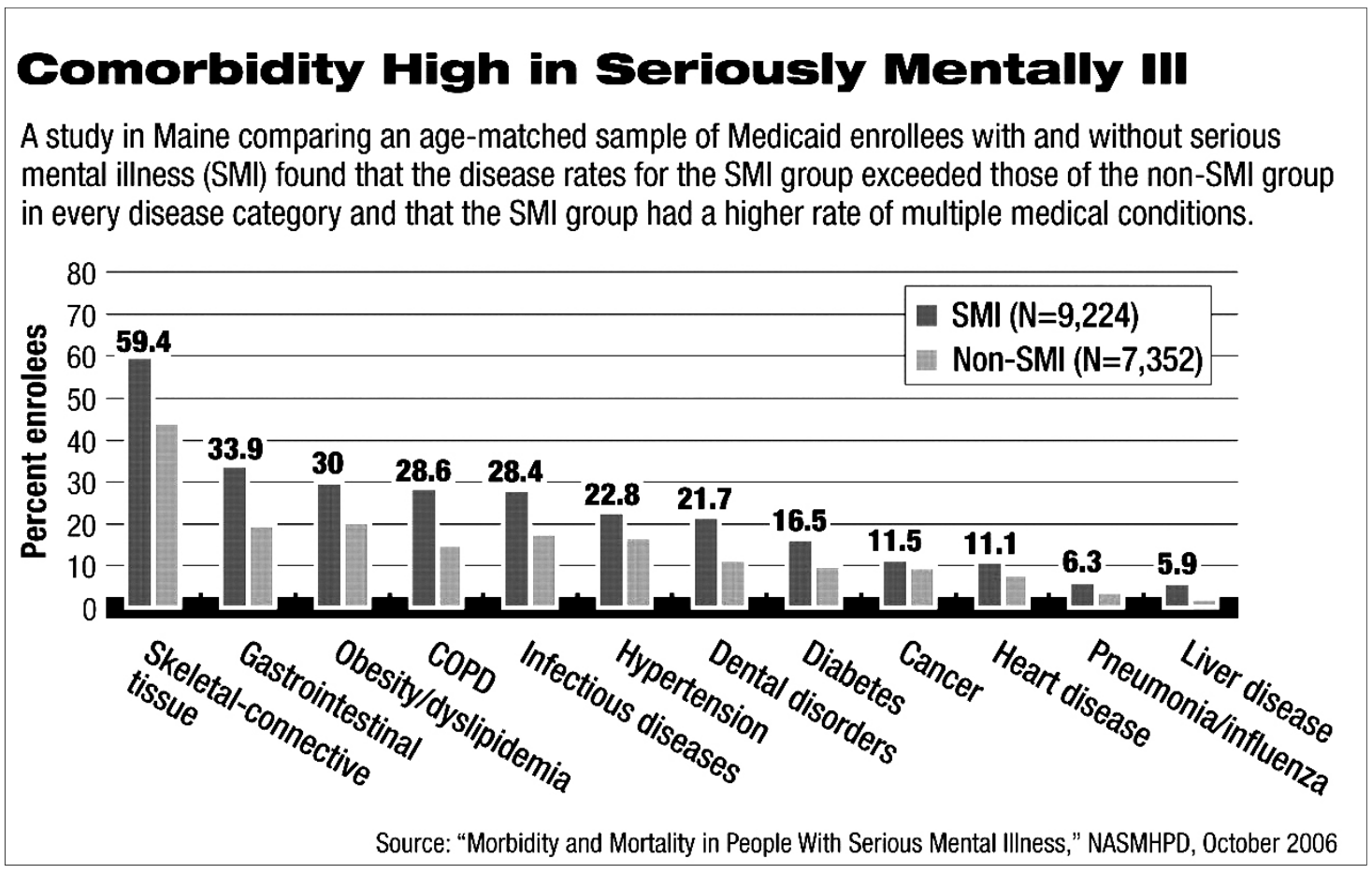
This is so true and so damaging to people with mental illness. We can't just treat the mind. The body is in need of care as well. People who rely on government entitlements for medical care are scorned for crowding emergency rooms when all they want is a chance to see a doctor.

Besides medical care, most people with SMI can't afford proper dental or vision care as well. My experience with Medicare was that when you had a dental problem, they would only cover having the tooth pulled rather than the more expensive repair and maintenance treatment. It is a terribly depressing blow to a person to loose their teeth in this way. The same goes for eye glasses. You may only be covered for a pair of lenses and frames every two or three years. And when you go for them they will only allow you lenses that help you with distance vision for example—even though you really need bifocals to help you read a book or a newspaper !!

This is not new, it has been going on for years and years. We must do everything in our power to call attention to the health disparities of people with serious mental illness. It is outrageous and unacceptable that people with SMI are now dying 25 years earlier than the general population. We must unite our voices to cry out for a solution to this problem.

I will devote next fall's issue theme to this topic. However, I believe that *this newspaper* must go further. If we could find adequate funding, I would urge my Board of Directors to help me develop and publish a special multi-page "Health and Wellness" section in each and every issue of the newspaper. In this way, we could continue to keep pace with the latest health news and provide the community with this vital source of advocacy and education. Please contact me personally at (570) 629-5960 if you can help us with this idea, and send your comments to me at mhnmail@aol.com. □

Good luck in your own recovery
and NEVER give up trying.
Wishing You a Wonderful Fall Season !!



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The mission of Autism Spectrum News will be to provide a readily available and up-to-date source of News, Information, Education, Advocacy and Resources about Autism Spectrum Disorders and the Autism Community.

Our primary audience will be parents, families, and individuals whose lives are directly impacted by autism spectrum disorders. Our secondary audience will include, treatment professionals, provider agencies, educators, and legislative decision makers.

Your input will help us determine how to best serve the autism community. Please send us your comments and ideas in the questionnaire below.

Your input and ideas are vital to our project's success - we thank you for your help !!
Cut out and mail to: Mental Health News, 16 Cascade Drive, Effort, PA 18330, or E-mail your responses to: mhnmail@aol.com

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Attendance is free. For registration, inquiries and electronic submission of proposals contact:

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MENTAL HEALTH NEWSDESK

Alzheimer's Association Awards Prestigious Grant To Three Nathan S. Kline Institute Dementia Researchers

Staff Writer
Mental Health News

Three research scientists at the Nathan S. Kline Institute for Psychiatric Research (NKI) have been awarded new grants totaling $ 720 thousand over three years from the Alzheimer's Association, the nation's leading voluntary health organization in Alzheimer's care, support and research. The prestigious investigator-initiated awards were made to Drs. Stephen Ginsberg, Efrat Levy, and Paul Mathews, who conduct cutting-edge prevention and treatment research on Alzheimer's disease (AD) and related dementias at the NKI Center for Dementia Research (CDR).

Stephen D. Ginsberg, PhD, will use a microarray-based molecular screening approach to identify why certain hippocampal neuronal populations are vulnerable in mild cognitive impairment (which precedes Alzheimer's disease in some patients) and in frank Alzheimer's disease. The study hopes to identify and develop biomarkers to track the progression of dementia that can pave the way for new treatments to delay the onset of cognitive impairment and other symptoms of the disease.

Stephen Ginsberg, PhD, Efrat Levy, PhD and Paul Mathews, PhD

Efrat Levy, PhD will study a novel approach to reduce Abeta amyloidogenesis by keeping it in a soluble form that prevents its deposition. This approach builds upon Dr. Levy's expertise in the biochemistry of the cysteine protease inhibitor cystatin C. A small sequence of cystatin C will be made so that it binds Abeta and keeps it from forming aggregates. This approach could lead to new therapies.

Paul Mathews, PhD will investigate the use of immunotherapy to reduce Abeta levels in the brain. Abeta is one of the primary problems in AD, and Dr. Mathews has developed an innovative strategy to use a vaccination approach to reduce Abeta. Using mice models, the approach will be tested and mechanisms associated with Abeta deposition and clearance will be investigated.

see Researchers on page 26

MHA of Nassau County Names David A. Nemiroff Executive Director

Staff Writer
Mental Health News

The Mental Health Association of Nassau County has named David A. Nemiroff, LCSW as its new Executive Director. Mr. Nemiroff was formerly Chief Support Services Officer for Family Residences and Essential Enterprises, Inc. (FREE), until his appointment..

Nemiroff who received his B.S. at SUNY Oneonta and his MSW from Stony Brook stated, "I am honored that the Board of Directors has chosen me for this position, and I look forward to continuing the MHA of Nassau County's 54-year tradition of grassroots advocacy, education, empowerment, service delivery and leadership in the human services field."

The new Executive lives in Dix Hills with his wife and two children.

The Mental Health Association of Nassau County is a not-for-profit membership organization dedicated to improving mental health through advocacy, education, program development and the delivery of direct services. It is a diverse agency with a broad array of services to support the rehabilitation and recovery of people with psychiatric disabilities and autism. These include housing with various levels of support, employment, education, case management, financial management, crisis respite for children and consumer self help and empowerment.

David A. Nemiroff, LCSW

For further information contact the MHA at (516) 489-2322. □

Paul Levine Becomes CEO of Jewish Board of Family and Children's Services

Staff Writer
Mental Health News

The Jewish Board of Family and Children's Services will complete its planned leadership transition when Executive Vice President and CEO Alan Siskind, PhD, retires on October 1 and Paul Levine, LCSW, assumes the CEO and Executive Vice President role.

Under Dr. Siskind's leadership the agency became one of the nation's leading providers of a comprehensive network of mental health services to people along a broad spectrum of needs. Mr. Levine plans to continue to build on this strong foundation.

"JBFCS has been a major provider of the most intensive residential mental health services for children and adults as well as more accessible 'gateway' services that all people need at some point in their lives," Mr. Levine notes. "We will continue to meet both of these essential functions for New Yorkers and make programs more available and tailored to serve the diverse communities throughout New York."

Dr. Siskind and Mr. Levine have worked together for nearly 30 years, and each feels very positive about the transition. "I have the highest confidence that as I step aside, JBFCS will be steered expertly for years to come," says Dr. Siskind. "We have carefully planned the transition to be as seamless as possible."

Paul Levine, LCSW

see CEO on page 34

MENTAL HEALTH NEWSDESK

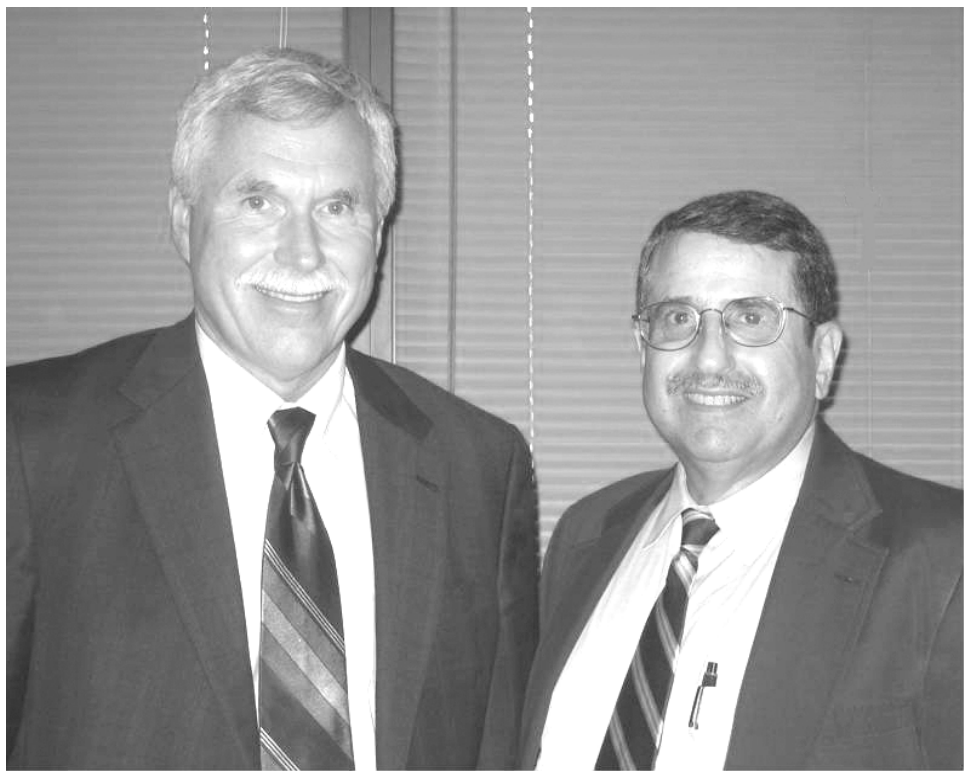
NYS Mental Health Commissioner Lectures at Saint Joseph's *"A Vision of the Public Mental Health System in New York State"*

Staff Writer
Mental Health News

Michael F. Hogan, PhD, Commissioner of the New York State Office of Mental Health (OHM), presented "A Vision for the Public Mental Health System in New York State" at a June event at Saint Joseph's Medical Center in Yonkers, New York.

Over 100 mental health professionals were in attendance today to hear Dr. Hogan, the distinguished guest speaker for Saint Joseph's 18th Annual Anthony Maniscalco, M.D., Lecture in Public Psychiatry.

Dr. Michael Hogan was confirmed in March 2007 as commissioner of Mental Health in New York. He served as Director of the Ohio Department of Mental Health from 1991 to 2007 and led Ohio to the top ranking in the 2006 rating of state mental health systems by the National Alliance of Mental Illness (NAMI). He was previously Commissioner of the Connecticut Department of Mental Health from 1987-1991.



Michael F. Hogan, PhD and Barry B. Perlman, MD

Dr. Hogan chaired the President's New Freedom Commission on Mental Health in 2002-2003, and was appointed in 2007 to serve on the Board of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), representing the behavioral health field. He served from 1994-1998 on the National Advisory Mental health Council, and as President of the National Association of State Mental Health Program Directors from 2003-2005. He has co-authored a book and several national reports, and written over 50 journal articles or book chapters.

In 2002 Dr. Hogan received the Distinguished Service to State Government Award from the National Governor's Association and the Distinguished Service Award from the National Alliance for the Mentally Ill. In 2006 he received a Special Leadership Award at the first national meeting of the Campaign for Mental Health Reform, and the SPAN USA Allies for Action Award fro the Suicide Prevention Action Network. In 2007 he received the Barton Distinguished Fellow

see Commissioner on page 34

Dr. Alan Siskind Bids Farewell To Mental Health News Board of Directors

Staff Writer
Mental Health News

With his retirement from his position as Executive Vice President and CEO of the Jewish Board of Family and Children's Services, Dr. Alan Siskind also bid farewell to the Board of Directors of Mental Health News Education, Inc. Dr. Siskind was elected in 2003 as the organization's first Chairman of the Board, and served an additional year to the two year Chairman's term until 2006 when Dr. Peter C. Campanelli, President and CEO of the Institute for Community Living was elected as Chairman of the Mental Health News Board.

"Dr. Siskind was instrumental in the formation of Mental Health News, and I will always be personally grateful for his kindness and dedication in working with me and our wonderful board," said Ira Minot, LMSW, Executive Director.

"Serving on the Mental Health News Board has always had special meaning for me, because mental health is about all of us," stated Dr. Siskind.

"Dr. Campanelli and I join with our entire Board of Directors in wishing Alan our deepest gratitude and best wishes following his stellar career and many

Alan B. Siskind, PhD

dedicated years of serving the needs of the mental health community. " said Janet Z. Segal, LCSW, BCD, Chief Operating Officer of Four Winds Hospital and Vice Chair of the Mental Health News Board of Directors. □

MHA of Westchester Welcomes Dr. Amy Kohn as Executive Director

Staff Writer
Mental Health News

Amy Kohn, DSW has recently taken the helm of the Mental Health Association of Westchester (MHA) as Executive Director. Dr. Kohn brings a wealth of experience in clinical work and executive management to MHA. She succeeds Carolyn S. Hedlund, PhD, who is retiring after 26 years of service to the agency.

