MENTAL HEALTH NEWS™

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Eating Disorders: Body and Mind in Conflict

Eating is controlled by many factors, including appetite, food availability, family, peer, and cultural practices, and attempts at voluntary control. Dieting to a body weight leaner than needed for health is highly promoted by current fashion trends, sales campaigns for special foods, and in some activities and professions.

Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. Researchers are investigating how and why initially voluntary behaviors, such as eating smaller or larger amounts of food than usual, at some point move beyond control in some people and develop into an eating disorder. Studies on the basic biology of appetite control and its alteration by prolonged overeating or starvation have uncovered enormous complexity, but in the long run have the potential to lead to new pharmacologic treatments for eating disorders.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own. The main types of eating disorders are anorexia nervosa and bulimia nervosa. A third type, binge-eating disorder, has been suggested but has not yet been approved as a formal psychiatric diagnosis. Eating disorders frequently develop during adolescence or early adulthood, but some reports indicate their onset can occur during childhood or later in adulthood.

Eating disorders frequently co-occur with other psychiatric disorders such as depression, substance abuse, and anxiety disorders. In addition, people who suffer from eating disorders can experience a wide range of physical health complications, including serious heart conditions and kidney failure which may lead to death. Recognition of eating disorders as real and treatable diseases, therefore, is critically important.

Females are much more likely than males to develop an eating disorder. Only an estimated 5 to 15 percent of people with anorexia or bulimia and an estimated 35 percent of those with binge-eating disorder are male.

Anorexia Nervosa

An estimated 0.5 to 3.7 percent of females suffer from anorexia nervosa in their lifetime. Symptoms of anorexia nervosa include:

- Resistance to maintaining body weight at or above a minimally normal weight for age and height

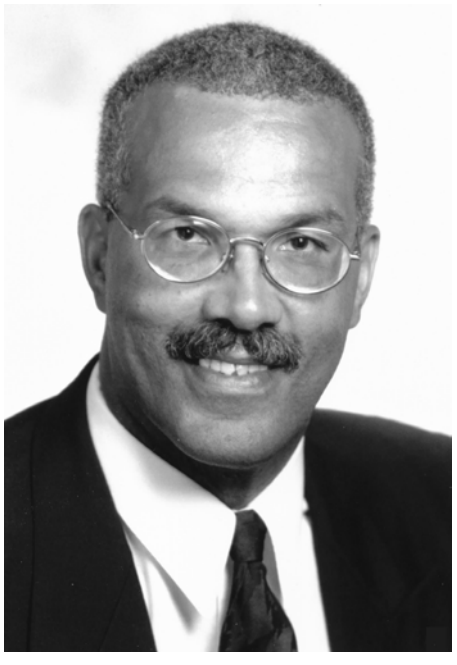
see Eating Disorders on page 26

State Prison Inmates with Psychiatric Disabilities Gaining Overdue Attention and Concern in NYS Assembly

New York Association of Psychiatric Rehabilitation Services (NYAPRS)

In recent years, state mental health policy, advocacy and media coverage has focused on two major groups of disadvantaged underserved and supported groups of New Yorkers with psychiatric disabilities, those who have sadly entered the ranks of the homeless and adult home residents.

Thanks to the work of a new coalition of legal and prisoners' rights groups and mental health advocacy organizations, the desperate plight of New York's 'silent forgotten,' state prison inmates with psychiatric disabilities is gaining long overdue attention and concern. This January, those advocates came to Albany to demonstrate and to testify at an Assembly Hearing conducted by Corrections Chair Jeffrion Aubry and Mental Health Chair



Jeffrion L. Aubry

Peter Rivera

Peter Rivera on new legislation that would ban the widespread current use of inhumane solitary confinements for mentally distressed prisoners.

The following is testimony in support of that legislation offered on behalf of the NYAPRS membership by Harvey Rosenthal, Executive Director presented on January 13, 2004 in Albany, New York.

Good morning. Thank you, Chairman Aubry and Chairman Rivera for your wonderful leadership and your sponsorship of new legislation aimed at ending the inhumane, and all too often, fatal disciplinary solitary confinement of state prisoners with psychiatric disabilities.

As executive director of the New York Association of Psychiatric Rehabilitation Services, I am here today representing the thousands of New Yorkers with psychiatric disabilities

see Inmates on page 24

New Columns: "The Campus Report" & "Latino Health News"

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Table of Contents

From The Publisher

NewsDesk

Cover Story: Eating Disorders

Special Supplement
Sponsored by Four Winds Hospital

Columns

Upcoming Issue Themes

Understanding Sleep Disorders
Summer 2004 Issue - Deadline May 1st

Cultural Diversity in Mental Health
Fall 2004 Issue - Deadline August 1st

Women's Issues in Mental Health
Winter 2005 Issue - Deadline November 1st

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MHA of New York City, Hall-Brooke Behavioral Health Services
Norwalk Hospital—Department of Psychiatry, Silver Hill Hospital
Family Service of Westchester, The Guidance Center, NARSAD
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From The Publisher

The Heck With Mars

We've Got A Great Cause Right Here

By Ira H. Minot, Publisher and Founder, Mental Health News

I grew up during the Kennedy years, and witnessed the incredible journeys and great strides we made as we ventured into space. I was a senior in high school in 1969 when Apollo Astronauts orbited the moon and Neil Armstrong took his historic step onto the lunar surface.

That was 35 years ago. Now, President Bush believes the United States should invest in a long-term commitment that will take us back to the Moon and on to Mars. He said: *This is a great cause that will unify America.*

The debate has already heated up. Tom Daschle, Senior Senator and Democratic Leader responded to the President's vision and said: *We don't need to go to Mars to find a great cause to unify America...we have plenty of great causes here at home.*

We're not sure if President Bush will be re-elected for a second term. Therefore, his call for space exploration may or may not have a future. Another question one might ask is why is the President speaking about all this *now*?

Certainly there have been many significant benefits to mankind that have resulted from our missions into space, including improvements in various areas of medicine and telecommunications.

President Bush's call for expanding space exploration is forcing many to ask: why go to the Moon and Mars when we have so many problems to solve right here on Earth?

I recently sent out an e-mail to our readers to see what they had to say. I got so many back, that there just wasn't enough room to put them all in this editorial. Here's just a sample:

"Until we eliminate discrimination here on Earth, and assure everyone with psychiatric disabilities full access to recovery, rehabilitation and rights, we will only take our archaic, discriminatory attitudes into space with us, and then what good will we be to anyone we may chance to meet there?"

Edy Schwartz

"As long as people's common human needs such as food, shelter, the right to live in peace, and the right to health care are not met, space exploration seems somewhat frivolous."

Meryl Nadel

"Lets work on the elimination of stigma and discrimination—nothing could be more unifying!"

Annora Karas

"Mapping Mars is a good idea. So is mapping the brain to better understand mental health. Let us focus our causes in *this* universe."

Benjamin R. Sher, MA, CSW

"The criminalization of mental illness and the institutionalization of the mentally ill in America's prisons may be the most significant negative social policy in the history of our country, and it just happened all by itself."