MHA of Westchester recently celebrated its 60th year of meeting the diverse mental health needs of Westchester County. Through advocacy, education and direct services, MHA serves more than 11,000 individuals and families each year. Among the broad range of services that MHA offers are mental health treatment, housing, employment, professional training, mentoring and children's case management.

Dr. Amy Kohn comes to MHA from the YWCA of White Plains and Central Westchester, where she served as Chief Executive Officer since January 2002. She received her Doctorate in Social Welfare from Columbia University and developed her clinical experience over the course of 15 years, with a focus on youth

Amy Kohn, DSW

and families. She taught clinical social work practice and policy at the graduate level and has lectured on secondary trauma, working with difference and group treatment.

see Dr. Kohn on page 34

The NYSPA Report

Finding The Right Psychotherapy

By C. Deborah Cross, MD, President
New York State Psychiatric Association

Psychotherapy is a unique intervention which provides the possibility of significant personal growth and change for those who undertake the hard work involved. The type of psychotherapy chosen should be based on the therapist's orientation and training, the patient's symptoms and diagnosis and the ability of the patient and the therapist to develop a therapeutic alliance in which to affect the most positive outcome for the patient.

Patients are often concerned about whether their therapist will be a man or a woman or from their own cultural and racial background. These issues are important since human experience is shaped by these factors. However, the emotional issues dealt with in psychotherapy are often extremely similar across racial, cultural and gender lines. Of utmost importance is the development between the patient and the therapist of a trusting and caring relationship which will allow the healing power of psychotherapy to be experienced.

"Psychotherapy" defines a number of different approaches employed by mental health professionals in providing services to their patients and clients and was originally called the "talking cure". It is aimed at changing behavior through verbal interactions. A general definition states that it is primarily a verbal interchange between two individuals in which one is designated an expert and the other a help-seeker, with the goal of identifying characteristic patterns of behavior that are causing symptoms and problems in living. Psychotherapy also occurs within a group setting, and in couples and family meetings.

General Characteristics

Essential elements of psychotherapy across all settings include a focus on verbal interactions, with the therapist providing opportunities for the patient(s) to talk about their difficulties. Psychotherapy is not an ordinary relationship, since a mutual sharing of thoughts and feelings is not expected, that is the therapist will not generally divulge much information about his/her life, likes, dislikes, etc. The psychotherapy relationship is not a friendship in which two people share a conversation. Instead, a psychotherapy session focuses on helping the patient/client discover what difficulties are occurring in his/her life and developing ways to change or cope with these difficulties.

General non-specific characteristics are also present in all psychotherapies and include the development of the therapeutic alliance between the therapist and the patient, which is a major component in a successful therapy. The trust and confidence which the patient develops in the therapist allows him/her to work on recalling painful emotions and events; the therapist provides an organizing rationale for seemingly unrelated symptoms and events and the patient is then able to begin the process of therapeutic change and growth.

C. Deborah Cross, MD

The integration of medication and psychotherapy allows the patient to gain the most benefit from the experience of psychotherapy. For example, when a patient is depressed often the depression is so overwhelming that the patient is unable to muster the necessary physical and psychological energy needed to participate in the psychotherapy. The use of antidepressant medication in combination with psychotherapy provides the most optimal way of addressing the symptoms associated with Major Depression.

Psychoanalysis

Given the basic concept of what psychotherapy is and is not, numerous ways of meeting this goal have developed. Initially, psychoanalysis was the only technique. Psychoanalysis, though still utilized today, is much less visible than in the past, primarily because of the length of time needed, 4 to 5 sessions a week for 3 to 6 years!

Psychodynamic Psychotherapy

Many of the techniques used by the psychoanalyst are also used in what is commonly called psychodynamic (or psychoanalytically oriented) psychotherapy which can be both long or short term. The focus is on the here and now, though psychological defenses and coping styles are still examined. The therapist's role is to help the patient understand various conflicts in his/her current life. Psychodynamic psychotherapy forms the basis for most psychotherapies, and most patients are usually treated with some variation of it.

Brief Psychodynamic Psychotherapy

A number of brief psychodynamic psychotherapies have been developed over the last 30 years with some commonalities such as limited focus and goals, limited time, selection criteria and increased therapist activity.

With the growth of managed care in the last 20 years, there has been increased focus on brief psychotherapies and specifically the concept of "brief, intermittent therapy throughout the life cycle". This concept has emerged as a way to enable patients to access therapy when changes in their life situation (e.g., marriage, birth of child, death of parent) disrupt or interfere with their normal coping skills and abilities.

Cognitive Psychotherapies

Many of the more recent brief psychotherapies are linked with cognitive approaches. One such psychotherapy is Interpersonal Psychotherapy (IPT) developed by Klerman and others in the 1980s. IPT's goal is to improve interpersonal communications and skills, test perceptions and clarify feelings. IPT is generally used for depressive symptoms.

Other cognitive psychotherapies include Beck's Cognitive Behavioral Therapy (CBT) and Linehan's Dialectical Behavior Therapy (DBT). Beck's CBT is short term and focuses on symptom reduction. The therapist is active and directive. Homework is part of the therapy and the therapist teaches the patient self help techniques to practice between sessions. One of the primary concepts Beck uses is that of cognitive distortion, in other words the patient does not think about events in his/her life in a rational way. CBT can be used to treat depression, panic disorder, obsessive-compulsive disorder, paranoid personality disorder and somatoform disorder. Sessions are structured and problem oriented with a focus on cognitive restructuring of such automatic thoughts, assumptions and core beliefs.

Linehan's DBT was initially developed for the treatment of Borderline Personality Disorder, but has also been found to be useful in the treatment of depression, anxiety, anger, impulsivity, and eating disorders. The focus is on helping people to move beyond bouncing back and forth from one extreme of emotions and actions to another. Linehan developed 4 skill modules to help the patient reach what she calls "wisemind" in which the patient blends the rational and emotional states of mind. Her 4 skill modules are: mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation.

Supportive Psychotherapy

Supportive psychotherapy uses many of the same techniques described above in

see Psychotherapy on page 32

POINT OF VIEW

Steps Toward Improving Geriatric Mental Health Policy and Practice in 2008

By Michael B. Friedman, LMSW and Kimberly A Steinhagen, LMSW

Meeting the mental health challenges of the elder boom is necessarily a multi-year undertaking. As the population of older adults in the U.S. with mental and substance use disorders grows over the next 25 years from 7 million to 15 million or more, there will need to be a vast increase and reorganization of services. The mental health, substance abuse, health, and aging services systems will need to pull their efforts together to build a comprehensive, integrated service system that is staffed by a clinically and culturally competent workforce far larger than the current workforce. It will need to do this at a time when the proportion of working age adults in the population is declining.

Sadly, preparing for demographic changes is not a high priority for federal, state, or local governments. One day the march of demography will force them to take serious notice and respond comprehensively, but for now it's a couple of steps at a time, one year at a time.

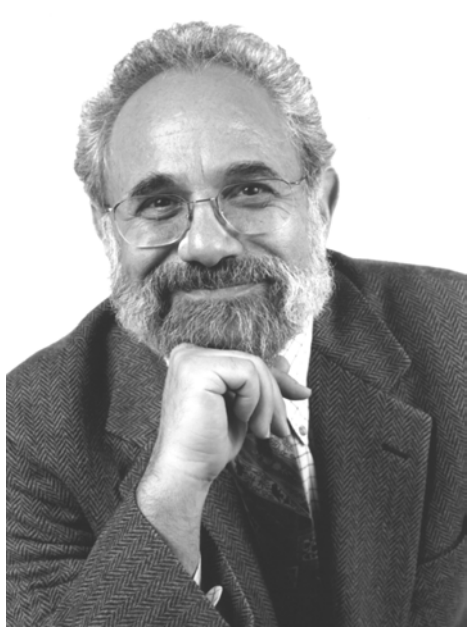
What are the steps to take this year? In New York, the Office of Mental Health and the Office for the Aging recently presented their answer to the Interagency Geriatric Mental Health Planning Council. At July's meeting they laid out several priorities for the state budget in 2008-9. In essence they said that NYS should:

- Confront issues of workforce development by establishing a **Center for Excellence** to foster best practices in geriatric mental health around New York State and by **training primary care physicians** in the identification and treatment of depression

- Expand state-of-the-art integrated services for older adults with mental health problems by funding **more services demonstrations grants**

- Confront the issue of the need for additional funding through a **Medicare optimization** initiative that would assure that New York State is getting all the Medicare funding for mental health services that it is entitled to.

We believe that these are good steps to take in the coming year. Do they address all of the critical challenges? Of course not. But they will certainly help us get there eventually.



Michael B. Friedman, LMSW

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A **Center of Excellence** would lay the groundwork for building a clinically and culturally competent geriatric mental health workforce in New York State. This includes recruiting and educating mental health professionals and paraprofessionals. Because they are so important in the lives of many older adults with mental health problems, The Center of Excellence should also provide training for health and aging services personnel. In addition, the Center would work with professional schools to improve education on geriatric mental health, provide technical assistance to organizations on best practices models, and serve as an information clearinghouse on practice, policy, research, and education.

Because they are 80% of the real workforce serving older adults with disabilities, we believe that the Center for Excellence should also provide supportive education to family and other informal caregivers. And we also believe that the Center should devote considerable attention to developing peer-to-peer models in which older adults—including those with mental disorders—help other older adults.

Training for primary care physicians is a critical part of the workforce development effort that should take place over the coming years. Most older adults with mental health problems who seek help at all (not a majority) go to primary care physicians first. Many physicians are unable to identify mental disorders, such as depression. In fact, 70% of older adults who complete suicide visit their primary care physicians within a month of their death. Obviously much needs to be done to help primary care providers. But this is far easier said than done. Training will need to draw from experience and research about how to educate them effectively.

Expansion of **services demonstration** grants makes great sense not only because it is one way of getting some service expansion and calling attention to best practice models. It also makes sense because 68 multi-organizational groups requested grants the last time around. This was the largest response to an RFP in the history of the Office of Mental Health. Only nine grants were funded. Obviously plenty of organizations are ready, willing, and able to provide innovative geriatric mental health services.

We believe, however, that there should be three modifications of last year's requests for proposals. (1) People with long-term psychiatric disabilities who are aging should be a target population. For example the RFP on integrating health and mental health could be broadened to include providing health care in mental health settings as well as vice versa. (2) Health and aging services organizations should be permitted to be lead agencies. And (3) applicants should be permitted—indeed encouraged—to use Medicare, Medicaid, and other funds in addition to grant funding to support their programs.

In general, efforts should be made to use all possible funding sources to support mental health services for older adults. From this point of view **Medicare optimization** is a no-brainer. Medicare does not pay for behavioral health to the extent one would expect. Only 3% of Medicare spending is for mental health or substance abuse services even though about 7% of all health spending is for behavioral health. And Medicare provides only 7% of all spending on behavioral health in this country even though 14% of the population has Medicare coverage. We know that many providers in NYS do not fully understand Medicare. Helping them learn how to bill appropriately has got to help NYS mount some of the needed additional services.

As we said, we support these preliminary steps toward a comprehensive geriatric mental health system, and we are glad that OMH and OFA have selected them as budget priorities for 2008-9. **But don't think that, because the Office of Mental Health and the Office for the Aging have announced them, they are done deals.** Not by a long shot! Those of us who care will have to work hard over the coming months to persuade the Governor and the Division of the Budget to include these proposals in the Governor's next budget request and to make a commitment to develop a multi-year plan to confront the challenges of geriatric mental health more comprehensively. Then we will need the support of the NYS Legislature.

There are also a number of critical items outside of OMH and OFA. These include continued access to psychiatric medications through both Medicaid and EPIC, an appropriation for housing to aid in nursing home diversion, inclusion of mental health services in long-term care reform proposals and in chronic health care initiatives, inclusion of older adults in the demonstration projects to integrate health and mental health services for high cost Medicaid cases, and more.

We urge you to **join the multi-year effort to build a comprehensive and integrated geriatric mental health system.** If you are not already a member, **please contact the Geriatric Mental Health Alliance of New York** to ask what you can do to help. Membership is free. Please call 212-614-5751 or E-mail center@mhaofnyc.org. And visit the Alliance's website for more information: www.mhawestchester.org/advocates/geriatrichome.asp.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of NYC and Westchester. He is also Chair of the Geriatric Mental Health Alliance of New York. Kimberly A. Steinhagen is Director of The Alliance. The opinions expressed in this column are their own and not necessarily the views of the MHAs. □

The Economics of Recovery:
How to Understand & Access Government Entitlements

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

Several years ago, the Center discovered that by plotting the earnings behavior of persons with psychiatric disabilities over time, then, overlaying key events in their lives to explain them, unlocks the dynamics of consumers in a new way. Their level of emotional functioning could be viewed as related to their level of earnings.

To accomplish this, the Center tracked five-hundred seventy Microsoft Office Applications' students over a five year period. Over fifty variables were measured including demographics, psychiatric diagnosis, employment history, government benefits received, Microsoft Certification, employment status, current earnings and more.

The students' annual earnings history was obtained from the Social Security Administrations' data base using form SSA-7004. Intake applications and personal interviews by the author completed the data gathering.

Of the some fifty variables measured, two factors were found to be critical to unlocking the dynamics:

1) The patterns of work history for Social Security Income (SSI) recipients are significantly different from those of recipients of Social Security Disability Income (SSDI).

2) Government policy varies significantly for SSI and SSDI recipients regarding earned income.

Our research found several dramatic differences between SSI & SSDI recipients. There was a significantly greater earned income across all life stages and events for the SSDI recipients. While the

Donald M. Fitch, MS

SSDI recipient's income rose quickly in their 20's, it rapidly declined in their 30's following the onset of illness. The initiation of their SSDI benefits halted this free fall and clearly provided a safety net and economic stabilization. (See chart below)

Microsoft Certified SSDI recipients were four times more likely to return to self-sustaining competitive employment, as the SSI Microsoft Certified recipients.

While both, SSI and SSDI recipients are considered by the Social Security Administration (SSA) to be disabled, i.e. unable to engage in competitive employment, generally, SSDI recipients have more than ten years (40 quarters) of work history whereas SSI recipients have much less.

Study variables which may explain this are the significant differences between SSI and SSDI populations in the years of education and competitive employment, severity of functional impairment/diagnosis and barriers of government policy regarding the economics of recovery. (See below)

With a $900/Mo cap on earned income for SSDI recipients, the economics of recovery demonstrates the feasibility of transitioning off disability to self-sustaining taxpayer status following the acquisition of sufficient marketable skills to earn at least $14/hr. and the endurance to work at least 35 hrs a week.

As the chart indicates, SSI recipients, in addition to being challenged to overcome their fewer years of schooling and work experience and, their greater severity of symptoms, are faced with a net loss of earnings even with the Medicaid buy-in elimination of the spend down.

Analysis of the macro-economics of recovery for SSI recipients reveals SSA's earnings penalties (after 1-2 years), is to deduct one-half of the Consumers' gross income after eighty-five dollars, each month. HUD's Section 8 housing program policy requires the consumer to pay 30¢ of each dollar earned.

Together, these two benefit programs take 75¢ out of each dollar earned. Payroll deductions, taxes, etc. and other expenses associated with employment; travel, meals, clothing, personal, etc. create a barrier so formidable that persons on SSI actually loose money when they try to work their way off of Government benefits.

Implications

Insure all intake, supported employment, academic research, PRO's, etc. include data on the various government benefit programs; SSI, SSDI, Section 8/Shelter Plus, Food Stamps, Medicaid/Medicare, Prescription Drug Benefit, etc. and their earnings/work history. Run these data using analysis of variance, multiple regression and mapping where possible. Mining Social Security's lifetime earnings tracking system data base (SSA-7004) provides an excellent research venue to verify these findings.