Richard J. Pratt, MPA

"When he heard about the proposed Mars project, an acquaintance of mine asked, "Why? Is there oil on Mars?" There are so many urgent and critical domestic social and economic policy issues that are being virtually ignored I could write pages to list them all—but I believe that our health care system in America is under siege, in both the mental health and physical health arenas."

Dennis McDermott

"We lack adequate funding for the services currently provided and services needed to promote recovery."

Elizabeth Hodgdon

"As much as I laud and value space exploration, I believe that here the government's sense of proportion and its priorities are wrong. I also fear Bush's initiative is cover for expansion of military spending. Money for mental health care is not alone the answer, however, for we will never adequately fund treatment for serious mental illness, in particular, without substantive health care reform, specifically some form of universal, single-payer health insurance."

Tim Sullivan, MD

Ira H. Minot, CSW

"As long as we're talking about spending more wisely, I think the 4.8 billion dollars spent for mental health annually in NYS is more than sufficient. What I believe we need is a better allocation of the dollars. If you divide the number of patients in NYS hospitals, by their budgets, you get an average annual expenditure of about $400,000 per patient. Maybe *we* should join a Union?"

Donald M. Fitch

"I think it's great if President Bush wants to have vocational training programs for prisoners. How about vocational and educational training for individuals recovering from mental illness. They too want to be integrated into society as productive citizens!"

Sarah Newitter

"I think it's OUTRAGEOUS that we are contemplating spending on space exploration when so many things (mental health services; day care; public education and health insurance, to name a few) are starving for adequate resources!"

Linda Bretton

I want to thank everyone for responding to this debate. It has obviously aroused the passion and concerns we all share about *our* cause—a cause that is spoken loud and clear in each issue of Mental Health News. In just a few short years, thanks to your continued readership and support, we have developed a new benchmark for providing mental health education. And the excitement keeps building.

In this issue we take a compelling look at Eating Disorders, and are honored to have articles by some of the mental health world's leading experts. We hope that the information and resources provided in these articles will make a difference in the lives of many people and their families.

In addition to the importance of our clinical focus, we felt it necessary to share this issue's front page with the desperate plight of New York's *silent forgotten*—state prison inmates with psychiatric disabilities. We can do no less then make these pressing issues high on our list of reporting priorities.

Finally, to 'top off' this spring's exciting issue I am very proud that we have launched two new and exciting columns: "The Campus Report" and "Latino Health News." These new columns reflect our desire to cover a diverse range of issues that affect the lives of many people each and every day from an ever widening spectrum of the population.

Mental health education is a vital component to recovery and a cornerstone for a comprehensive and effective mental health recovery system. On another front, mental health education helps to foster a greater understanding of daily life in every community, where difficulties in peoples lives can escalate into more serious problems if they are not taken seriously and addressed in their early stages. We are making a difference in reducing the stigma toward mental illness, and by doing so, are removing many barriers to treatment.

In the coming months we will be embarking on a campaign to bring our message to the attention of the corporate community. It is our hope that the business community will work with us to bring a fresh and forward thinking approach to addressing mental health issues in the workplace.

I wish to thank you all for your calls and e-mails which play such an important role in our efforts. Your participation and support is what inspires us and fuels our commitment to our mission.

Have A Great Spring!
Ira H. Minot, CSW

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Ira H. Minot, C.S.W., Founder & Publisher

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Mental Health Award Honors Citizens Who Improve The Lives of Others

Jennifer Schaffer

Andy Spano

Staff Writer
Mental Health News

The County Executive Andy Spano and Jennifer Schaffer, Ph.D., Commissioner of the Department of Community Mental Health, recognized eight individuals and a local organization on December 11, 2003, by honoring them with county's annual Mental Health Awards.

The Mental Health Awards were established 21 years ago by the community mental health department as a way to give special recognition to individuals and exemplary programs for enhancing the lives of individuals who have mental illness, developmental disabilities alcohol and/or substance abuse problems. The individuals and organizations recognized are not part of the traditional service delivery system here in Westchester County. Instead they have volunteered their time talent and energy to provide services to those in need. Some of the organizations honored have created job opportunities for many individuals who may need some job support when initially entering the work force. These companies are to be commended for their vision and help with integrating our communities.

The ceremony was attended by the honorees, their families, co-workers, and the community members who nominated them. The County Executive Andy Spano said, "These individuals have gone above and beyond the call of duty to improve the lives of others. None of them have to do what they do. Each one has made a personal commitment to act from the heart. And because of them, we have stronger, more vibrant and diverse community." Commissioner Schaffer said, "Participating in this particular event gives me great joy. I am happy to be able to personally recognize and finally meet these individuals who truly give so much of themselves."

This year's recipients were as follows:

- Phillipa Campbell- Jack – supervisor and cash department head for Super Stop and Shop in Mamaroneck. For the past 11 years she has supervised 10 individuals who are developmentally disabled and emotionally challenged.
- Lynne Giordano is the owner of TCA Fulfillment Services, a company that processes rebates for a large variety of retail stores and hires individuals with mental illness and developmental disabilities.
- Marie Cassidy volunteers her time weekly at Mount Vernon Hospital. She visits individuals who have mental illness and provides special gifts.
- Karen Devitt has provided her generous services to adults living with mental illness at the New Rochelle Home for Adults for the past 28 years.
- Elizabeth Bergman and Andrea Kissel, two extraordinary girls who graduated from Ardsley High School in June 2003.They created a special Girl Scout troop in May 2001 for developmentally disabled girls.
- Hero, Inc., in Purchase, offers recreational programs. to enhance the lives of 800 children and adults with developmental disabilities.
- Marcia Agwu volunteers her personal time in Yonkers to fight stigma and raise community awareness for individuals living with mental illness.
- Phileña Bolden has volunteered her services to help individuals with mental illness at both the Friends of Mental Health Board thrift shop and at the local library in Peekskill.

MENTAL HEALTH NEWSDESK

Scientists Discover Emotion Regulating Protein Lacking in Panic Disorder Patients

National Institute of Mental Health
Mood and Anxiety Disorders Program

Three brain areas of panic disorder patients are lacking in a key component of a chemical messenger system that regulates emotion, researchers at the NIH's National Institute of Mental Health (NIMH) have discovered. Brain scans revealed that a type of serotonin receptor is reduced by nearly a third in three structures straddling the center of the brain. The finding is the first in living humans to show that the receptor, which is pivotal to the action of widely prescribed anti-anxiety medications, may be abnormal in the disorder, and may help to explain how genes might influence vulnerability. Drs. Alexander Neumeister and Wayne Drevets, NIMH Mood and Anxiety Disorders Program, and colleagues, report on their findings in the January 21, 2004 Journal of Neuroscience.

Each year, panic attacks strike about 2.4 million American adults "out of the blue," with feelings of intense fear and physical symptoms sometimes confused with a heart attack. Unchecked, the disorder often sets in motion a debilitating psychological sequel syndrome of agoraphobia, avoiding public places. Panic disorder runs in families and researchers have long suspected that it has a genetic component. The new finding, combined with evidence from recent animal studies, suggests that genes might increase risk for the disorder by coding for decreased expression of the receptors, say the researchers.

NIMH grantee Dr. Rene Hen, Columbia University, and colleagues, reported in 2002 that a strain of gene "knockout" mice, engineered to lack the receptor during a critical period in early development, exhibit anxiety traits in adulthood, such as a reluctance to begin eating in an unfamiliar environment. More recent experiments with the knockout mice show that a popular SSRI (serotonin selective reuptake inhibitor) drug produces its anti-anxiety effects by stimulating the formation of new neurons in the hippocampus via the serotonin 5-HT1A receptor.

In the current study, Neumeister and Drevets used PET scans (positron emission tomography) to visualize 5-HT1A receptors in brain areas of interest in 16 panic disorder patients – seven of whom also suffered from major depression – and 15 matched healthy controls. A new radioactive tracer (FCWAY), developed by NIH Clinical Center PET scan scientists, binds to the receptors, revealing their locations and a numerical count by brain region. Subjects also underwent structural MRI (magnetic resonance imaging) scans, which were overlaid with their PET scan data to precisely match it with brain structures.

In the panic disorder patients, including those who also had depression, receptors were reduced by an average of nearly a third in the anterior cingulate in the front middle part of the brain, the posterior cingulate, in the rear middle part of the brain, and in the raphe, in the midbrain. Previous functional brain imaging studies have implicated both the anterior and posterior cingulate in the regulation of anxiety. Stimulation of 5-HT1A receptors in the raphe regulates serotonin synthesis and release. In an earlier PET study of depressed patients, using a different tracer, Drevets and colleagues found less dramatic reductions of the receptor in the anterior and posterior cingulate, but a 41 percent reduction in the raphe. These findings add to evidence for overlap between depression and anxiety disorders.

Although animal experiments have shown that cortisol secretion triggered by repeated stress reduces expression of the gene that codes for the 5-HT1A receptor, such stress hormone elevations are usually not found in panic disorder. Noting the recent discovery of a variant of the 5-HT1A receptor gene linked to major depression and suicide, the researchers suggest that reduced expression of the receptor "may be a source of vulnerability in humans, and that abnormal function of these receptors appears to specifically impact the cortical circuitry involved in the regulation of anxiety."

Other researchers who participated in the study are Drs. Earle Bain, Allison Nugent, Omer Bonne, David Luckenbaugh, Dennis Charney, NIMH; Richard Carson, William Eckelman, Peter Herscovitch, Warren G. Magnuson Clinical Center.

The National Institute of Mental Health (NIMH) and the Warren G. Magnuson Clinical Center are parts of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services.

People with Traumatic Brain Injury: A Community Seeking a Beacon of Hope in the Darkness

Staff Writer
Mental Health News

Traumatic Brain Injury (TBI) is not a mental illness, but people with TBI and their families experience many of the same challenges and struggles familiar to those in the mental health community.

People with TBI endure the harmful effects of stigma towards their illness. Because of the extreme difficulty they have with memory and thinking ability, people with TBI are often forced to stop working—adding to the stigma of being a "non-productive" individual. Quite often, community resources have limited funding and agencies are hard pressed to outwardly promote their services. Many victims may be eligible for Federal and State service and stipend programs, but without a personal advocate familiar with the process, many individuals and families give up trying to understand and apply for them.

When asked about TBI, Ira H. Minot, Founder and Publisher of Mental Health News spoke about his new and compelling interest in Traumatic Brain Injury.

According to Minot: "I have been learning about Traumatic Brain Injury from a Mental Health News subscriber in upstate Syracuse, New York who sustained TBI in an auto accident several years ago."

TBI can have a devastating and profound impact on a person, from a physical, cognitive and emotional standpoint. Serious mental illnesses frequently co-occur in people with TBI. Conditions such as Posttraumatic Stress Disorder and Clinical Depression are frequent, as is the looming danger of suicide. In addition, many people with TBI sustain other bodily trauma which may include spinal cord injury. Living with and managing pain becomes a primary factor.

According to the Brain Injury Association of America, each year, at least 1.5 million Americans sustain a traumatic brain injury—resulting in more than 4,000 individuals sustaining a TBI on a daily basis.

Minot, an advocate and innovative provider of mental health education became concerned that the upstate reader had great difficulty locating TBI resources in Syracuse: "I know that there is often a gap between a consumers ability to find out about vital programs in their community—not because of any fault on the part of either the consumer or the programs that are out there."

Sure enough, after making a few calls, Minot spoke with Richard Pratt, Executive Director of Transitional Living Services of Onondoga.

"Ironically, I was introduced to Richard during a visit to Syracuse when meeting with David Brownell, Commissioner of Onondoga County's Department of Mental Health," Minot recalled, "but I didn't realize that Richard's organization also provided services to people with Traumatic Brain Injury."

Among their many other community programs, Transitional Living Services provides advocacy and support services to people with TBI, and is the home of The David Clark Learning Center—a unique and multifaceted program that provides a special setting which allows survivors of brain injuries to learn ways to face the challenges of integration into society—beyond the traditional rehabilitation program model. Their web address is www.tls-onondaga.org.

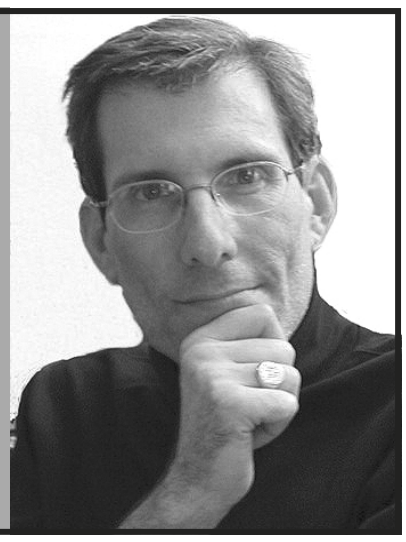
In the New York City area The Brain Injury Society, founded by Kayla Menucha Fogel, is helping provide help and empowerment to clients and families and can be visited at www.bisociety.org.

The first steps in finding a happy ending for our friend in Syracuse are underway. The good people at TLS have begun meeting with her to initiate the advocacy and intake process. "What I learned," Minot said, "is that people with Traumatic Brain Injury may be another segment of the community that is seeking a resource that can help them keep up with the latest news, education, advocacy and resources."

Minot, whose vision is never daunted by new challenges contends: "I would love to help organize the leaders of our regions Traumatic Brain Injury community behind a project to fund a TBI newspaper which could make a difference in the lives of people with TBI, as Mental Health News has done for people with mental illness. I hope they will read this and give me a call."

A Voice of Sanity

A Column by Joshua Koerner
Consumer Advocate and Executive Director, CHOICE, New Rochelle, New York



Food Fight

By Joshua Koerner

In recovery we have an expression: "The war is over." It means that we admitted that we were powerless over our addictions, and so gave up, surrendered, and stopped trying to use successfully. It is the first critical step of the 12 steps of recovery, the only one we have to do perfectly all the time, because it is the one that allows us to cease using the addictive substance. But of all the substances to which I have been addicted – alcohol, marijuana, cocaine and nicotine among them – food is in some ways the worst. With food the war is never over, because food is a necessity of life. You never stop using it, and so the battles never end.