Be aware that combining the SSI, SSDI (and Welfare) populations, whether in research or recovery, averages out their dynamics. The increased clarity in understanding their uniqueness has enabled us to tailor our training, techniques, staff assignments, expectations and timetables to optimize our limited funds.

Legislation to remove significant economic disincentives for SSI recipients is still critical. The Medicaid Buy in, Pass Plan, 1619b, Ticket-to-Work, etc. do not address the enormity of this issue.

Recommendations

From our data, business analysis and experience we have formulated two recovery strategies for these populations.

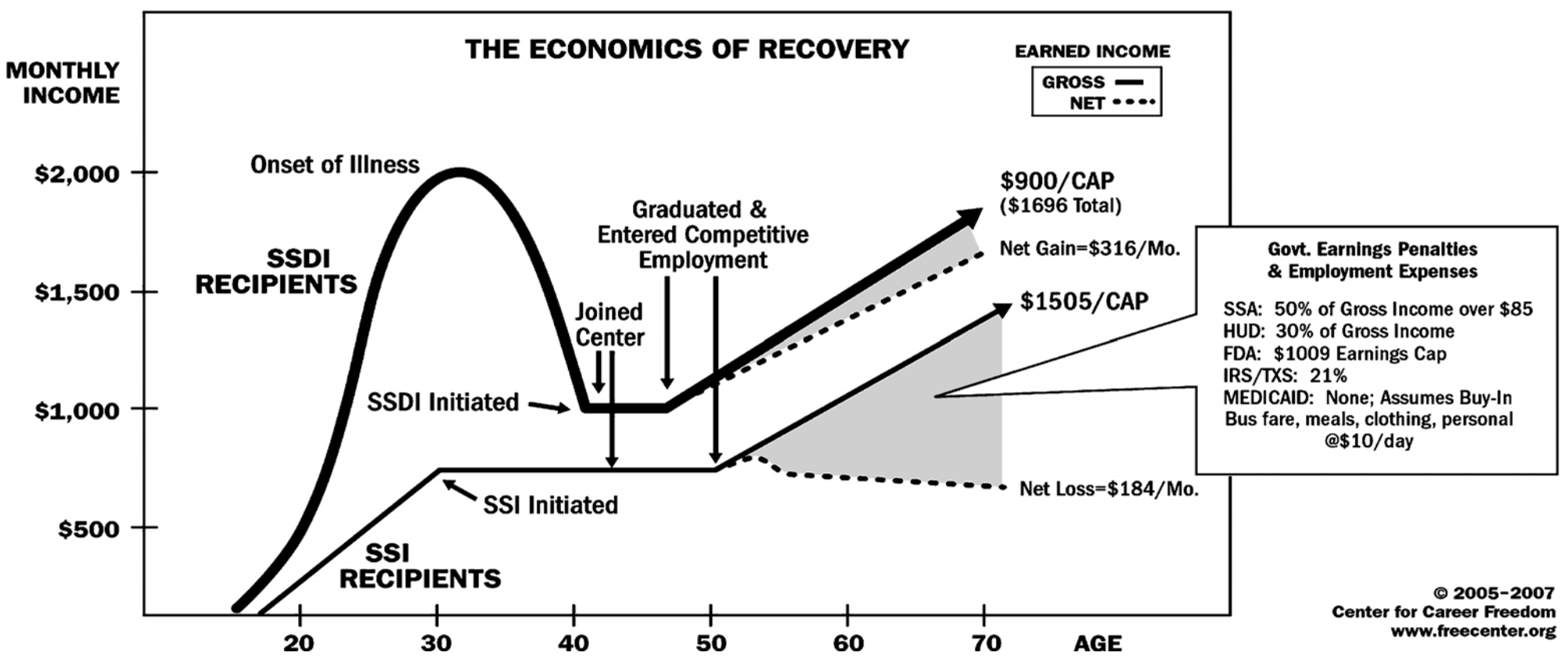
SSDI Recipients: Build upon their education and employment experience, update their work skills and provide extended supported employment, (funded for longer than 90 days).

SSI Recipients: Design a recovery program to address their fewer years of education, work experience and skills, and their more severe functional impairments.

In the US, of the 10 million people 18-64 years with disabilities, reportedly most (70%) would like to return to work. However, about seven million disabled people on SSI cannot because of the cumulative earnings penalties stipulated by the Social Administration and the Housing and Urban Development Corp.

The Social Security Administration estimates that if ½ of 1% of the seven million persons on SSI return to competitive employment, the contribution to the Social Security Trust Fund would be thirty-billion dollars.

Until legislation can be passed to eliminate these barriers, waivers for a model demonstration Back-to-Work program which reduces/eliminates their earnings penalties should be pursued. □



THE MENTAL HEALTH LAWYER

The Psychiatric Advance Directive

By Douglas K. Stern, Esq.
Abrams, Fensterman, Fensterman, et al.

Today, the need to plan for the unexpected is more important than ever before. We buy insurance, save for our children's education, execute Wills and save money for retirement all in an effort to ease our family's burden in a time of need. Individuals and families who struggle with Bipolar illness learn very quickly that treatment is a lifelong commitment.

In 1991, Congress enacted the Patient Self-Determination Act which requires all states receiving Medicaid and Medicare funds to inform individuals that they have the right to execute advance directives relating to their future healthcare decisions. Generally, an advance directive is a legal document that becomes effective when an individual loses decision making capacity. The advance directive can relate to any healthcare related decision including, where one will receive care, how care will be administered and even end-of-life decision-making. Additionally, a Healthcare Agent can be appointed to serve as a healthcare decision-maker to ensure that the author of the advance directive, the "creator's," expressed preferences and wishes are followed during times of mental incapacity. When care and treatment of a mental illness becomes an issue, the following question has developed - since psychiatric care is a subset of healthcare, is there a legally competent method of specifically addressing an individual's need to plan for future psychiatric care and treatment?

The concept of the Psychiatric Advance Directive (PAD) is not specifically defined by the Federal statute but is believed by many to be a natural progression in the trend to allow individuals to plan in advance for their care and treatment. To date, most states have developed their own laws which create the process by which individuals can execute advance directives for general medical healthcare decision making, but only a minority of states recognizes the PAD.

New York's Public Health Law defines the parameters for general medical advance directives within the state. There is no specific reference or authority to create a PAD or to incorporate specific psychiatric instructions within a general medical advance directive. The courts, to date, have been silent as to the validity of the PAD or an advance directive with psychiatric instructions, as an advance planning tool. As a result, the advance directive with psychiatric instruction or the PAD's validity in New York, from a legal perspective, is still in question. Nonetheless, the concept of the PAD or including psychiatric instructions within a general medical advance directive has many significant functions and should not necessarily be dismissed.

Douglas K. Stern, Esq.

Why is the Psychiatric Advance Directive Useful? The PAD and other similar documents help to empower an individual to assess and take control of many elements of possible future psychiatric treatment and allows for meaningful discourse amongst treatment recipients, loved-ones and healthcare providers. This exchange can result in written instructions to treatment providers of the creator's preferences and wishes regarding psychiatric treatment when he/she becomes incapacitated. The Healthcare agent, usually a relative or someone close to the creator, can be a helpful source of information in dealing with the complex and sometimes difficult nature of acute or long-term psychiatric treatment. The PAD has the potential to create treatment efficiency by notifying treatment providers of the success or failure of certain medications, treatments and programs previously experienced by the creator. Furthermore, when loved-ones and treatment providers are made aware of the creator's preferences and wishes they can better formulate a comprehensive treatment plan when the creator becomes incapacitated and needs psychiatric care and treatment. Additionally, there is the potential to minimize the need for crisis management and police and/or judicial intervention.

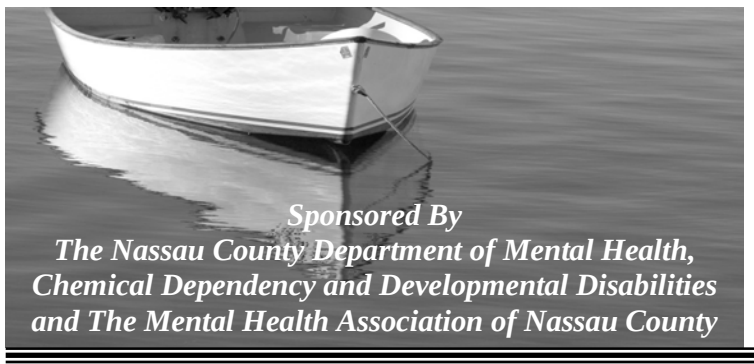
According to the Bazelon Center for Mental Health Law, the following criteria should be considered and addressed when executing a PAD or similar advance planning tool: [1]

- Designation of a Healthcare Agent.
- The authority granted to the Healthcare Agent.
- Preferences should there be a need for a Court Appointed Guardian.
- Preference for a treatment facility– should inpatient treatment be necessary.
- Programs as alternatives to inpatient treatment.
- Preference for a treating psychologist/psychiatrist.
- Preference regarding ECT.
- Preferences regarding emergency intervention (restraint, seclusion, etc.).
- Consent for experimental studies.
- Who should be notified immediately if hospitalized.
- Temporary custody of children while hospitalized.
- Preference as to revocation of the PAD during incapacity.
- Duration of PAD generally, regardless of incapacity.

The key elements of the PAD are the nomination of a healthcare agent, the authority to be given to the healthcare agent and a statement as to the revocation and/or expiration of the PAD. Optional elements, but of great importance, are all of the categories dealing with stated preferences. The essence of the PAD is the ability for the creator to convey his/her preferences and wishes to the Healthcare Agent. For example, statements as to whether a particular medication is helpful or harmful to the creator, whether one inpatient program is preferred over another or who the treating psychiatrist should be, will guide the Healthcare Agent in consenting to or arranging for care and treatment.

Unfortunately, there are several unanswered questions that leave the future of the PAD and similar devices in question. These unresolved issues run the gambit of legal, ethical and medical concerns. Primarily, the controversy surrounds the administration of medications, the use of seclusion and restraint and the need for involuntary hospitalization. It is unclear as to whether the PAD or similar devices can preempt existing laws that currently govern in these areas. Because, the New York State Legislature and the courts have given us little guidance in this area, proponents of the PAD will have to work diligently to educate the public, healthcare providers and our lawmakers to garner support for the PAD to make it a generally acceptable advance planning tool. □

[1] It should be noted that these are not necessary criteria but areas to be considered. Any individual executing a PAD should insure that the PAD complies with the formalities of their state's law regarding healthcare directives and/or consult a professional.



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Nassau County Section

Essentials for Working With Adolescents

By Andrew Malekoff, LCSW, CASAC
Executive Director and CEO, North Shore Child & Family Guidance Center

Andrew Malekoff, LCSW, CASAC

Adolescents diagnosed with bipolar disorder and other serious emotional disturbances can benefit from a well-planned medication management group. However, as with any group membership, if they feel as though they are participating on an involuntary basis they may not take best advantage of such a group.

Involuntary group members are a staple for group workers who work with adolescents. Typically, an outside sanctioning force is their "motivation" for attending a group. This might include the threat of a court order, legal action, or less ominous but equally compelling pressure from parents or other adults in positions of authority.

Resistance is manifest in a variety of ways including denial of the problem (i.e. regarding drug use), superficial compliance, testing the limits, silence, externalizing the problem (i.e. blaming others), minimizing, and devaluation of the group worker and or group.

Approaches to be aware of that are considered unsuccessful with involuntary group members include those that 1. focus only on insight and don't include problem solving and pro-social dimensions, 2. interventions without a clear purpose, 3. a pessimistic view by the worker of the group member's capacity to change, 4. a sole focus on the individual rather than the family and social context as contributing factors, and 5. ambiguity about the role of the worker as a social control agent or helper.

Overcoming resistance among involuntary group members requires worker authenticity and a sense of trust and safety in the group. Group members need to be clear about how the worker's authority might be used with respect to understanding the balance between help and social control (e.g. being held accountable, as in a drug program that administers urine testing). Clarity of purpose and developing a clear and explicit contract makes a difference, especially when feedback from group members is welcomed and important issues such as confidentiality are discussed openly. Following is an illustration.

When involuntary group members feel in control of their fate their motivation increases. Although it was not their choice to join the group, it can be their choice to participate freely once there. Motivating involuntary group members is a delicate dance of locating the resistance, setting manageable goals, demanding work, being sympathetic, using humor, holding group members to imposed sanctions, and building a culture of mutual aid that fosters playfulness, a sense of safety, and movement towards taking risks.

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The North Shore Child and Family Guidance Center is located at 480 Old Westbury Road, Roslyn Heights, NY 11577. To phone call (516) 626-1971. Andrew Malekoff, LCSW, CASAC is author of Group Work with Adolescents: Principles and Practice. Now in its second edition, the book was chosen as a main selection by the Behavioral Science Book Club. □

A group worker who was about to begin an adolescent "medication management" group wondered, during a group supervision meeting that I was leading, how such a group could work, "Everybody I talked to said the same thing: 'Medication management groups don't work. None of the kids ever want to be there. They feel that all it's about is monitoring compliance, you know that their taking their meds." After a sigh he continued, "The resistance is just too great. Their parents make them come and even some of them seem ambivalent." After an exploration of needs, a group purpose started to come into focus that lifted his confidence a bit. The tentative purpose included: 1. gaining knowledge about medications and their side effects through education, 2. overcoming stigma, 3. developing simple language to explain their medication and its function to questioning peers, 4. learning to effectively mediate with the school (i.e. to arrange for medication to be taken, for example, without announcing it to the "whole world" on the public address system), and 5. developing refusal skills to prevent them from using alcohol and other drugs. As the purpose took shape and reflected some of the needs and wants of the group members, their resistance lessened. They recognized that the group could be about more than, "just making sure we take our medication."

Diagnosing Bipolar Disorder

Tina Reich, PhD, Director
Nassau-Suffolk Mental Health Center

Bipolar diagnosis has changed since most of us have had our training. Studies have shown that it takes the average bipolar patient 7 years to be accurately diagnosed. The classic patient who presents in a manic episode is easy to diagnose. However, most bipolar patients present when in a depressive episode. Research has indicated that depressive episodes increase over the life span, and therefore, we are more likely to see a bipolar patient during a depressive episode. Also depressive symptoms are more ego dystonic to patients, and they will present for treatment more at those times. Accurate diagnosis is crucial in terms of how a patient is medicated. Bipolar patients, at best will be partial responders to antidepressants, and at worst, antidepressants may precipitate manic episodes or more rapid cycling.

There are several ways to improve the accuracy of our diagnosis. The most important is to take a complete history. Are there family members with a bipolar diagnosis? There is a strong genetic component. First degree relatives may be ten times more likely to share the diagnosis, then the general population. Also it is very important to take a detailed history of the patient's symptoms. You need to look for the presence of other depressive episodes. Also the occurrence of two types of depression in the same patient may signal the presence of a bipolar disorder. Patients may experience a depression characterized by underactivation, apathy, withdrawal, amotivation and also experience and an overactive depression, characterized by irritability, anxiety, restlessness, and a racing, "jump out of your skin" feeling.. In this regard it is important to note that manic states often do not include "highs" or up moods. The patient may present with a dysphoric agitated state. The patient may describe mood instability and lability. Also manic symptoms may be more ego syntonic to the patient. They may not report to you shopping sprees or periods of sleeplessness and "intense creativity." A history of substance abuse, gambling, instability in relationships may also indicate a bipolar diagnosis, if combined with the affective instability.

Another suggestion is to have the patient fill out The Mood Disorder Questionnaire, at your first consultation. Studies have shown that patients often reveal more to a self-report instrument than in a clinical interview. The presence of at least 7 "yes" answers, coupled with "yes" on Question 2, plus "moderate" or "serious" on Question 3, may be indicative of a bipolar disorder diagnosis.