Food was my first addiction; I learned early that chocolate bars, Twinkies and Hostess cupcakes made me feel better. Those were the sweet food group. The salty group included pretzels, Fritos, and later, when my palette became more sophisticated, Doritos with French onion dip. Potatoes were their own group: French fries, mashed potatoes, baked potatoes, potato skins (with bacon and cheese) and, God help me, I went through a Tater Tot phase as well.

It wasn't just what I ate: it was the manner in which I ate that was also disordered. I didn't eat, chew, savor, or swallow. I crammed. As I learned years later, the brain takes a while to realize the stomach is full, so by the time I finished eating I wasn't just full -- I was stuffed. To this day I am embarrassed when I see that a whole table's worth of dinner companions are still eating, while the plate before me has been empty for ten minutes.

I ate because I was unhappy, shy, quiet, alienated and withdrawn. The more overweight I became, the more I became an outcast, and so more alienated, more unhappy. Even my friends would treat me one way when we were alone, yet make fun of me if other kids were around. Food was my only true friend. By age 16 I weighed nearly 250 pounds. I was enormous; my ill-fitting clothes accentuated my bulk. Cinched at the waist by pants that were a size and a half too small, each button of my shirt seemed ready to pop off from the pressure of rolls of fat underneath.

Shopping for clothes was a nightmare: having to behold my misshapen form in the multiple perspective mirrors of the fitting room was horrifying. Eventually, my choices at the regular clothing outlets dwindled to the point where I could shop only at Big and Tall Men's stores. I was frequently the only customer there who didn't shave yet, and although I had a much wider selection (pun intended) of clothes, just walking into such a place was an additional humiliation.

In my family I was certainly not an exception: my father had already died of a heart attack, secondary to both obesity and high blood pressure, and both my mother and sister were overweight. Food addictions, like any other, run in families. But I was fortunate because my mother decided that we were all going to lose weight together. First, all the bad foods were removed from the house. Goodbye, Oreos! So long, sundae cones! Then she started to cook Weight Watcher meals. Back then there were no Weight Watcher frozen dinners, or Lean Cuisine, or Healthy Choice. If you wanted diet food you had to cook it from scratch. Mom used to make lean ground turkey meat into a variety of foods, like chili, or meatloaf, and for dessert there was Alba 77, a skim powdered chocolate milk you could put it in a blender with ice and make into a diet shake.

Over the next year I lost 65 pounds. It was an amazing transformation. I went from a 46 waist to a 34. I could buy regular sized clothes off the rack at a regular store! It was like becoming a member of society for the first time. But inside there was still a miserable, maladjusted fat boy trying to get out. At 18 I switched addictions: I started to smoke pot. And of course pot gives you the munchies. I took a healthy approach to weight control: I started smoking cigarettes. Whenever I got the urge to put something in my mouth I lit up. By the time I dropped out of college I was addicted to booze, drugs, and cigarettes. But at least I was thin.

The drugs wrecked my life, and the ensuing mental illness brought it to a grinding halt. I have since come to realize that being The Fat Kid was my first stigma, the one that taught me that I was different, and that it was acceptable for everyone else – friends, casual acquaintances and even total strangers – to treat me as if the most important facet of my being was Fatness. As a Mental Patient, I was already trained to allow Illness to become the most salient aspect of who I was. I would again have people taunting me for being different, only this time it would be cops and psych techs, and this time my tormentors had handcuffs, restraints and medications.

The one time I put most of the weight back on was during my longest hospitalization. I was locked in for six months, more depressed and isolated than ever. My family brought food at every visit. Under my bed I had cheese in a can and Triscuits. When I had grounds passes I would go down to the gift shop and buy half pound bags of peanut M&Ms.

That was seventeen years ago. I haven't had any symptoms of acute mental illness since 1991. I haven't had a drink or a drug since 1992, and I quit smoking in 1994. Yet food continues to bedevil me. When I tell people I am a food addict, they frequently respond with surprise: "But you're so thin!" How little they understand that maintaining my weight is a constant, never ending series of battles. The holiday season is always difficult: a seemingly endless round of parties at the office, among friends, even at twelve step meetings. There is also the endless series of daily battles. 9:30 PM is a minefield: too late to eat, too early to go to bed. The weekends are tricky because they lack the regimentation of the weekdays, and there are other, frequent enticements to eat: at the movie theatre or visiting someone whose house is chock full of stuff that I don't keep at home, like Triscuits, pretzels, Chex mix. In fact, I go shopping every two days, because I only keep a two-day supply of food in my house.

How much simpler life would be if I could just avoid food altogether. It was tough giving up drugs, and cigarettes were the worst, but in both cases I had only one objective: *don't use.* The longer I go without a joint or a line or a pill or a smoke, the easier it becomes. But food? Worse even than the plethora of daily eating choices is the cacophony of emotions that accompanies every food-related decision: You shouldn't have eaten that! You're weak! Did you have to have TWO pieces of bread with dinner? You're fat! You should have had the baked potato, not the fries!

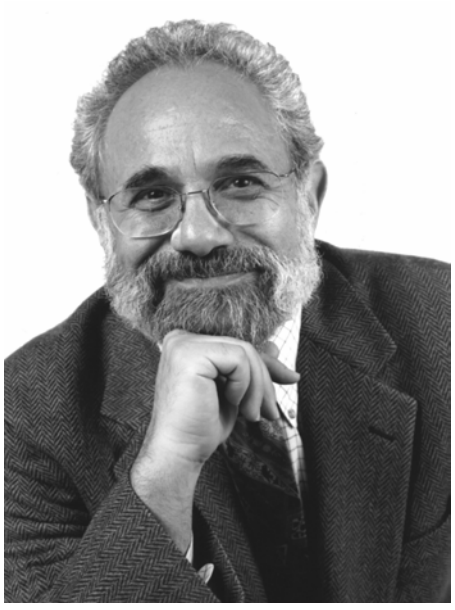
I shall never be free of food, its joys but also its misery. Every meal is a temptation to binge, an invitation to indulge. It was an apple that got Adam tossed out of Eden; it is food that consigns me to Hell.

POINT OF VIEW

POINT OF VIEW

Beyond the Politics of Hospital Closures

By Michael B. Friedman, CSW



Michael B. Friedman

The New York State Governor's Budget Request this year includes a proposal to establish a bi-partisan Commission for the Closure of State Psychiatric Centers. It's the right thing to do.

For the past few years progress in community mental health in New York State has been stymied by the politics of hospital closures. The Governor has proposed closing state psychiatric hospital centers in *The Executive Budget Request*. Local communities, which would take an economic hit and lose services, have reacted with outrage. Unions which represent state workers have fought to retain jobs. Family members who have come to rely on these particular state facilities have reacted with fear about what will happen to their loved ones. Some mental health advocacy organizations have opposed the closures because of concerns about loss of vital services without a clear plan to replace them. And in response to all this agitation, the Legislation has recoiled in political horror and refused to go along with the Governor.

Given the lack of public planning for hospital closures, the Legislature's response is understandable. But in fact it makes good economic sense to close more psychiatric centers. The same number of beds can be provided in fewer hospitals. Why spend money to renovate and maintain inpatient facilities if (and this is a big if) the same services can be provided elsewhere? So much is needed to provide a comprehensive community-based mental health system that every effort should be made to take the savings that are possible without loss of necessary services and to reinvest them in community services.

The Commission the Governor has proposed can help the state move past the politics of closure. But to do so it will need to address some very tough questions. In general it will have to determine what the impact of particular closures is on patients and their families, on local mental health systems, on the education of mental health professionals, on state workers, on the mental health system, and on the economy of the community. The Commission will also have to determine how much will be saved, what assurance there is that the savings will be reinvested in community-based services, and whether these gains counterbalance the unquestionable pain that will be caused in economic losses and in increased difficulty of access to services for some people.

Here are some critical questions the Commission must be able to answer about each hospital considered for closure.

Impact on Service

- What are the fundamental facts about utilization? Capacity? Occupancy over the past two years? Annual admissions? Average length of stay? Number of long-term patients?
- What are the current discharge patterns? How many patients are discharged to adult homes? How many non-geriatric patients are discharged to nursing homes? How many patients are discharged to facilities outside the local community? How many go out of state?
- What is the geographic distribution of patients and their families? How many families are able to visit using public transportation that takes one hour or less?
- To what facilities would patients be transferred? How far away are they? What provisions would be made for families to visit?
- Will outpatient services be expanded?
- In general, what is the plan to serve the populations currently served by the facility that will be closed?

Impact on the Local System of Care

- To what extent is the facility an element of the local system of care?
- Does it provide acute admissions, intermediate care, or only long-term care?
- What are the referral sources to state psychiatric centers? Where will they make referrals if the facility closes?
- Are there local facilities which can provide acute and intermediate care? How much acute and intermediate care is currently provided outside of the local community?
- To what extent will changes in systems other than mental health increase or decrease need for the services currently provided by the facility?
- In general, how will the functions served by the state facility in the local system of care be replaced?

Costs and Savings

- What renovations are required to have an adequate physical plant?
- How much will these renovations cost? Capital costs? Debt service costs?
- How much will be saved by closing the facility if the beds are transferred to another facility?
- How will the savings be used?
- Is it possible to sell the land for other uses? Can the land be used to provide housing and community services for people with mental illnesses? How will it be used?
- In general, will savings in capital and operating expenses be reinvested in community mental health or will they dissipate in general state savings?

Impact on Education of Mental Health Professionals

- What training programs currently use the facility as a training site? How many people are trained annually? What professions? What specialties?
- Will training be discontinued? If so, what will be the loss in the development of well-trained mental health personnel? If training will be continued, what is the plan?

Impact on Employees

- How many jobs will be eliminated?
- What percentage of new jobs in the community will go to state workers?
- What efforts will be made to help employees find new state jobs? Other jobs?
- What is the anticipated impact of employees with seniority bumping employees who have special training and/or experience serving special populations?

Impact on the Economy of the Local Community

- What is the anticipated economic impact on the local community?
- What provisions will be made to help the community develop economic alternatives?

These are tough questions, but they need to be answered, and answered publicly, because too many people are affected by hospital closures to take them lightly.

The bi-partisan Commission proposed by the Governor is the right way to take on the issues. Let's hope that it can be done with a minimum of political posturing and that decisions can be made which will make it possible for New York State to regain momentum towards the development of a high quality, comprehensive, community mental health system.

Michael B. Friedman, CSW is The Director of The Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester. The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.

The NYSPA Report

Practice Guidelines: Process and Promise

By John S. McIntyre, M.D.
Vice President for Behavioral Health and Chair, Dept of Psychiatry and Behavioral Health, Unity Health System, Rochester, New York

Over the past several decades there have been great advances in our understanding of mental illnesses and their treatment. Much has been learned about the genetics and etiologies of these illnesses and research has identified psychotherapeutic, pharmacological and social treatments that work. A significant challenge we face is the incorporation of this knowledge, about what is effective, and what is not, into the day-to-day treatment of our patients.

One approach to meeting this challenge is the development and implementation of practice guidelines. Practice guidelines have been defined as strategies for the care of patients that are developed to assist clinicians and patients in their choice of treatments.

Guidelines are being developed by professional associations, professional consortiums, hospital and provider organizations, managed care organizations and the federal and state governments.

The American Psychiatric Association launched a Practice Guideline project in 1990. The Association was guided by an Institute of Medicine report (1990) that identified elements of a "good" guideline and the work of the Royal College of Psychiatrists of Australia and New Zealand who had begun to develop guidelines in the early 1980's. APA has now published 13 guidelines, most recently a Guideline for the Treatment of Patients with Suicidal Behaviors (November 2003.) The guidelines are increasingly being used by clinicians and systems of care as well as by managed care and review organizations.

Generally, APA guidelines focus on a disorder(s). The exception has been a guideline on the psychiatric evaluation of adults and, as noted above, a guideline on suicidal behaviors.

The first guideline published by the APA was a Practice Guideline for Eating Disorders (February 1993). Eating Disorders was chosen as the first guideline for several reasons. It clearly is a major illness with very significant morbidity and at times mortality. There was a substantial body of research (which has grown considerably in the last decade.) Also, it was felt that better dissemination of the findings of the research and implementation of the best practices that had been described, could significantly improve the quality of care available to patients with these disorders and their families. Joel Yager, M.D. was chosen as the Chair of the Work Group.

After being formed the workgroup first conducts a comprehensive literature search and develops evidence tables. For eating disorders, as for all disorders, there are significant gaps in the research base and clinical consensus must be used to develop many of the recommendations. It is very important that in the guideline the nature of the evidence that has led to the recommendation is clearly defined. Each APA guideline begins with an executive summary which includes the major recommendations, each coded according to the following criteria: (I) Recommended with substantial clinical confidence, (II) Recommended with moderate clinical confidence, (III) Options that may be recommended on the basis of individual circumstance. Each reference cited is categorized, in the reference section, as to the nature of evidence it includes (e.g. randomized clinical trial, or longitudinal study or review with secondary analysis.)

The APA development process is iterative, with three drafts, each draft having a larger number of reviewers. Many of the comments submitted are incorporated into the subsequent draft. Reviewers include national and international experts, psychiatrists working in a variety of practice settings with varying patient populations, other professional organizations including the other mental health disciplines, lay organizations and advocacy groups. Finally, the guideline is approved by the APA Assembly and Board of Trustees. Hence the guideline carries the imprimatur of the organization as an official position statement. Each guideline is published in the American Journal of Psychiatry. Every 2 years a compendium of all the guidelines is also published. Each guideline is also available on the APA web site www.psych.org.