With a little more effort (and some "detective work") each one of us can become experts in diagnosing this complex, and often hidden disorder. □

Preventing Medical Emergencies: Lithium Toxicity

By Colm James McCarthy
Emergency Medical Technician

Colm James McCarthy

Lithium was the first medication made available to treat mania. Many physicians still regard it as one of the most effective medications in all of psychiatry. Lithium is taken orally and the pills dissolve in the GI tract and are absorbed from there into the blood. Since lithium is a salt, it is eliminated from the body by the kidneys. Lithium's half life in the body (the amount of time to reduce the total amount of lithium by 50%) ranges from 12-27 hours. In the elderly and those suffering from kidney disease, the half life can be considerably longer.

There is no "right" lithium dose for everyone. Rather, a simple blood test is required to monitor lithium's concentration in the blood. This allows doctors to lithium doses are individually adjusted to achieve an effective blood level. The therapeutic serum level is between 0.7-1.4 milli-equivalents per liter (mEq/L). The upper levels are often used to control acute mania. Once the dose necessary to achieve an effective level is found, blood tests continue but less frequently, because the toxic level common begins around 1.5 mEq/L or, sometimes, even lower. The toxic level is very close or even overlaps the therapeutic range. . Too much lithium may cause toxicity but too little may lead to relapse into mania. Since there is a very small difference between the amount of lithium that can be helpful and the amount that can be harmful (technically called a narrow therapeutic index), lithium must be closely monitored. Nevertheless, every year in the United States there are approximately 10,000 cases of moderate to sever lithium toxicity, and 20% of these cases occur in children younger than 19 years old. These cases of toxicity may be the result of intentional or accidental overdose or they may be the result of other factors that may contribute to the development of elevated lithium levels.

What are the signs of lithium toxicity?

- Shaking and trembling
- Nausea and Vomiting
- Slurred speech
- Confusion
- Abdominal pain
- Diarrhea
- Weakness, fatigue and lethargy
- Unsteadiness on the feet
- Uncoordinated movement of the hands and arms
- Muscle twitching, and seizures
- Coma

The early signs of lithium toxicity are diarrhea, vomiting, drowsiness, muscular weakness, and lack of coordination. As the toxicity worsens the more severe igsof toxocoty are seen. These include failure or irregular muscle action, giddiness, tinnitus (ringing in the ears), blurred vision, and a large output of dilute urine. All of these signs worsen as the amount of lithium in the blood increases. Fortunately, most cases of lithium toxicity have a very good outcome, but up to 10% of individuals with severe toxicity will develop chronic neurological problems.

What should you do if some may be toxic? What will happen to them?

If you or a loved one has these symptoms of lithium toxicity, do not take any more lithium unless you are told to do so by your doctor, but do drink a few glasses of water. Immediately go to a hospital, even if you are not sure if you are really toxic. . (Better safe than sorry). If someone can not drive you there call 911 and have the police take you. Potentially toxic patients should not drive. Bring all medication bottles (including all over the counter medications bottles) to the hospital.

Once you have arrived at the hospital, your blood test will be taken and the medical staff will monitor your heart and level of consciousness. Typically you will receive IV fluids and in very severe cases, renal dialysis. Patients with suspected lithium toxicity are usually observed for at least 24 hours to make sure they are fine and most patients recover within this time. However, in severe cases, clinical improvement may take up to three weeks.

How to prevent lithium toxicity.

The best emergencies are those that do not happen and prevention of lithium toxicity is relatively easy.

see Emergencies on page 26

1 in 5 People
Will Experience a Mental Illness

Photography by Jean Miele

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The Development of Resiliency in Adolescence

By Barbara Greenberg, PhD
Four Winds Hospital
Program Director of Adolescent Unit

Anne Frank clearly describes a resilient mindset in her diary: "I have lots of courage, I always feel so strong and as if I can bear a great deal, I feel so free and so young! I was glad when I first realized it, because I don't think I shall easily bow down before the blows that inevitably come to everyone." (Frank 1993, 260)

While this courageous young girl was able to describe her ability to deal with adversity, many adolescents also face their struggles with hope and competence. While almost all adolescents experience this time period as tumultuous, nonetheless most grow into adulthood with the ability to face struggles boldly. Adolescents that are encouraged to navigate this time with courage, often development a set of strengths that they are able to tap into for the rest of their lives.

Resilience is the ability to adapt successfully to difficult or challenging life events. As parents, we are in the unique position of teaching our children the qualities that will assist them in bouncing back from disappointments and thriving even when faced with pressure and challenges. Our goal, of course, is to raise children who will deal with problems without acting in self-destructive ways. The most effective way of teaching our children to be resilient is to role-model resilient attitudes and problem solving styles. Clearly as Bandura, 1977, stated; individuals are most likely to imitate those behaviors that result in successful outcomes. Thus, as parents we are in the unenviable position of being the most important role models for effective behavior for our children.

Parents often wonder what these resilient characteristics are. The answers are not necessarily what one would expect. Consider for example, modeling what Siebert, 1966, describes as the ability to respond flexibly in any situation. This is the ability to act one way or another depending on what the situation calls for. So, it is important to model being sensitive and unreactive, shy and bold; the same holds true for all behaviors. Demonstrating the use of all types of behaviors teaches children to be flexible. Flexibility leads to adaptability, which is the key characteristic of anyone who is able to meet the challenges of daily life in a healthy, competent manner. Consider: there are situations in which being serious is more adaptive and others in which being silly can defuse a difficult atmosphere. There are situations in which it is helpful to appear involved and others in which it is helpful to present as less interested. When considering the qualities of those who appear to get through the day effortlessly one often thinks of those who in adulthood maintain the playfulness of children and the wisdom attained in adulthood.

Keep in mind that you are more likely to raise thinking, highly resilient children, if you yourself model an ability to tap into a varied repertoire of responses including playful buoyancy, seriousness, and other varied behaviors as they seem appropriate for the situation at hand.

It is my belief that all children are born with the ability to be resilient. It is an error to believe that one is either born with resiliency or with a deficit in this trait. Like any other skill, resiliency, the ability to rise above adversity and to recover and to function following setbacks, can be taught.

In an effort to foster our children's ability to thrive and experience pleasures in our less than perfect world, there are many things that we as parents and practitioners can do. First and foremost, the child needs to know that you believe in him/her. This also involves the ability to tolerate your child's mistakes and sometimes mishandling of situations. You must resist the urge to take over and handle all difficult situations for your child. You want to give the child the message that you believe in her and that you would like to see her attempt to manage the situation. Over time, the child will become more proficient at dealing with the subtleties inherent in complicated situations. If you consistently take over situations, the child is getting the message that you don't believe in them and that they are incompetent to handle situations. Children and their parents must learn to tolerate ambiguity and the lack of a quick solution to most problems.

In therapy with adolescents, it is crucial that therapists assess the child's strengths and help the child build on these. Typically, when adolescents are brought to therapy; they feel inadequate having been unable to negotiate peer and/or familial problems. They often feel overwhelmed by school and other issues.

The goal of therapy then should be to help the adolescents understand and interpret social situations accurately. Many distort situations and feel that others dislike them when this is actually not the case. Many also feel terribly misunderstood by their parents. The goals in this case is to teach the children how to communicate honestly and precisely with their parents. Teaching adolescents how to interpret situations accurately and how to make them understood adds two significant strengths to their repertoire of positive skills. As they get more and more practice using these skills they will become more confident as they gain a higher level of social understanding and an improved ability to be understood by others.

Additional strengths that adolescents can learn in therapy are the ability to tolerate ambiguity, emotion and disappointment. Learning that these experiences are common to all is often a surprise to the adolescent who feel that they are alone with their feelings of unpleasant emotions, lack of clarity, and disappointments. In therapy, they can be taught to engage in positive self-talk, despite having experienced frustrations and unpleasant situations. Positive self-talk can lead to positive expectations and optimism. Optimism, in turn leads to a tendency to both try new and engage in new activities and an overall sense of confidence and resiliency over time. The optimistic child is less likely to retreat significantly following a setback. This child is more inclined to forge ahead and expect success.

As our adolescents learn new skills to cope with the occurrences of daily life, they are also learning how to deal with adversity. As one feels confident in the ability to handle everyday events, this overall feeling of confidence will foster a sense of resiliency. When the adolescent begins to believe that she has a sense of mastery over most situations; she will recover more quickly from adversity with the sense that she will return once again to leading an effective, competent life. □

FOUR WINDS HOSPITAL • FALL 2007

October 2007

GRAND ROUNDS

Friday, October 12 • 9:30 - 11:00 am

Bullying Prevention: Hidden Dangers, Unseen Opportunities

Andrea Fallick, LCSW, CASAC, CPP

Assistant Director for School Based Programs, Student Assistance Services; Certified Olweus Bullying Prevention Trainer Assistant Director for School Based Programs, Student Assistance Services; Certified Olweus Bullying Prevention Trainer

This session on bullying will provide practical information and skills to mental health professionals, school personnel, administrators, and others who are concerned about the effects of bullying on children who bully, targets of bullying, and bystanders. Drawing on research and theory this workshop will help participants to:

- Examine the short and long term effects of bullying on children.
- Understand how to identify the wide range of bullying related behavior and how one can intervene in the schools, private practices and in other programs to help children who are the targets of bullying or who bully others.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

SPECIAL TRAINING

Thursday, October 18

9:30 am - 12:00 pm

Child Abuse Identification and Reporting

Valerie Saltz, L.C.S.W.

Four Winds Hospital

New York State recognizes certain professionals to be specially equipped to hold the important role of mandated reporter of child abuse or maltreatment. These include Mental Health Counselors, Marriage and Family Therapists, Creative Arts Therapists, Licensed Social Workers, Physicians, Dentists, Psychologists, RN's, School Administrators, Teachers, etc. A State Education Department Certificate of Completion will be given at the end of the class.

Fee: $45.00 payable to the Four Winds Foundation, a not-for-profit organization

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Registration is Required for All Programs.

Please Call 1-800-546-1754 ext. 2413.

Register online at www.fourwindshospital.com

November 2007

GRAND ROUNDS

Friday, November 9, 2007 • 9:30 - 11:00 am

Post Traumatic Stress Disorder: How To Help Our Veterans Recapture Their Lives

Larry Winters, BPS, LMHC

Senior Clinician, Four Winds Hospital, Katonah, NY;
Vietnam Veteran and Author, *The Making and Un-Making of a Marine*

There have been 250,000 troops deployed in Iraq since the beginning of the war, making the number of veterans returning home to their lives ever increasing. What is the fate of these men and women after they have finished serving our country? How can we integrate these men and women back into our culture? At the conclusion of this program participants should be able to:

- Identify and describe the physical, psychic and spiritual pain soldiers carry.
- Understand the significance of PTSD, addiction and other mental health conditions as risk factors for veterans.
- Explore ways for our veterans to reintegrate into their worlds.

Fee: $15.00 payable to Four Winds Hospital

1.5 CME Credits Available

Book Sale Following Lecture

GRAND ROUNDS

Friday, November 30 • 9:30 - 11:00 am

Confronting Illness and Disability: Coping and Resiliency Strategies for Older Adults

The Werner & Elaine Dannheisser Memorial Lecture Series

David Drassner, Ph.D.

Psychologist in Independent Practice, Rockland County, NY;
President, Rockland Resiliency Institute

Older adults often confront illness and disability challenges, which precipitate or are concurrent with other stressors in the emotional, financial, family, social and occupational domains. While themes of loss and decline are often associated with such life events, these experiences can also be transformative in eliciting coping, resilience, and for many, the perception of "derived benefits" despite adversity. This program will enable participants to:

- Explore the nature of "invisible disability."
- Enhance their knowledge of the "posttraumatic growth paradigm" and the positive transformative potential inherent in overtly adverse events.
- Enhance counseling and intervention strategies, which amplify coping and resilience in older adults.

Fee: $20.00 payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

This lecture is made possible by a Grant from the Werner & Elaine Dannheisser Testamentary Trust Fund.

Community and Professional Education Programs

December 2007

SPECIAL EVENT

Friday, December 7 • 9:30 - 11:30 am

West Side Story at 50: The Mind and Music of Leonard Bernstein

Richard Kogan, M.D.

Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital; Private Practice, New York City

Composer, conductor, educator, and pianist, Leonard Bernstein was one of the most brilliantly gifted and charismatic figures in all of classical music. And yet, in spite of his dazzling achievements--probably the greatest conductor of his generation, the composer of *West Side Story, Mass, The Age of Anxiety,* and other masterpieces, a television personality who opened the world of classical music to millions--he himself was never fully satisfied with his accomplishments. How did Bernstein's complex inner--and outer--life affect his work as a composer? How do we hear this in his music? In this lecture and concert, on the occasion of the 50th anniversary of the Broadway premiere of *West Side Story,* Dr. Richard Kogan will examine Bernstein's genius, giving a psychiatrist's perspective on Bernstein's often-conflicted personality. Illustrating his insights, he will perform some of Bernstein's greatest music. This program will enable participants to:

- Understand some of the fundamental concepts about creativity.
- Recognize the psychological factors that influenced Bernstein's artistic development.

Fee: $20.00 payable to Four Winds Hospital

2.0 CME Credits Available

Albert Einstein College of Medicine designates each continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

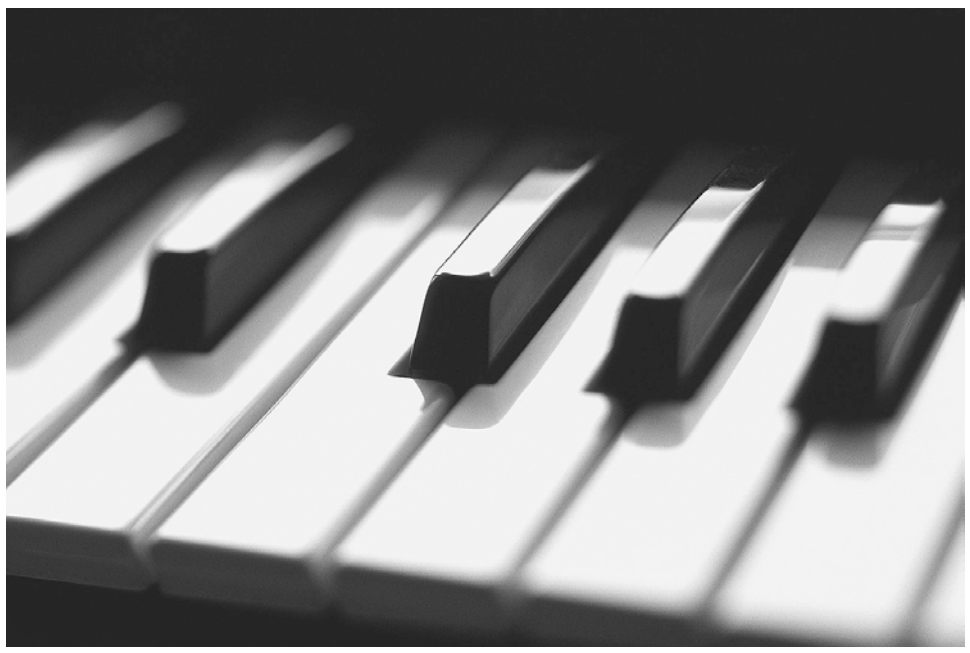
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

A Bravura Musical Performance and a Mental Health Lecture

Pianist and Psychiatrist Dr. Richard Kogan Appear at Four Winds

By Eve Marx
This article was originally published in the Record Review



Shamans used music as medicine, said Richard Kogan, M.D., referring to the unique connection between music and the mind. Dr. Kogan speaks of what he knows. A storied psychiatrist and Director of the Human Sexuality Program at Weill-Cornell Medical Center and New York Presbyterian Hospital, the doctor is also an acclaimed concert pianist. On December 8th he visited Four Winds Hospital in Cross River to play for a packed house of therapists, doctors and psychiatric social workers who came to hear him discuss the mind of George Gershwin, one of the century's greatest composers and a sufferer of impulsivity, inattentiveness and hyperactivity.