APA's and other guidelines can be accessed through the federal government's (ARQ) National Guideline Clearinghouse www.guideline.gov/

As noted above, APA's practice guidelines are increasingly being used (and some have been translated into 10 different languages.) However, there is still much room for improvement. Following the publication of the first few guidelines, including the eating disorder guideline, feedback was received that the guideline was too long to be helpful in the patient encounter. This feedback led to the development of a Quick Reference Guide (QRG) for each guideline, which presents the key recommendations in an algorithmic and bullet format. The QRGs have been very well received. Other dissemination strategies (e.g. PDA versions) are being explored. To further encourage effective use of the guideline, a continuing medical education (CME) course is developed for each guideline in cooperation with APA's Office of Education, and published on APA's CME website at www.psych.org/cme. Also, questions from the guidelines are being used in various testing settings – including American Board of Psychiatry and Neurology certification and recertification.

Monitoring adherence to a guideline requires the use of monitors or indicators. The American Psychiatric Institute for Research and Education (APIRE) uses APA practice guidelines to develop quality of care indicators.

An essential aspect of good guidelines is that the recommendations be current. Guidelines must be revised at regular intervals. In the APA project, guidelines are to be revised at 5-year intervals (or sooner.) The Eating Disorder guideline was revised and published in 2000.

The primary goal of practice guidelines is to improve the quality of care patients receive. One mechanism by which this can be achieved is the identification of gaps in the research base as the guideline is being written. These gaps should drive a research agenda by identifying those areas in which further research is necessary and should be supported. Each APA guideline has a section focusing on future research directions. The Eating Disorder Guideline identifies 20 areas where additional research would be very helpful in formulating further and improved treatment recommendations.

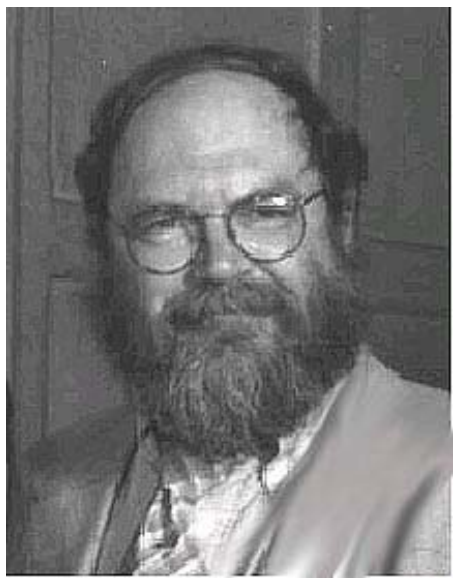
The advantages in the use of evidence-based guidelines in the treatment of patients are considerable and their use will increasingly contribute to improvement in the quality of care available to patients.

John S. McIntyre, M.D. is Former President, American Psychiatric Association. He is Chair of the Steering Committee on Practice Guidelines for the American Psychiatric Association.

WORKING WITH MEDICATIONS

What is a Formulary and Why Should I Care?

By Richard H. McCarthy M.D., C.M., Ph.D. Comprehensive NeuroScience



Dr. Richard H. McCarthy

In prior columns, I have addressed issues that influence a psychiatrist's choice of medications. The factors that have been discussed thus far have focussed on the place where treatment takes place, the individual characteristics of the patient and physician and the problems or symptoms that are the targets of treatment. All of these columns have assumed that there is a list from which medications are selected. There is, and that list is called a Formulary. If every drug that was available was on every formulary there would be no particular reason for this column. Physicians could open some book that lists all of the available medications and select whichever one was appropriate for the patient. There is such a complete list; it is the list of all medications that are approved by the FDA. This list includes all medications, brand name and generic equivalents that may be legally prescribed by a physician and sold by a pharmacy in this country. This FDA list also spells out what is known about the medication, its approved uses and adverse effects. In a way, the list of FDA approved medications is the national formulary. The medications appearing there are known to be effective to treat some illness. The risks and benefits of such treatments are made clear. Medications not on the FDA list have not been approved for use in medical treatment. The PDR (Physicians Desk Referenceä) is a book that contains the FDA approved description of the medication, its uses, benefits and adverse effects. (Please note that this discussion does not include over the counter medications or nutritional supplements, the so-called nutraceuticals. These substances do not have to be shown to be useful; they merely have to not be dangerous.) While the FDA list may be the National, all-inclusive formulary, there are many, smaller local formularies. Every state has its own formulary, so too does every hospital. Increasingly, insurance companies that pay for medications are developing their own formularies. The problem is that not all formularies include every drug, and some formularies exclude some drugs that you may be taking or want to take. If your medication is not on the formulary, you might not be able to get it at all. If you could get it you would most likely have to pay for it yourself. This is important because insurers have decided that they should have some, if not absolute control, over the medications that they will pay for. Most importantly, for the poor and disabled, Medicaid, and likely Medicare in the future, intend to further limit their formularies. Thus, medications that are now on the list may not be available in the future. How formularies are made up, then, becomes crucial in determining what medications are available to be used for treatment.

For almost every illness there are many available medications that can be used to treat the problem. So, for depression we have at least 3 classes of medications, the tricyclics, MAOIs and the SSRIs. The tricyclics include effective medications such as imipramine (Tofranilä), amitriptyline (Elavilä) and nortriptyline (Pamelorä). These are older medications, all are available as generics and are all rather inexpensive compared to the newer medications. The MAOIs (**M**ono **A**mine **O**xidase **I**nhibitors) such as phenelzine (Nardilä), isocarboxid (Marplanä) and tranylcyproamine (Parnateä) are also older, cheaper, effective medications used to treat depression. Finally, the newer agents, the SSRIs, which include fluoxetine (Prozacä), paroxetine (Paxilä) and Sertraline (Zoloftä) among others, are also effective, have a very different adverse effect profile than the older medications and are much more expensive. You will have no doubt noticed that all of these medications are effective, all have adverse effects and some are more expensive, sometimes much more expensive than others. If all of these medications were equally effective for most people then it would be unreasonable to purchase expensive medications when cheaper ones would do. It would only make sense if there were some other persuasive reason to buy the more expensive one. (While we all are likely to agree with this, in real life we often do not follow this simple idea. For example, there are huge differences in price among clothing items such as designer jeans, even though there may be minimal differences between the items, and no difference at all in the items ability to be worn.) In general, in internal medicine, there tend to be very few differences between medications. So, one beta-blocker (medication used to treat rapid heart rate, among other things) is pretty much the same as another and people do not have big differences in how they respond to them. A State Formulary would then tend to limit the number of available beta blockers that could be prescribed, so that the state could arrange to buy a few in bulk and the others not at all. Obviously, a pharmaceutical manufacturer would very much want to have its medication on as many formularies as possible and would tend to reduce its price, or take other action (such as special rebates) to accomplish this. Since the overwhelming majority of people could use just one or two agents, the insurer could save money. The small number of people who could not use the "approved" beta-blocker, would have to pay for it themselves, or go through a special review and approval process or go without.