Alternately seated in front of a baby grand piano or standing behind a podium, Dr. Kogan explained that George Gershwin's childhood could have "gone off the rails if not for music." The Gershwin household was peripatetic to say the least. Madcap socializers and petty gamblers, the family moved 28 times before George turned 18. "The children raised themselves," Dr. Kogan said. "The parents were too busy living their own lives."

Early on, George displayed behavioral problems. Today he would have been dosed with Ritalin. Ira, his older brother took on the role of parent, a role he would have throughout the two brothers' lives. When George was quite young, he became friends with a boy who played the violin and George was able to persuade his parents to pay for piano lessons. As soon as he took up the instrument, many of his most egregious behavioral problems disappeared.

George Gershwin's ego was enormous. At first it surpassed his talent. "He was convinced of his own excellence even before he was very proficient," Dr. Kogan said. Gershwin dropped out of school at 15 to become a song plugger on Tin Pan Alley. It was the heyday of sheet music and he was soon hired to annotate the music of Irving Berlin. Early on, he chafed at the notion of playing other peoples' songs, so the job didn't last long.

While still in their teens, George and Ira Gershwin hit the ground running as a song writing team. Ira was a stabilizing force in his brother's mercurial life. They got a big break when Paul Whiteman assembled a panel on American music and George composed "Rhapsody in Blue," as his contribution. One of Gershwin's great gifts, Dr. Kogan said, was, "His remarkable ability to construct music out of what other people would perceive as noise."

A gifted pianist in his own right, Dr. Kogan held the audience in rapt attention with selections from "An American in Paris," "Rhapsody in Blue," and "Porgy and Bess." Many closed their eyes to better absorbed the music and allow it to wash over them. It was very healing just to be there, listening. In between songs, Dr. Kogan spoke of Gershwin being a bundle of nervous energy and retold Gershwin's famous remark regarding the jerky, fast pace of much of his music. "We live in an age of staccato not rigatto," Gershwin said.

Gershwin, the individual, he said, was sometimes hard to take. "He bragged constantly about his sexual prowess, never giving up his bachelor status," the psychiatrist said. "He was rude and liked to keep people waiting and he spoke about himself in the third person." And yet the man was staggeringly compelling and appealing and maintained an extraordinarily close relationship with his family, even if they were exhausting. "His father was not too swift," Dr. Kogan said.

George Gershwin experienced his first spells of depression at the age of 35, for which he sought psychiatric treatment. He was in therapy five times a week for a year before he decided it was interrupting his creative processes. He moved to Hollywood to score films, work he found emotionally unfulfilling. By then the brain tumor that eventually would kill him was causing him to have headaches and experience memory loss. Composing right up until the moment he checked into Cedars Lebanon Hospital in Los Angeles, he was deemed such an important patient that no neurosurgeon felt qualified to operate. Gershwin died rather quickly at the age of 38, leaving behind an legacy of music that continues to bring in royalties to this day. His ego being too great to have planned for his demise, Gershwin died intestate, all his property passed to his mother. He is interred at the Westchester Hills Cemetery in Hastings-on-Hudson. His music lives on, elevating spirits and transporting audiences, not just at Carnegie Hall, but in the conference room of Four Winds.

For more information about the hospital's Grand Round series which begins again in the spring, contact the marketing department at 1-800-546-1754, ext. 2413. For copies of Dr. Kogan's new DVD, "Music & the Mind," a unique presentation and performance featuring the life and works of classical composers, contact TouchStar Productions at keb@touchstarpro.com. □

SAVE THE DATE!

St. Vincent's Hospital Westchester and
The Westchester County Office of Hispanic Affairs
Present:

The First Latino Mental Health Summit

Cumbre Latina de Salud Mental

Thursday, October 18, 1:00 p.m. to 5:00 p.m.

St. Vincent's Hospital Westchester
275 North Street, Harrison, NY 10528

Topics will include:

- Emotional Impact of Immigration on Westchester's Hispanic Families
- Effects of Substance Abuse on the Latino Family
- Resistance and Engagement Strategies: Accessing Agencies and Services

The conference will conclude with an interactive panel discussion of available support services and how to access them on behalf of Latino and immigrant families. The panel (in formation) will include representatives from area private and public agencies.

There is no cost to attend this presentation, but pre-registration is required by October 5. *SPACE IS LIMITED.*

Please register by email to tezekiel@svcmcny.org or call (914) 925-5051.

Westchester gov.com
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275 North Street, Harrison, NY 10528
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Weill Cornell Psychiatry (888) 694-5700

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NewYork-Presbyterian
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Columbia Psychiatry

NewYork-Presbyterian Hospital/ Columbia University Medical Center
622 West 168th Street
New York, NY 10032
212-305-6001

NewYork-Presbyterian Hospital/ The Allen Pavilion
5141 Broadway
New York, NY 10034
212-305-6001

New York State Psychiatric Institute
1051 Riverside Drive
New York, NY 10032
212-543-5000

Weill Cornell Psychiatry

NewYork-Presbyterian Hospital/ Weill Cornell Medical Center
Payne Whitney Manhattan
525 East 68th Street
New York, NY 10021
888-694-5700

NewYork-Presbyterian Hospital/ The Westchester Division
Payne Whitney Westchester
21 Bloomingdale Road
White Plains, NY 10605
888-694-5700

The Mental Health News

New York City Section

NYC's Efforts To Combat Bipolar Disorder Focus On Recovery

By Jorge R. Petit, MD and Jody Silver

Jorge R. Petit, MD

Like all mental illnesses, bipolar disorder poses particular and difficult challenges. The extreme mood swings characteristic of this disorder can lead to risky behavior, damaged relationships and careers -- and even suicidal thoughts and attempts if the disorder is not treated adequately or in a timely fashion.

But we know that individuals with bipolar disorder (an estimated 84,000 adult residents of New York City suffer from the disorder over the course of one year) can lead productive and fulfilling lives. Recovery from bipolar disorder, as with any mental illness, is more likely if the disorder is treated effectively with therapy, medication and peer support -- and if all stakeholders in the mental hygiene system are committed to recovery.

New York City's Department of Health and Mental Hygiene (DOHMH) is committed to helping consumers work toward recovery from bipolar disorder and all other forms of mental illness. Indeed, many programs at the Department's Division of Mental Hygiene (DMH), including housing, peer support and health and wellness initiatives, help consumers do just that.

For individuals with bipolar disorder who are homeless, getting off the street and into housing is often a crucial first step in recovery. DOHMH, along with other city agencies, is part of New York/New York III, a City-State partnership that will transform the landscape of supportive housing in the City by creating 9,000 new supportive housing units over the next 10 years. The program will serve those with a mental illness, as well as populations never previously served by government supportive housing programs in New York City, such as those who have both a mental illness and a substance use disorder.

Clubhouses and other programs can help those who are working toward recovery by employing peers with personal experience in the mental hygiene system who serve as positive role models and offer hope. DMH funds 37 clubhouses at agencies throughout the City. These clubhouses offer informal gathering places where consumers partner in their own healing by sharing experiences and helping one another navigate the social service system, as well as providing needed employment, education and social supports.

DMH's Office of Consumer Affairs focuses on strengthening the role of consumers in their own recovery. Last year, the OCA launched the Recovery Pilot Project, in which peer staff work in continuing day treatment programs to accelerate consumers' recovery. With support from the OCA and local agencies, peer facilitators worked at two day treatment programs. We are currently evaluating the program and plan to expand it. To further demonstrate the benefits of employing consumers, DMH is introducing this fall a transitional employment position within the Division itself that will be filled by two or three consumers working part time. This experience will hopefully help the consumers find permanent jobs.

Recovery from mental illness can also improve physical health. Indeed, physical health and mental health are inseparable. Individuals in the public mental health system can lose between 13 and 30 years of potential life, according to an article in the journal Preventing Chronic Disease that evaluated public health data in eight states. DOHMH is doing something about it. This year, along with community partners, the OCA is sponsoring a yearlong series of workshops on health, wellness and recovery. Specific workshops focus on empowering consumers to take control of their own health, learn stress-reduction techniques and understand the side effects of psychiatric medications.

In June, the Office of Consumer Affairs, along with the New York State Office of Mental Health, the New York City Health and Hospitals Corporation and a host of other groups, also sponsored a daylong conference on peer specialists working within the NYC human service arena at Hunter College in New York City. Specific workshops at the conference focused on professional development and recovery.

The President's New Freedom Commission on Mental Health called for recovery to be the "common, recognized outcome of mental health services" in the United States. Consumers in New York City and across the country, no matter what their mental illness, deserve nothing less.

Dr. Petit is Associate Commissioner for Mental Hygiene at the New York City Department of Health and Mental Hygiene. Jody Silver is director of the Office of Consumer Affairs at the Department's Division of Mental Hygiene. □

Bipolar Spectrum Disorder May Be Underrecognized and Improperly Treated

By The National Institute of Mental Health (NIMH)

A new study supports earlier estimates of the prevalence of bipolar disorder in the U.S. population, and suggests the illness may be more accurately characterized as a spectrum disorder. It also finds that many people with the illness are not receiving appropriate treatment. The study, published in the May 2007 issue of Archives of General Psychiatry, analyzed data from the National Comorbidity Survey Replication (NCS-R), a nationwide survey of mental disorders among 9,282 Americans ages 18 and older. The NCS-R was funded by the National Institutes of Health's National Institute of Mental Health (NIMH).

NIMH researcher Kathleen Merikangas, Ph.D. and colleagues identified prevalence rates of three subtypes of bipolar spectrum disorder among adults. Bipolar I is considered the classic form of the illness, in which a person experiences recurrent episodes of mania and depression. People with bipolar II experience a milder form of mania called hypomania that alternates with depressive episodes. People with bipolar disorder not otherwise specified (BD-NOS), sometimes called subthreshold bipolar disorder, have manic and depressive symptoms as well, but they do not meet strict criteria for any specific type of bipolar disorder noted in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), the reference manual for psychiatric disorders. Nonetheless, BD-NOS still can significantly impair those who have it.

The results indicate that bipolar I and bipolar II each occur in about 1 percent of the population; BD-NOS occurs in about 2.4 percent of the population. The findings support international studies suggesting that, given its multi-dimensional nature, bipolar disorder may be better characterized as a spectrum disorder.

"Bipolar disorder can manifest itself in several different ways. But regardless of type, the illness takes a huge toll," said NIMH Director Thomas R. Insel, M.D. "The survey's findings reiterate the need for a more refined understanding of bipolar symptoms, so we can better target treatment."

Most respondents with bipolar disorder reported receiving treatment. Nearly everyone who had bipolar I or II (89 to 95 percent) received some type of treatment, while 69 percent of those with BD-NOS were getting treatment. Those with bipolar I or II were more commonly treated by psychiatric specialists, while those with BD-NOS were more commonly treated by general medical professionals.

However, not everyone received treatment considered optimal for bipolar disorder. Up to 97 percent of those who had some type of bipolar illness said they had coexisting psychiatric conditions, such as anxiety, depression or substance abuse disorders, and many were in treatment for those conditions rather than bipolar disorder. The researchers found that many were receiving medication treatment considered "inappropriate" for bipolar disorder, e.g., they were taking an antidepressant or other psychotropic medication in the absence of a mood stabilizing medication such as lithium, valproate, or carbamazepine. Only about 40 percent were receiving appropriate medication, considered a mood stabilizer, anticonvulsant or antipsychotic medication.

"Such a high rate of inappropriate medication use among people with bipolar spectrum disorder is a concern," said Dr. Merikangas. "It is potentially dangerous because use of an antidepressant without the benefit of a mood stabilizer may actually worsen the condition."

see Spectrum on page 34

Researchers from page 8

All three investigators hold appointments on the faculty of the New York University (NYU) School of Medicine. Dr. Ginsberg is an assistant professor of psychiatry and physiology and neuroscience; Dr. Levy is an associate professor of psychiatry and pharmacology; and Dr. Mathews is an assistant professor of psychiatry.

"An important criterion for these awards was the likelihood that these studies would have a high impact on the field of Alzheimer's research in terms of understanding the underlying disease mechanisms or leading the way to treatment," says Ralph Nixon, PhD, MD, Director of the CDR at NKI, and a professor and vice-chair at the NYU Department of Psychiatry.

"We are very fortunate to obtain this support and recognition from the Alzheimer's Association," said psychiatrist Harold Koplewicz, MD, Director of NKI, and chair of the NYU Department of Child and Adolescent Psychiatry and the founder and director of the NYU Child Study Center. "These investigator-initiated awards are highly competitive and rarely do multiple awards go to investigators at a single institution. We are fortunate to have these and other talented scientists at NKI who are at the forefront of dementia research."

"All of the Alzheimer's Association's research efforts are aimed at some aspect of improving the quality of life of people with Alzheimer's disease and their families," said Maria Carrillo, PhD, director of medical and scientific relations for the Alzheimer's Association. "In that spirit, we're very pleased to fund these three NKI scientists and their projects that seek to discover innovative ways to detect, treat and perhaps prevent Alzheimer's disease."

More than 5 million Americans now have Alzheimer's. Although symptoms can vary widely, the first problem many people notice is forgetfulness severe enough to affect their work, lifelong hobbies or social life.

About the NKI Center for Dementia Research

The Center for Dementia Research (CDR) is a consortium of independent laboratories and research programs at the Nathan Kline Institute. Directed by Ralph A. Nixon, PhD, MD, the CDR comprises over 15 principal investigators and 60 staff and is dedicated to studies on the pathogenesis, diagnosis, and treatment of Alzheimer's disease (AD) and other major neurodegenerative diseases. Affiliated with New York University School of Medicine, NKI is one of two major institutes for psychiatric research supported in part by the Office of Mental Health of the State of New York.

A major emphasis of the CDR is "translational" research, which is aimed at understanding the molecular basis of Alzheimer's disease and other neurodegenerative states (e.g. Parkinson's disease (PD), Huntington disease (HD), Amyotrophic Lateral Sclerosis (ALS), stroke, etc.) in order to develop accurate animal models, which are then used to devise new strategies for early diagnosis (e.g. neuroimaging, biomarker identification) and treatment. The Center's pre-clinical research activities interface with the NKI Geriatric Research Program (directed by Nunzio Pomara, MD) focusing on the development of more effective pharmacological strategies for the treatment of Alzheimer's disease and the identification of neurobiological predictors of therapeutic response.

The Nathan Kline Institute for Psychiatric Research is a facility of the New York State Office of Mental Health. Affiliated with New York University School of Medicine, NKI is known nationally and internationally for its pioneering contributions to psychiatric research. On the web at www.rfmh.org/nki □

Emergencies from page 16

1. Have regular lithium level blood tests as advised by your doctor. Your doctor will adjust your dose based on these blood tests. Remember, lithium levels are always done in the morning and the medication is not taken before the blood test that day, but immediately.

2. Drink plenty of fluids, at least 6 glasses of water (or milk, fruit juice, soft drink) each day. Be aware that caffeinated drinks do not count towards this total, since caffeine is a mild diuretic and causes the body to lose water.

3. Do not become dehydrated because the level of lithium in your blood will increase. Hot sweaty weather, outdoor work, strenuous exercise, and vomiting most especially diarrhea all increase water loss. It will be important to drink extra water if these events occur.

4. Do not start a salt-reduced diet while taking lithium. A low salt intake can increase the level of lithium in the blood. (Note also that a high salt intake can lower the level of lithium in the blood.)

5. Whenever your doctors give you new medications, always ask them to check to see if this will alter your lithium level. Ask your doctor to send you for a lithium level if there is even a question that the new medication may cause problems with lithium Remember, too much lithium may cause toxicity but too little may lead to relapse into mania. Consider going for an additional blood test to make sure that the level does not decrease, perhaps leading to a relapse or increase leading to toxicity.

6. Be careful of over the counter medications. Almost all of the newer pain medications such as ibuprofen (Advil, Motrin, et al.), naproxen (Aleve, Anaprox) and others may raise lithium levels and lead to toxicity. Speak with your doctor and pharmacist before you use any of these medications.

Remember, lithium is one of the most effective medications in all of medicine. Your awareness of lithium toxicity and attention to the hints above will help you and those you love get the most out of this medication.

Colm James Mc Carthy is an emergency medical technician dedicated to educating people about ways to avoid medical emergencies before they happen. □

the mental health association of new york city, inc.

Alleviating Bipolar Disorder with Family Help

By Giselle Stolper
Executive Director
The Mental Health Association of New York City

The New York City Department of Health and Mental Hygiene (DOHMH) reports that close to 80,000 New Yorkers, ages 18 to 54, suffer from bipolar disorder, out of an estimated 320,000 individuals in the same age group who have psychiatric disorders. The National Institute of Mental Health (NIMH) indicates that nationwide, 1 percent of children ages 14 to 18, and about 1.2 percent (2.3 million) of the population age 18 and older, in any given year, have bipolar disorder.

Bipolar disorder manifests itself in extreme mood swings — from euphoria to extreme depression. Bipolar disorder can strike children, teenagers, adults and senior citizens.

Parent Resource Centers Provide an Umbrella of Support for Families

Children who have parents or relatives with bipolar disorder are more at risk to develop the illness. A study by the Mayo Foundation for Medical Education and Research (MFMER) finds that a family history of depression appears to exist in 80 to 90 percent of bipolar cases. All too often, families do not recognize the early signs as a treatable illness. Parents can overlook the fact that they, too, may have the symptoms of bipolar disorder or a form of depression that stems from heredity. In many cases, parents assume their children's mood swings are merely attributable to "growing pains," particularly as children approach adolescence.

Peer support is vitally important in helping parents, caregivers and their children find the help they need. However, they may be tangled in a web of bureaucracy. That is where the Mental Health Association of New York City (MHA of NYC) can help. MHA of NYC Parent Resource Centers in Manhattan, Queens and the Bronx are staffed with parent advocates who have struggled with the problems of raising children with myriad emotional challenges, bipolar disorder among them. Parent Resource Center staff members have undergone extensive training to provide a variety of services – providing information and referrals to other community organizations, teaching parenting skills, running support groups, and assuming an advocacy role in helping families who are faced with governmental agency obstacles. The services provided by our Parent Resource Centers are free with no

Giselle Stolper

waiting time. In addition, services are provided in English or Spanish, and some services are also available in Cantonese or Mandarin.

The Vega family was referred to the MHA of NYC Parent Resource Center in Queens by the City's Advocate Office. Mrs. Vega had been diagnosed with bipolar disorder, and her child had been diagnosed with attention-deficit/hyperactivity disorder at age 3 and bipolar disorder at age 6. She was overwhelmed, angry and frustrated by the difficulty she had faced from the Board of Education and various hospitals as she struggled to get the best services in place for her child and herself.

As Mrs. Vega was uncertain about the decision-making process concerning her child's medication, school referrals and proper evaluations, she requested support and advocacy from our Parent Resource Center. Our Queens advocate was able to help Mrs. Vega prioritize her goals and coach her in communicating productively with the providers assigned to her so she could convey her concerns and enlist their help and support to get the services she needed for her child. The advocate also accompanied Mrs. Vega to her child's annual Individualized Education Plan (IEP) review, where she was able to communicate her concerns in a much more positive manner. This proved to be empowering, in that her local school district's Committee of Special Education (CSE) agreed with her decisions.

Putting the Puzzle Together to Find Resources and Help

Children normally go through behavioral changes in their development toward adulthood, and bipolar disorder may not be the underlying cause. Family members and friends are usually the first to notice dramatic "spikes" in an adult's behavior. It is critically important that they recognize the possible signs of bipolar disorder and encourage the person to seek professional help in the form of physician screening, diagnosis, treatment, psychotherapy and appropriate medication. One important aspect is to take a supportive role and create an atmosphere of ongoing and consistent help and concern. Delayed diagnosis can be devastating — not only to the person who shows symptoms of bipolar disorder — but to his or her family members, friends and co-workers.

MHA of NYC has also developed the Coordinated Children's Services Initiative (CCSI) for parents — an innovative model of care for New York City families of special needs youngsters who are at risk of being removed from the home into hospitals or residential programs. CCSI is a multi-agency effort that creates locally coordinated systems of care. This model helps youngsters return to school after long absences and keeps families together and children symptom free.

CCSI promotes the core principle that parents and/or caregivers should be equal partners with health care professionals to develop and carry out a thorough program of coordinated care that addresses the fragmented and inflexible nature of children's services systems. The CCSI program includes cooperative interagency planning and integrated services, individualized care planning and a strength-based approach that emphasizes the empowerment of clients as full partners in their service planning.

The CCSI model uses family network conferences to bring together representatives of all the agencies and community resources involved in a child's treatment. During a meeting with the family, these representatives develop a coordinated care plan to help keep the child at home or in the community.

While there is no quick-fix solution for bipolar disorder, early screening and diagnosis, followed by a regimen of medication, psychotherapy, and self-care go a long way toward alleviating and stabilizing the condition.

If you believe that you, or a loved one, may have symptoms of bipolar disorder, call 1-800-LIFENET for more information about screening and referrals to treatment. LifeNet is operated by the MHA of NYC in partnership with the NYC Department of Health and Mental Hygiene.

Cathy Moran, Director of Children & Family Services for CCSI contributed to this article. □

Look for the Warning Signs in Your Children to Get Early Treatment

Children and teenagers with bipolar disorder can be effectively treated. Patient and family education is important, coupled with mood stabilizing medications and psychotherapy. When mood swings are first noticed, parents should observe and monitor their child's behavior over an extended period of time. Should the mood swings continue, an evaluation by a child or adolescent psychiatrist to identify bipolar disorder should be done, followed by appropriate treatment and medication.

Parents should keep a watchful eye when they suspect unusual emotional and behavioral symptoms of "highs" or mania in their children, and carefully monitor the pattern. Manic behavior includes:

- Increased energy and/or restlessness
- Lack of sleep
- Aggressive and defiant behavior
- Frequent temper tantrums
- Excessive and rapid talking/ easily distracted
- Decline in academic functioning

Conversely, parents may witness a radical change in behavior within days (or even hours) when their children sink into a depressive state. Be on the lookout for:

- Loss of appetite
- Lack of interest in school and activities
- Extreme feelings of sadness and hopelessness
- Inability to concentrate
- Irrational fear and anxiety
- Decrease interest in maintaining peer relationships

Many Faces of Bipolar Disorder

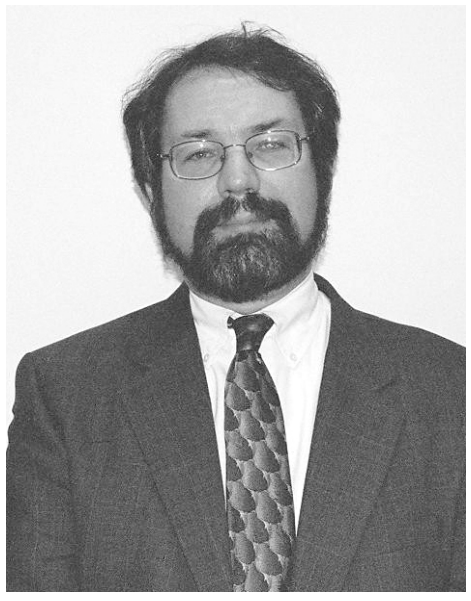
By Richard J. Gersh, MD
Executive Deputy Chief Psychiatrist
Jewish Board of Family and Children's Services

Harry is the life of the party. He's fun, energetic, creative, with a quick wit and charm. He talks a mile a minute and seems to be juggling several projects at once, without needing much time to stop for sleep or even meals. People envy him, but even close friends and family don't know about the periods when he withdraws and doesn't function for days or weeks at a time. He's not merely a super achiever; Harry has bipolar disorder.

Sally has a history of depressive episodes over several years. She responds well to antidepressants, and functions very well when she is not depressed. She is able to stop taking medication and continue to do well for months or years at a time, before her next episode of depression. At times she feels so good, in fact, that she treats herself to expensive items and spur of the moment vacations. Her psychiatrist feels Sally has recurrent depression, but she actually has bipolar disorder.

Bobby is having trouble in grade school. He interrupts his friends, can't stay with one task very long, has difficulty completing assignments, and tends to be moody and irritable. His teachers think he may have attention deficit disorder, but Bobby has bipolar disorder.

Martha spent years in a state psychiatric facility, having periods of extreme agitation because she believed others were jealous and continually trying to kill her. At times she filled notebooks with her delusional theories of re-ordering the world. Other times she was isolative, motionless, and silent. She has made several suicide attempts. She was diagnosed with schizophrenia and treated with first-generation antipsychotics, which left her sedated, with involuntary muscle movements. Eventually a new doctor reassessed her case, changed her antipsychotic to lithium, and she was able to return home and start working again. She didn't have schizophrenia. Martha has bipolar disorder.



Richard J. Gersh, MD

It's not that bipolar disorder is hard to diagnose, but it is easy to misdiagnose, and easy to miss altogether. Classically it is characterized by periods of depression and periods of mania, with periods of normal mood and functioning in between. Not everyone with bipolar disorder, however, presents with the familiar clear-cut signs and symptoms. The good news is that, when recognized correctly, very good treatments are available, and outcomes can be excellent.

The example of Harry is, perhaps, the most challenging subject to treat properly, or at all. During his manic episodes he feels terrific, experiencing explosions of creativity and energy, and his life can be quite exciting and fun. These manic episodes are not so severe that he needs hospitalization; he does not become overly grandiose or delusional, and his wild behavior is interpreted by others as eccentric and colorful. His depressive episodes are, similarly, not so profound that he seeks help, and easily dismissed as exhaustion from weeks of working at a break-neck pace. It would be very hard to convince Harry that he has a biological disorder, one that would benefit from treatment with psychotherapy and medications. Even if he did seek help – during a particularly bad depressive episode, for example—and did accept treatment, Harry might very possibly stop his medication after a while. Many individuals with bipolar disorder miss the euphoric highs of mania, which are normalized on medication.

Sally, on the other hand, knows she has a problem and is comfortable accepting treatment, when she and her doctor believe she has simple recurrent depression – sometimes called unipolar depression to distinguish it from bipolar disorder. Taking an antidepressant is fairly common among her friends these days. However, this treatment does not adequately prevent episodes of depression from recurring, and she has these episodes of mild manic symptoms, which we call "hypomania," that undermine her goals. The proper diagnosis and treatment would stabilize her life even more, but could be a "bitter pill" to swallow. Taking medication for bipolar disorder may not be as simple as taking an antidepressant from time to time. What's more, for many, the diagnosis of bipolar disorder seems so much more serious and ominous than regular depression or anxiety. Until she learns more about it, Sally may initially believe that having bipolar disorder means she is really crazy.

Similarly, Bobby and his parents may accept that something is wrong, because his teachers recognize the signs that his difficulties warrant special attention. ADHD has been the pediatric diagnosis du jour for many years now. In fact, it is only relatively recently that psychiatrists have come to believe that bipolar disorder can start in childhood. Previously it was seen as a disorder of late adolescence and early adulthood. ADHD and bipolar disorder can exist simultaneously, but the treatments are very different, and treating one without the other will be frustrating. Some behaviors will improve, but other problems will remain. If the wrong diagnosis is made, valuable time can be lost. With proper treatment, Bobby can do quite well, and realize his potential.

Severe bipolar disorder, especially manic episodes with prominent psychotic features, can easily be mistaken for schizophrenia. Antipsychotics, prescribed to treat schizophrenia, can actually improve bipolar disorder quite nicely, and were the standard treatment before lithium was introduced in the 1960's, followed by other mood stabilizers. The older antipsychotics, such as Thorazine and Haldol, were likely to cause muscular side effects, such as stiffness, tremors and involuntary movements. Many clinicians believe patients with bipolar disorder, in contrast to patients with schizophrenia, are more likely to develop these side effects from the older antipsychotics, so it is important to recognize the difference. Newer antipsychotics, such as Risperdal, Zyprexa and Seroquel, have been shown to be effective in treating aspects of bipolar disorder, with less likelihood of producing these side effects. Mood stabilizers, such as lithium, Depakote, Lamictal and carbamazepine, are still considered important options for treatment.

Medications, as good as they can be at managing bipolar disorder, will not enter the picture without proper diagnosis and achieving an effective alliance between patient and clinician. The key, accordingly, is often time, patience, careful listening, and asking the right questions. Then comes education, encouragement and support. Thankfully, there is material available to help patients learn about bipolar disorder: signs and symptoms to look for, mood charts to monitor the effects of treatment, famous and successful individuals sharing their own experiences with the condition, behavioral recommendations to help stabilize the condition, and descriptions of the medications involved.

At the Jewish Board of Family and Children's Services, we have a comprehensive network of services for bipolar disorder and other mental illness, including day treatment programs, supportive housing and outpatient mental health clinics in all five boroughs. For more information, please see our website at www.jbfcs.org. □

Psychotherapy from page 10

psychodynamic and cognitive psychotherapies—and the above psychotherapies all use elements of supportive psychotherapy. In psychodynamic and cognitive psychotherapies there is a major focus on personality and behavior change whereas in supportive psychotherapy the primary goal is to help the patient maintain or reestablish his/her best possible level of functioning given the limitations of the patient's illness and/or life circumstances. Patients who most benefit from this type of psychotherapy are those with life-long illnesses such as bipolar disorder, schizophrenia and recurrent major depression. The therapist works to maintain a reality-based relationship with the patient that is grounded in support, concern and problem solving. The therapist uses suggestions, reinforcement, advice, cognitive restructuring, reassurance, limit setting and reality testing to help the patient achieve and maintain his/her highest level of psychological functioning.

Group Psychotherapy

All of the above types of psychotherapy can be utilized both in an individual setting (the patient and the therapist), in a group setting or in treating couples or families. Group psychotherapy is an extremely powerful form of psychotherapy in which not only the therapist but also the other group members interact and the individual patient can avail him or herself of the feedback of the group to either reinforce positive interactions or to challenge maladaptive interpersonal skills and coping mechanisms. Groups can be either long term or time limited; be focused on a specific topic, e.g., pain management or anxiety disorders, or have members with a number of different problems and diagnoses.

Picking the Right Psychotherapy

As discussed above, most forms of psychotherapy have criteria and work better for some illnesses rather than others. However, the single most important criteria for finding the "right psychotherapy" is finding the right psychotherapist! The therapeutic alliance is the most basic component in any psychotherapy and is responsible for the majority of successful psychotherapy cases. That does not mean that the patient and the therapist will always be in agreement about everything that occurs in therapy, nor does it mean that the patient will never get angry with his/her therapist. The therapeutic alliance is developed when the patient and therapist agree that they can work together in psychotherapy with a shared common goal and a shared belief that working together will bring a positive benefit to the patient. In that regard, when psychotherapy is considered, the prospective patient should try to meet with several potential therapists to increase the likelihood that he/she will be able to find one that will optimize the potential for development of the critical therapeutic alliance. It is also important, of course, to know what kind of therapy the therapist expects to utilize and whether that particular therapy is one that the patient will be comfortable with.

Once a therapeutic alliance has been developed the patient is responsible for helping the therapist monitor the progress of the psychotherapy and, if the patient's goals are not being met, even with repeated discussions with the therapist, then the possibility of finding another therapist should be explored.