Restricted formularies make sense when different medications are largely equivalent; when real savings can be achieved by the restrictions and when very few people are seriously inconvenienced or harmed by the restrictions. So far, so good. Unfortunately, for psychiatric medications, there are very real disagreements about most of this. There have been a number of studies that state that older antidepressants are not better than the newer ones. Likewise there have been a few studies that state that the newer so-called atypical antipsychotics are not better than the older antipsychotics, called neuroleptics. The cost differences between these new and old medications are enormous. Any study that states that there is no difference in effect will make it very hard, if not impossible, to justify buying the newer expensive ones, rather than the older cheaper ones. I must say that almost all clinicians, and most researchers dispute the findings of these studies. But, if you were the insurer, which studies would you choose to believe? Which medications would you include on your formulary?

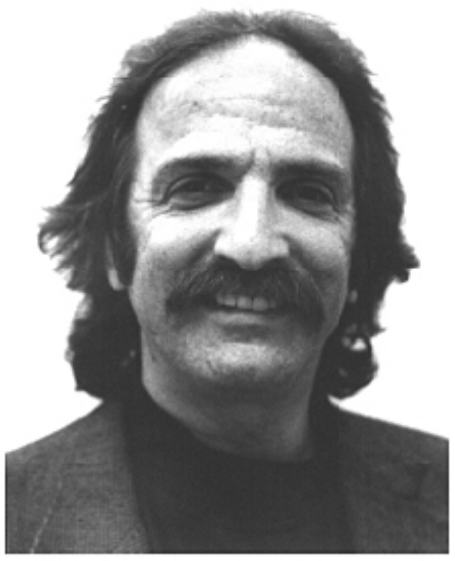
Likewise, there is no particular reason why a patient would respond to one medication rather than another, but the fact is that people do. Some patients respond to an SSRI but not to the older, cheaper tricyclic. Worse yet, a patient may respond to one SSRI, such as sertraline, and not to another, such as fluoxetine. Such differences in clinical response are common. A similar situation occurs for medications used to treat psychosis. In all cases, it is rare that a patient responds equally to every medication within a class, much less to every medication, such as antidepressants, used to treat a given illness. From this standpoint, a restricted formulary may delay or, in the worse possible case, prevent a persons getting on the medication that might be needed. In this situation, which medications would you put on your formulary?

Most studies that we have about medications provide us with information about how groups of people respond to any given agent. While this is certainly helpful in selecting medications, we have almost no studies that tell us how a specific individual will respond to any specific medicine. The literature does not help us with this question. Physicians treat individuals not groups. For psychiatric medications, there is no good information that suggests that all of our medications are equivalent. In fact, clinical experience, and the bulk of information suggest that they are not.

Formulary restrictions make sense, if the medications are equivalent, if people will respond to one or another of them the same way and if money can be saved. Psychiatric medications do not clearly meet the first two criteria. Formulary restrictions for psychiatric medications may save some money, but this is yet to be proven. They will almost certainly delay the time to recovery for some patients who will not be able to receive the necessary medications without a considerable delay. Formulary restrictions will certainly increase the paperwork necessary to obtain medications and, to the extent that patients are started on cheaper, but less effective medications, they may actually increase not only patient suffering, but increase costs as well. Formulary restrictions may not be such a good idea for people with psychiatric illnesses.

THE NYAPRS ADVOCACY WATCH

By Harvey Rosenthal
Executive Director, NYAPRS
New York Association
of Psychiatric Rehabilitation Services



Harvey Rosenthal

Testimony Before the NYS Legislative
Joint Fiscal Committees
Mental Hygiene Budget Hearing
February 4, 2004

Thank you, Chairman Johnson, Chairman Farrell, Chairman Rivera, Chairman Libous and the other members of the Committees for this opportunity to present to you the concerns of the thousands of New Yorkers represented by the New York Association of Psychiatric Rehabilitation Services, a unique statewide partnership of New Yorkers with psychiatric disabilities and the community mental health professionals who support them in over 150 community mental health service settings from every corner of the state.

I'm Harvey Rosenthal, NYAPRS Executive Director. The following testimony incorporates the direct input of almost a thousand NYAPRS members who gathered at local forums in New York City, Long Island, Binghamton, Poughkeepsie, Fishkill, Olean, Elmira, Westchester, Syracuse, Watertown, Glens Falls and Batavia during the last three months.

After decades of being represented by others, New Yorkers with psychiatric disabilities are at long last speaking for themselves, as evidenced by last Tuesday's NYAPRS Legislative Day, when, over 500 New Yorkers with serious mental illnesses braved the bitter winter weather to carry their agenda here in Albany in support of their personal recovery, rehabilitation and rights.

As you can see, state mental health policy is a very personal matter for the NYAPRS community. In that same spirit, it's been a very personal one for me, as someone who began his life's work in mental health in 1971 as a patient, struggling with a very severe depression that led to a six week stay in a Rockville Center hospital psychiatric unit. At that time, New York's mental health system was institutionally based, centering around 32 large state facilities that were filled with almost 90,000 individuals.

By the 1980's, New York had more fully committed itself to a more progressive, humane policy of deinstitutionalization that gave rise to local community mental health rehabilitation, employment and support services for adults and children in every county of the state, funded with Aid to Localities mental health dollars. Our policies no longer relied primarily on hospital care, outpatient medication and lethargic smoke-filled day programs but spawned a host of new programs designed to bring mental health support to normative roles in community environments: hence the rise of supported employment and education and New York's own historic clubhouse movement.

By the 1990's, thanks to the great leadership of the State Legislature, we passed the Community Reinvestment Act, committing ourselves to moving state mental health dollars to where the people were or wanted to be, in their home communities. Reinvestment closed 5 state hospitals and hundreds of state hospital beds and redirected over $180 million of the savings over the next decade into some of the most progressive recovery-based programs in the country.

Together, we've worked to maximize opportunities for recovery, empowerment and employment, we've sought to ensure that all are afforded respect and dignity and are assured fully informed choice of services and practitioners and full protections of their human and civil rights. We've worked to develop progressive new rehabilitative and self-help service models and more effective medicines and we've worked hard to press each year to provide a more adequate array of appropriate and diverse housing opportunities.

During this period, state and local hospital censuses have shrunk leaving us with the belief and hope that the thousands who otherwise would have languished in outmoded institutional settings had gone on to better lives, free to enjoy the advances of the last few decades.

Tragically, this better life hasn't been shared by tens of thousands in our community, as our concerns for state prisoners with psychiatric disabilities, adult home residents and the homeless contained within this testimony and the attached materials will bear out.

The Governor's Executive Budget proposal for the upcoming fiscal year contains some historic advances in extending the promise of recovery. After 2 years of dormancy, it resumes funding the landmark Reinvestment program; it advances a State Hospital Closure Commission proposal advocates have sought for almost a decade, and creates the means to use future closure savings to boost both state operated and voluntary community services in areas directly affected by a closure; it recognizes the terrible plight of New York's 'silent forgotten,' funding $13 million in more appropriate prison treatment settings for state inmates with psychiatric disabilities than the inhumane solitary confinements or 'SHUs' currently used; it takes an important step towards ensuring the stability and staff retention of existing community mental health housing services by enhancing their funding; it funds 600 new supported housing beds that, added to previously authorized or promised new housing expansion, will create upwards of 4,400 new community beds over the next three years and it expands funding for important new initiatives aimed at helping adult home residents with psychiatric disabilities.