Conclusion

Psychotherapy is a positive life altering experience. For patients who have difficulties in coping with physical and mental illness or with relationship problems, participating in psychotherapy can lead to a much improved and more satisfying life.

C. Deborah Cross, MD is President of the New York State Psychiatric Association (NYSPA), and is Associate Professor of Psychiatry at New York Medical College, Westchester Medical Center in Valhalla, New York. □

Medications from page 1

Furthermore, in mania and hypomania patients typically feel good when they are ill and it is hard to get anyone that feels good to seek help, especially if they will feel "less good" after they are treated. This all ends up being important because the medications that are used to treat Unipolar depression can make with Bipolar 1, 2 or Mixed persons worse and all of these people are typically showing up at the doctor's office saying that they are depressed.

Medications For Treating Depression

Depression can be treated with a variety of medications that are all lumped together as antidepressants. This includes medications from such different classes as the tricyclics, the MOAIs , the SSRIs and the SNRIs. The tricyclics are older medications such as Amitriptyline (Elavil) and its metabolite nortriptyline as well as imipramine (Tofranil) and its metabolite desipramine. These medications have more side effects than some of the newer medications and their use has decreased over the years. The MAOIs include medications such as tranylcypramine (Parnate), phenelzine (Nardil) and several others. These medications require a special diet so they are not often the first choice drug for depression. The SSRIs are the newer medications such as fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil) and others that are quite well known. These are relatively easy to use medications that have many fewer side effects when compared to the older medications. The SNRIs are similar to the SSRIs but work at more places in the brain. The SNRIs include medications such as venlafaxine (Effexor) and duloxetine (Cymbalta).

Richard H. McCarthy, MD, CM, PhD

Unfortunately, Bipolar 1 patients, when treated with antidepressant can switch into a manic phase. Therefore these patients are rarely treated with an antidepressant medication alone, but usually also are treated with a mood stabilizer. One antidepressant that is in a class of its own has been reported to be an exception to this tendency for antidepressants to precipitate mania, bupropion (Welbutrin). This medication is also used to help people to quit smoking.

Mood Stabilizers.

Mood stabilizers are medications that are used to stabilize mood, specifically mania, that also prevent relapse of bipolar disorder and do not promote switching between mania and depression. The first mood stabilizer and still the best is lithium, a salt that is unusually effective in treating mania, decreasing the risk of suicide, helping antidepressants and antipsychotic medications work better and increasing nerve sell growth in the brain. It is an excellent medication but it has some unpleasant side effects, and if used incorrectly can be toxic. Lithium toxicity is easily recognizable and treatable, but is very serious. Since a large number of other medications have been developed to treat mania, lithium's use has decreases. This is unfortunate because lithium is still the gold standard against which all other mood stabilizers are judged. Many psychiatrists believe that all bipolar patients deserve a lithium trial. Other classes of medications that have been shown to be useful in bipolar disorder are the atypical antipsychotics, many of the anti-seizure drugs and some of the so called calcium channel blockers. I mention this last group for completeness but their use is quiet limited and somewhat technical so I will not go into them further. The atypical antipsychotics were primarily developed to treat psychosis but they were also found to be helpful in bipolar disorder. Those atypical antipsychotics that are approved by the FDA for the treatment of bipolar disorder include risperidone, (Risperdal) olanzapine (Xyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify). An olanzapine/ fluoxetine fixed combination (Symbax) is approved to treat depressive disorders associated with bipolar illness. Quetiapine has also been approved for the treatment of depression in bipolar disorder. Finally, a number of medications that are used to treat seizures are also mood stabilizers. This includes medications such as carbamazepine (Tegretol) and an extended version of carbamazepine (Equestro), valproate in its many forms (Depakote and Depakene). Another anti-seizure medication, lamotrigine (Lamictal) is unusual because it treats not only affective instability but also depression and mixed manic states.

How To Choose.

If you have a Unipolar Depression and not Bipolar 1, 2 or mixed any of the antidepressant is likely to be helpful. There is no good evidence that any one of them is better than any of the others. Some of them have indications for treating anxiety, or phobias and some do not, but, in general, they are all quite good. Typically, the side effect profile of the particular medication (or what your insurance company will pay for) is what carries the day. If you have Bipolar 1, 2 or Mixed and you are depressed, make sure you talk to your physician about taking a mood stabilizer along with any antidepressant you might choose. Those mood stabilizers that also help with depression such as lamotrigine, quetiapine or the olanzapine/fluoxetine combination might be particularly good choices. Likewise, if you have a psychosis as well as mood instability than the atypical antipsychotics might be particularly helpful since they can treat both sets problems. And finally, if you just have good old fashioned mania, the untreatable illness of 30 year ago, any of these dozen or so agents will be helpful. This is a good problem to have, and you should talk to your doctor to work out which of these many agents is most appropriate for you.

Richard H McCarthy, MD, CM, PhD is a Research Psychiatrist and a member of the Consult Service for New York State's Office of Mental Health and, the opinions expressed in this article are his own. He also has a small private practice. □

Spectrum from page 25

Merikangas and colleagues speculate that as people seek treatment for anxiety, depression or substance abuse disorders, their doctors, especially if they are not mental health specialists, may not be detecting an underlying bipolar condition in their patients.

"Because bipolar spectrum disorder commonly coexists with other illnesses, it is likely underrecognized, and therefore, undertreated. We need better screening tools and procedures for identifying bipolar spectrum disorder, and work with clinicians to help them better spot these bipolar symptoms," concluded Dr. Merikangas. □

CEO from page 8

The Jewish Board of Family and Children's Services is one of the nation's premier voluntary mental health and social service agencies. Through a diverse network of more than 185 community-based programs, residential facilities and day-treatment centers, JBFCS annually serves more than 65,000 New Yorkers of all religious, ethnic and socioeconomic backgrounds in the city's five boroughs and in Westchester. □

Dr. Kohn from page 9

Dr. Kohn applies a strong business perspective to managing not-for-profit agencies. Her formal management training took place at Columbia University School of Business, where she graduated from the Not-for-Profit Executive Management Program. She went on to hold top leadership positions in nonprofit and mental health organizations in Westchester.

As Associate Executive Director at Westchester Jewish Community Services (WJCS) WJCS, Dr. Kohn led a $4 million expansion of community-based treatment for individuals with serious mental illnesses. She has spearheaded diversity initiatives at each of the agencies that she has led and takes pride in having built exceptional strong staff teams, a hallmark of her leadership style.

"Dr. Hedlund positioned MHA well to address the upcoming challenges that the community faces," says MHA Board President Mary F. Foster. "Dr. Kohn is widely respected as a clinician, administrator and leader. MHA is in good hands as it moves into a new era of change and growth."

Dr. Kohn looks forward to all aspects of leading MHA's work. She is particularly interested in expanding access to services provided in the home and community as well as bolstering MHA's public education efforts. Under her leadership, MHA will continue to provide services to all, regardless of clients' income level or insurance coverage. □

Commissioner from page 9

Award from the American College of Mental Health Administration.

"We are very honored to have Dr. Hogan as our speaker this year," said Barry B. Perlman, MD, Saint Joseph's Director of Psychiatry, who is also the immediate past President of the New York State Psychiatric Association and currently Chair of its Committee on Legislation as well as the Chairman of the New York State Mental Health Services Council. "He has a wealth of knowledge and experience and will play a critical role in shaping the future of mental health care in New York State. It was a very informative lecture about the progress made in recent decades by the mental health system and the challenges and opportunities that lie ahead." Dr. Hogan presented data distilled by health economists Richard G. Frank and Sherry A. Glied and presented in their book, "Better But Not Well: Mental Health Policy in the United States since 1950". They identify areas of progress in recent decades such as increased access to care, more effective care, less out of pocket costs borne by the patient, better living conditions, more attention to patients' rights among others while at the same time elaborating on the distance yet to be traveled in these domains. He then spoke of his hope that during his tenure as Commissioner advances would continue to be made towards the goal of an improved "person centered, family driven" system of care. He focused his attention on then need for the centrality of the constructs of "Recovery, Resiliency, and Transformation" in the mental health system.

Saint Joseph's is a leading resource for mental health services in Westchester. The hospital offers inpatient care, as well as an outpatient clinic, day treatment program, supportive case management and substance abuse programs. The lecture is sponsored by Saint Joseph's Department of Psychiatry in honor of the late Dr. Maniscalco who was Director of the Department from 1970-1980.

The lecture was open to health care professionals and members of the mental health community. An informal reception followed. For additional information, please call Saint Joseph's Department of Psychiatry at (914) 378-7342. □

Bipolar Disorder from page 1

weight loss or gain; chronic pain or other persistent bodily symptoms that are not caused by physical illness or injury; and thoughts of death or suicide, or suicide attempts.

A depressive episode is diagnosed if five or more of these symptoms last most of the day, nearly every day, for a period of 2 weeks or longer.

A mild to moderate level of mania is called hypomania. Hypomania may feel good to the person who experiences it and may even be associated with good functioning and enhanced productivity. Thus even when family and friends learn to recognize the mood swings as possible bipolar disorder, the person may deny that anything is wrong. Without proper treatment, however, hypomania can become severe mania in some people or can switch into depression.

Sometimes, severe episodes of mania or depression include symptoms of psychosis (or psychotic symptoms). Common psychotic symptoms are hallucinations (hearing, seeing, or otherwise sensing the presence of things not actually there) and delusions (false, strongly held beliefs not influenced by logical reasoning or explained by a person's usual cultural concepts). Psychotic symptoms in bipolar disorder tend to reflect the extreme mood state at the time. For example, delusions of grandiosity, such as believing one is the President or has special powers or wealth, may occur during mania; delusions of guilt or worthlessness, such as believing that one is ruined and penniless or has committed some terrible crime, may appear during depression. People with bipolar disorder who have these symptoms are sometimes incorrectly diagnosed as having schizophrenia, another severe mental illness.

It may be helpful to think of the various mood states in bipolar disorder as a spectrum or continuous range. At one end is severe depression, above which is moderate depression and then mild low mood, which many people call "the blues" when it is short-lived but is termed "dysthymia" when it is chronic. Then there is normal or balanced mood, above which comes hypomania (mild to moderate mania), and then severe mania.

In some people, however, symptoms of mania and depression may occur together in what is called a mixed bipolar state. Symptoms of a mixed state often include agitation, trouble sleeping, significant change in appetite, psychosis, and suicidal thinking. A person may have a very sad, hopeless mood while at the same time feeling extremely energized.

Bipolar disorder may appear to be a problem other than mental illness—for instance, alcohol or drug abuse, poor school or work performance, or strained interpersonal relationships. Such problems in fact may be signs of an underlying mood disorder.

Diagnosis of Bipolar Disorder

Like other mental illnesses, bipolar disorder cannot yet be identified physiologically—for example, through a blood test or a brain scan. Therefore, a diagnosis of bipolar disorder is made on the basis of symptoms, course of illness, and, when available, family history. The diagnostic criteria for bipolar disorder are described in the Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM-IV).2

Descriptions by people with bipolar disorder give valuable insights into the various mood states associated with the illness:

Depression: I doubt completely my ability to do anything well. It seems as though my mind has slowed down and burned out to the point of being virtually useless…. [I am] haunt[ed] … with the total, the desperate hopelessness of it all…. Others say, "It's only temporary, it will pass, you will get over it," but of course they haven't any idea of how I feel, although they are certain they do. If I can't feel, move, think or care, then what on earth is the point?

Hypomania: At first when I'm high, it's tremendous… ideas are fast… like shooting stars you follow until brighter ones appear…. All shyness disappears, the right words and gestures are suddenly there… uninteresting people, things become intensely interesting. Sensuality is pervasive, the desire to seduce and be seduced is irresistible. Your marrow is infused with unbelievable feelings of ease, power, well-being, omnipotence, euphoria… you can do anything… but, somewhere this changes.

Mania: The fast ideas become too fast and there are far too many… overwhelming confusion replaces clarity… you stop keeping up with it—memory goes. Infectious humor ceases to amuse. Your friends become frightened…. everything is now against the grain… you are irritable, angry, frightened, uncontrollable, and trapped.

Suicide

Some people with bipolar disorder become suicidal. Anyone who is thinking about committing suicide needs immediate attention, preferably from a mental health professional or a physician. Anyone who talks about suicide should be taken seriously. Risk for suicide appears to be higher earlier in the course of the illness. Therefore, recognizing bipolar disorder early and learning how best to manage it may decrease the risk of death by suicide.

Signs and symptoms that may accompany suicidal feelings include:

- talking about feeling suicidal or wanting to die
- feeling hopeless, that nothing will ever change or get better
- feeling helpless, that nothing one does makes any difference
- feeling like a burden to family and friends
- abusing alcohol or drugs
- putting affairs in order (e.g., organizing finances or giving away possessions to prepare for one's death)
- writing a suicide note
- putting oneself in harm's way, or in situations where there is a danger of being killed

If you are feeling suicidal or know someone who is:

- call a doctor, emergency room, or 911 right away to get immediate help
- make sure you, or the suicidal person, are not left alone
- make sure that access is prevented to large amounts of medication, weapons, or other items that could be used for self-harm

While some suicide attempts are carefully planned over time, others are impulsive acts that have not been well thought out; thus, the final point in the box above may be a valuable long-term strategy for people with bipolar disorder. Either way, it is important to understand that suicidal feelings and actions are symptoms of an illness that can be treated. With proper treatment, suicidal feelings can be overcome.

What Is the Course of Bipolar Disorder?

Episodes of mania and depression typically recur across the life span. Between episodes, most people with bipolar disorder are free of symptoms, but as many as one-third of people have some residual symptoms. A small percentage of people experience chronic unremitting symptoms despite treatment.3

The classic form of the illness, which involves recurrent episodes of mania and depression, is called bipolar I disorder. Some people, however, never develop severe mania but instead experience milder episodes of hypomania that alternate with depression; this form of the illness is called bipolar II disorder. When four or more episodes of illness occur within a 12-month period, a person is said to have rapid-cycling bipolar disorder. Some people experience multiple episodes within a single week, or even within a single day. Rapid cycling tends to develop later in the course of illness and is more common among women than among men.

People with bipolar disorder can lead healthy and productive lives when the illness is effectively treated (see below—"How Is Bipolar Disorder Treated?"). Without treatment, however, the natural course of bipolar disorder tends to worsen. Over time a person may suffer more frequent (more rapid-cycling) and more severe manic and depressive episodes than those experienced when the illness first appeared.4 But in most cases, proper treatment can help reduce the frequency and severity of episodes and can help people with bipolar disorder maintain good quality of life.

Can Children and Adolescents Have Bipolar Disorder?

Both children and adolescents can develop bipolar disorder. It is more likely to affect the children of parents who have the illness.

Unlike many adults with bipolar disorder, whose episodes tend to be more clearly defined, children and young adolescents with the illness often experience very fast mood swings between depression and mania many times within a day.5 Children with mania are more likely to be irritable and prone to destructive tantrums than to be overly happy and elated. Mixed symptoms also are common in youths with bipolar disorder. Older adolescents who develop the illness may have more classic, adult-type episodes and symptoms.

Bipolar disorder in children and adolescents can be hard to tell apart from other problems that may occur in these age groups. For example, while irritability and aggressiveness can indicate bipolar disorder, they also can be symptoms of attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, or other types of mental disorders more common among adults such as major depression or schizophrenia. Drug abuse also may lead to such symptoms.

For any illness, however, effective treatment depends on appropriate diagnosis. Children or adolescents with emotional and behavioral symptoms should be carefully evaluated by a mental health professional. **Any child or adolescent who has suicidal feelings, talks about suicide, or attempts suicide should be taken seriously and should receive immediate help from a mental health specialist.**

What Causes Bipolar Disorder?

Scientists are learning about the possible causes of bipolar disorder through several kinds of studies. Most scientists now agree that there is no single cause for bipolar disorder—rather, many factors act together to produce the illness.

Because bipolar disorder tends to run in families, researchers have been searching for specific genes—the microscopic "building blocks" of DNA inside all cells that influence how the body and mind work and grow—passed down through generations that may increase a person's chance of developing the illness. But genes are not the whole story. Studies of identical twins, who share all the same genes, indicate that both genes and other factors play a role in bipolar disorder. If bipolar disorder were caused entirely by genes, then the identical twin of someone with the illness would always develop the illness, and research has shown that this is not the case. But if one twin has bipolar disorder, the other twin is more likely to develop the illness than is another sibling.6

In addition, findings from gene research suggest that bipolar disorder, like other mental illnesses, does not occur because of a single gene.7 It appears likely that many different genes act together, and in combination with other factors of the person or the person's environment, to cause bipolar disorder. Finding these genes, each of which contributes only a small amount toward the vulnerability to bipolar disorder, has been extremely difficult. But scientists expect that the advanced research tools now being used will lead to these discoveries and to new and better treatments for bipolar disorder.

Brain-imaging studies are helping scientists learn what goes wrong in the brain

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Bipolar Disorder from page 36

to produce bipolar disorder and other mental illnesses.8,9 New brain-imaging techniques allow researchers to take pictures of the living brain at work, to examine its structure and activity, without the need for surgery or other invasive procedures. These techniques include magnetic resonance imaging (MRI), positron emission tomography (PET), and functional magnetic resonance imaging (fMRI). There is evidence from imaging studies that the brains of people with bipolar disorder may differ from the brains of healthy individuals. As the differences are more clearly identified and defined through research, scientists will gain a better understanding of the underlying causes of the illness, and eventually may be able to predict which types of treatment will work most effectively.

How Is Bipolar Disorder Treated?

Most people with bipolar disorder—even those with the most severe forms—can achieve substantial stabilization of their mood swings and related symptoms with proper treatment.10,11,12 Because bipolar disorder is a recurrent illness, long-term preventive treatment is strongly recommended and almost always indicated. A strategy that combines medication and psychosocial treatment is optimal for managing the disorder over time.

In most cases, bipolar disorder is much better controlled if treatment is continuous than if it is on and off. But even when there are no breaks in treatment, mood changes can occur and should be reported immediately to your doctor. The doctor may be able to prevent a full-blown episode by making adjustments to the treatment plan. Working closely with the doctor and communicating openly about treatment concerns and options can make a difference in treatment effectiveness.

In addition, keeping a chart of daily mood symptoms, treatments, sleep patterns, and life events may help people with bipolar disorder and their families to better understand the illness. This chart also can help the doctor track and treat the illness most effectively.

Medications

Medications for bipolar disorder are prescribed by psychiatrists—medical doctors (M.D.) with expertise in the diagnosis and treatment of mental disorders. While primary care physicians who do not specialize in psychiatry also may prescribe these medications, it is recommended that people with bipolar disorder see a psychiatrist for treatment.

Medications known as "mood stabilizers" usually are prescribed to help control bipolar disorder.10 Several different types of mood stabilizers are available. In general, people with bipolar disorder continue treatment with mood stabilizers for extended periods of time (years). Other medications are added when necessary, typically for shorter periods, to treat episodes of mania or depression that break through despite the mood stabilizer.

- Lithium, the first mood-stabilizing medication approved by the U.S. Food and Drug Administration (FDA) for treatment of mania, is often very effective in controlling mania and preventing the recurrence of both manic and depressive episodes.

- Anticonvulsant medications, such as valproate (Depakote®) or carbamazepine (Tegretol®), also can have mood-stabilizing effects and may be especially useful for difficult-to-treat bipolar episodes. Valproate was FDA-approved in 1995 for treatment of mania.

- Newer anticonvulsant medications, including lamotrigine (Lamictal®), gabapentin (Neurontin®), and topiramate (Topamax®), are being studied to determine how well they work in stabilizing mood cycles.

- Anticonvulsant medications may be combined with lithium, or with each other, for maximum effect.

- Children and adolescents with bipolar disorder generally are treated with lithium, but valproate and carbamazepine also are used. Researchers are evaluating the safety and efficacy of these and other psychotropic medications in children and adolescents. There is some evidence that valproate may lead to adverse hormone changes in teenage girls and polycystic ovary syndrome in women who began taking the medication before age 20.13 Therefore, young female patients taking valproate should be monitored carefully by a physician.

- Women with bipolar disorder who wish to conceive, or who become pregnant, face special challenges due to the possible harmful effects of existing mood stabilizing medications on the developing fetus and the nursing infant.14 Therefore, the benefits and risks of all available treatment options should be discussed with a clinician skilled in this area. New treatments with reduced risks during pregnancy and lactation are under study.

Treatment of Bipolar Depression

Research has shown that people with bipolar disorder are at risk of switching into mania or hypomania, or of developing rapid cycling, during treatment with antidepressant medication.15 Therefore, "mood-stabilizing" medications generally are required, alone or in combination with antidepressants, to protect people with bipolar disorder from this switch. Lithium and valproate are the most commonly used mood-stabilizing drugs today. However, research studies continue to evaluate the potential mood-stabilizing effects of newer medications.

- Atypical antipsychotic medications, including clozapine (Clozaril®), olanzapine (Zyprexa®), risperidone (Risperdal®), quetiapine (Seroquel®), and ziprasidone (Geodon®), are being studied as possible treatments for bipolar disorder. Evidence suggests clozapine may be helpful as a mood stabilizer for people who do not respond to lithium or anticonvulsants.16 Other research has supported the efficacy of olanzapine for acute mania, an indication that has recently received FDA approval.17 Olanzapine may also help relieve psychotic depression.18 Aripiprazole (Abilify) is another atypical antipsychotic medication used to treat the symptoms of schizophrenia and manic or mixed (manic and depressive) episodes of bipolar I disorder. Aripiprazole is in tablet and liquid form. An injectable form is used in the treatment of symptoms of agitation in schizophrenia and manic or mixed episodes of bipolar I disorder.

- If insomnia is a problem, a high-potency benzodiazepine medication such as clonazepam (Klonopin®) or lorazepam (Ativan®) may be helpful to promote better sleep. However, since these medications may be habit-forming, they are best prescribed on a short-term basis. Other types of sedative medications, such as zolpidem (Ambien®), are sometimes used instead.

- Changes to the treatment plan may be needed at various times during the course of bipolar disorder to manage the illness most effectively. A psychiatrist should guide any changes in type or dose of medication.

- Be sure to tell the psychiatrist about all other prescription drugs, over-the-counter medications, or natural supplements you may be taking. This is important because certain medications and supplements taken together may cause adverse reactions.

- To reduce the chance of relapse or of developing a new episode, it is important to stick to the treatment plan. Talk to your doctor if you have any concerns about the medications.

Thyroid Function

People with bipolar disorder often have abnormal thyroid gland function.4 Because too much or too little thyroid hormone alone can lead to mood and energy changes, it is important that thyroid levels are carefully monitored by a physician.

People with rapid cycling tend to have co-occurring thyroid problems and may need to take thyroid pills in addition to their medications for bipolar disorder. Also, lithium treatment may cause low thyroid levels in some people, resulting in the need for thyroid supplementation.

Medication Side Effects

Before starting a new medication for bipolar disorder, always talk with your psychiatrist and/or pharmacist about possible side effects. Depending on the medication, side effects may include weight gain, nausea, tremor, reduced sexual drive or performance, anxiety, hair loss, movement problems, or dry mouth. Be sure to tell the doctor about all side effects you notice during treatment. He or she may be able to change the dose or offer a different medication to relieve them. Your medication should not be changed or stopped without the psychiatrist's guidance.

Psychosocial Treatments

As an addition to medication, psychosocial treatments—including certain forms of psychotherapy (or "talk" therapy)—are helpful in providing support, education, and guidance to people with bipolar disorder and their families. Studies have shown that psychosocial interventions can lead to increased mood stability, fewer hospitalizations, and improved functioning in several areas.12 A licensed psychologist, social worker, or counselor typically provides these therapies and often works together with the psychiatrist to monitor a patient's progress. The number, frequency, and type of sessions should be based on the treatment needs of each person.

Psychosocial interventions commonly used for bipolar disorder are cognitive behavioral therapy, psychoeducation, family therapy, and a newer technique, interpersonal and social rhythm therapy. NIMH researchers are studying how these interventions compare to one another when added to medication treatment for bipolar disorder.

- Cognitive behavioral therapy helps people with bipolar disorder learn to change inappropriate or negative thought patterns and behaviors associated with the illness.

- Psychoeducation involves teaching people with bipolar disorder about the illness and its treatment, and how to recognize signs of relapse so that early intervention can be sought before a full-blown illness episode occurs. Psychoeducation also may be helpful for family members.

- Family therapy uses strategies to reduce the level of distress within the family that may either contribute to or result from the ill person's symptoms.

- Interpersonal and social rhythm therapy helps people with bipolar disorder both to improve interpersonal relationships and to regularize their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

- As with medication, it is important to follow the treatment plan for any psychosocial intervention to achieve the greatest benefit.

Other Treatments

- In situations where medication, psychosocial treatment, and the combination of these interventions prove ineffective, or work too slowly to relieve severe symptoms such as psychosis or suicidality, electroconvulsive therapy (ECT) may be considered. ECT may also be considered to treat acute episodes when medical conditions, including pregnancy, make the use of medications too risky. ECT is a highly effective treatment for severe depressive, manic, and/or mixed episodes. The possibility of long-lasting memory problems, although a concern in the past, has been significantly reduced with modern ECT techniques. However, the potential benefits and risks of ECT, and of available alternative interventions, should be carefully reviewed and discussed with individuals considering this treatment and, where appropriate, with family or friends.19

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Bipolar Disorder from page 37

- Herbal or natural supplements, such as St. John's wort (Hypericum perforatum), have not been well studied, and little is known about their effects on bipolar disorder. Because the FDA does not regulate their production, different brands of these supplements can contain different amounts of active ingredient. Before trying herbal or natural supplements, it is important to discuss them with your doctor. There is evidence that St. John's wort can reduce the effectiveness of certain medications.20 In addition, like prescription antidepressants, St. John's wort may cause a switch into mania in some individuals with bipolar disorder, especially if no mood stabilizer is being taken.21
- Omega-3 fatty acids found in fish oil are being studied to determine their usefulness, alone and when added to conventional medications, for long-term treatment of bipolar disorder.22

A Long-Term Illness That Can Be Effectively Treated

Even though episodes of mania and depression naturally come and go, it is important to understand that bipolar disorder is a long-term illness that currently has no cure. Staying on treatment, even during well times, can help keep the disease under control and reduce the chance of having recurrent, worsening episodes.

Do Other Illnesses Co-occur with Bipolar Disorder?

Alcohol and drug abuse are very common among people with bipolar disorder. Research findings suggest that many factors may contribute to these substance abuse problems, including self-medication of symptoms, mood symptoms either brought on or perpetuated by substance abuse, and risk factors that may influence the occurrence of both bipolar disorder and substance use disorders.23 Treatment for co-occurring substance abuse, when present, is an important part of the overall treatment plan.

Anxiety disorders, such as post-traumatic stress disorder and obsessive-compulsive disorder, also may be common in people with bipolar disorder.24,25 Co-occurring anxiety disorders may respond to the treatments used for bipolar disorder, or they may require separate treatment. For more information on anxiety disorders, contact NIMH (see below).

How Can Individuals and Families Get Help for Bipolar Disorder?

Anyone with bipolar disorder should be under the care of a psychiatrist skilled in the diagnosis and treatment of this disease. Other mental health professionals, such as psychologists, psychiatric social workers, and psychiatric nurses, can assist in providing the person and family with additional approaches to treatment.

Help can be found at:

- University—or medical school—affiliated programs
- Hospital departments of psychiatry
- Private psychiatric offices and clinics
- Health maintenance organizations (HMOs)
- Offices of family physicians, internists, and pediatricians
- Public community mental health centers

People with bipolar disorder may need help to get help

- Often people with bipolar disorder do not realize how impaired they are, or they blame their problems on some cause other than mental illness.
- A person with bipolar disorder may need strong encouragement from family and friends to seek treatment. Family physicians can play an important role in providing referral to a mental health professional.
- Sometimes a family member or friend may need to take the person with bipolar disorder for proper mental health evaluation and treatment.
- A person who is in the midst of a severe episode may need to be hospitalized for his or her own protection and for much-needed treatment. There may be times when the person must be hospitalized against his or her wishes.
- Ongoing encouragement and support are needed after a person obtains treatment, because it may take a while to find the best treatment plan for each individual.
- In some cases, individuals with bipolar disorder may agree, when the disorder is under good control, to a preferred course of action in the event of a future manic or depressive relapse.
- Like other serious illnesses, bipolar disorder is also hard on spouses, family members, friends, and employers.
- Family members of someone with bipolar disorder often have to cope with the person's serious behavioral problems, such as wild spending sprees during mania or extreme withdrawal from others during depression, and the lasting consequences of these behaviors.
- Many people with bipolar disorder benefit from joining support groups such as those sponsored by the National Depressive and Manic Depressive Association (NDMDA), the National Alliance for the Mentally Ill (NAMI), and the National Mental Health Association (NMHA). Families and friends can also benefit from support groups offered by these organizations.

What About Clinical Studies for Bipolar Disorder?

Some people with bipolar disorder receive medication and/or psychosocial therapy by volunteering to participate in clinical studies (clinical trials). Clinical studies involve the scientific investigation of illness and treatment of illness in humans. Clinical studies in mental health can yield information about the efficacy of a medication or a combination of treatments, the usefulness of a behavioral intervention or type of psychotherapy, the reliability of a diagnostic procedure, or the success of a prevention method. Clinical studies also guide scientists in learning how illness develops, progresses, lessens, and affects both mind and body. Millions of Americans diagnosed with mental illness lead healthy, productive lives because of information discovered through clinical studies. These studies are not always right for everyone, however. It is important for each individual to consider carefully the possible risks and benefits of a clinical study before making a decision to participate.

In recent years, NIMH has introduced a new generation of "real-world" clinical studies. They are called "real-world" studies for several reasons. Unlike traditional clinical trials, they offer multiple different treatments and treatment combinations. In addition, they aim to include large numbers of people with mental disorders living in communities throughout the U.S. and receiving treatment across a wide variety of settings. Individuals with more than one mental disorder, as well as those with co-occurring physical illnesses, are encouraged to consider participating in these new studies. The main goal of the real-world studies is to improve treatment strategies and outcomes for all people with these disorders. In addition to measuring improvement in illness symptoms, the studies will evaluate how treatments influence other important, real-world issues such as quality of life, ability to work, and social functioning. They also will assess the cost-effectiveness of different treatments and factors that affect how well people stay on their treatment plans.

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) is seeking participants for the largest-ever, "real-world" study of treatments for bipolar disorder. To learn more about STEP-BD or other clinical studies, see the Clinical Trials page on the NIMH Web site www.nimh.nih.gov, visit the National Library of Medicine's clinical trials database www.clinicaltrials.gov, or contact NIMH.

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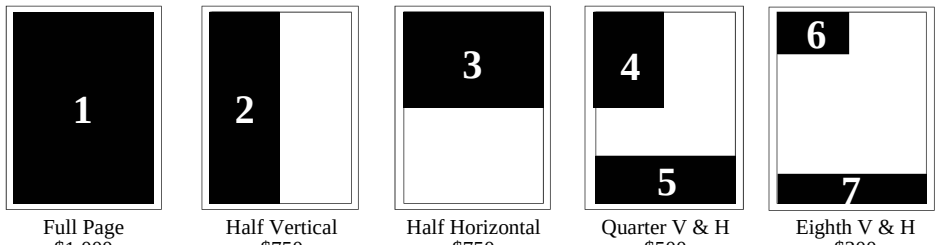

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