Yet the Executive Budget also includes several very disturbing negatives. It levels a very damaging cut to local rehabilitative, self-help, employment, multicultural and local coordinating services for adults and children; it continues plans to convert $50 million of many of the same core community rehabilitative services to a new Medicaid funding and programmatic program called PROS *without* providing a trended increase that would help guarantee their stability and survival in the future, and it provides not one single bed of alternative community housing that is dedicated for current residents of New York's troubled adult homes and it introduces hurtful Medicaid drug co-pays, wipes out essential psychological, dental, podiatry and nursing Medicaid coverage, introduces a controversial preferred drug program and levies cruel TANF cuts to families with disabilities.

Since our focus here is on state mental health expenditures and my time is limited, I'd like to focus on 4 major budget priorities for NYAPRS members, and refer you to the attached materials for more detailed presentations on our other priorities.

Restoration of Cuts to Core Community Rehabilitative Mental Health Services

The Governor's budget cuts $7.7 million in 'Aid to Localities' community mental health funding that would take down a critical portion of the core community services safety net we have worked so hard and so long to develop. These are the same services that I referred to earlier as critical to New York's deinstitutionalization and community-based recovery initiatives that I mentioned earlier.

These cuts could cut deeply into local community mental health service safety nets and could actually wipe out entire core programs that adults and children with serious psychiatric disabilities currently rely on each day to support their recovery and to avoid painful and costly relapses.

County mental health officials are required to reduce their total Aid to Localities mental health allocations by 5%: they can either levy an across-the-board-cut or choose to eliminate entire programs.

As you can see from the following list, the cuts would undermine local efforts to provide core rehabilitation, employment, peer-run, advocacy, emergency, children's, transportation and local administrative support in every county in NYS.

A Sampling of 'Aid to Localities' Funded Core Community Services That Are Being Threatened with Reductions or Elimination include:

- Advocacy Services
- Affirmative Business/Industry
- Alternative Crisis Support
- Assisted Competitive Employment,
- Bridger/Transition Management Services
- Coordinated Children's Services Initiative
- Crisis Intervention
- Crisis Outreach
- Drop In Centers
- Enclave in Industry
- Family Support Services
- Local Governmental Unit Administration
- Mobile Treatment Team/Crisis Outreach
- Multicultural Initiative
- Neighborhood Care Team
- Ongoing Integrated Supported Employment
- On-Site Rehabilitation
- Outreach
- Peer Advocacy
- Psychosocial Club
- Recreation
- School Based Initiative
- Self-Help Programs
- Sheltered Workshop
- Social Adult Day Care
- Supported Education
- Transitional Employment Placement
- Transportation
- Vocational Services–Children & Family and Work Program

Moreover, given the state's recent trend to convert community mental health services to Medicaid (see next piece on PROS), these damaging cuts will further jeopardize already diminishing flexible mental health care for needy non-Medicaid eligible New Yorkers.

Accordingly, NYAPRS members urge the Governor and our State Legislators to protect local community mental health service safety nets and to restore the $7.7 million in Aid to Localities-funded community mental health services.

see Testimony on page 53

The NAMI-NYS Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness. Helpline: 1 800-950-3228 (NY Only) - www.naminys.org - Families Helping Families

By J. David Seay, J.D.
Executive Director - NAMI-NYS

J. David Seay, J.D.

The New Year began like a blizzard in Albany for NAMI New York State. Governor Pataki's Executive Budget was released on January 20th, our semi-annual Board of Directors and Affiliate Presidents' Dinner was held on February 2nd, our annual Legislative Breakfast and Conference was conducted on February 3rd and we delivered our budget testimony on February 3rd. Whew! And as with most blizzards, shovels have been necessary. Even as I write this column I am working with the NAMI-NYS Government Affairs Committee to craft our budget testimony and prepare for the Legislative Day. By the time you read this our testimony will be public and you can get copies by contacting any of the staff at NAMI-NYS.

In this NAMI Corner I want to highlight our 2004 Legislative Agenda for Action. As with last year, our theme this year is "Fight for Care" for New Yorkers with mental illness. Five top priorities were established by the Board of Directors upon recommendation of the Government Affairs Committee. In addition, a listing of "other major concerns" was included. Those priority issues include:

Fight For Housing

Ask your legislator to increase the budget for housing for New Yorkers with mental illness. Thousands have been dumped out of the state system into adult homes, jails, prisons, homeless shelters and nursing homes while others live at home with aging parents terrified of what will happen when they can no longer care for them. Estimates show that 40,000 - 70,000 more housing units are needed. NAMI-NYS calls for a waiting list bill, commitment to 4,000 new units a year and a long-term plan for housing and services.

Fight For Timothy's Law

Demand that comprehensive mental health parity legislation be enacted in New York. Pass "Timothy's Law," the bill named for 12 year old Timothy O'Clair from Schenectady who tragically completed suicide three years ago after his family's mental health benefits ran out. His courageous parents have come forward to tell their devastating story, convinced that Timothy would be alive and getting the treatment he needed had New York's laws prohibited discrimination against persons with mental illness.

Fight to "Boot the SHU"

NAMI-NYS calls for passage of Assembly Bill 8849 to ban the use of prison "special housing units" (SHUs) -- the punitive 23-hour lockdowns also known as "the box" -- for persons with mental illness. It is time to end this barbaric practice.

Fight for Access to Medications

Restrictions to access for psychiatric medications under the Medicaid program must not be allowed. "Preferred drugs lists" (PDL), formularies, prior authorizations and other mechanisms designed to save money by blocking or slowing access are unacceptable. NAMI-NYS joins Assemblyman Rivera's opposition to any PDL.

Fight for Research

Demand that the Legislature stop efforts to slowly starve the research budget through staff cuts and attrition. Keep the Nathan S. Kline Institute for Psychiatric Research in Rockland County and the Psychiatric Institute for Research in Manhattan whole and intact. Research is our hope for the future.

Other Major Conderns

Adult Homes: NAMI-NYS applauds the Governor's $10 million in new funds for adult homes and residents. At the same time NAMI-NYS fights for new housing earmarked for many of the people who do not belong in adult homes in the first place, and for more rigorous enforcement of regulations aimed at adult home operators.

Medicaid: The Medicaid budget must not be balanced on the backs of poor, sick and disabled New Yorkers. The Executive Budget would restrict access to medications by a Preferred Drug List and would eliminate coverage for dental, nursing, podiatry and psychological services. NAMI-NYS fights this type of Medicaid reform.

Community Safety Net Programs: Under the new Personalized Recovery-Oriented Services (PROS) program, small local club houses, drop-in centers, vocational programs and other providers of community mental health services may be put in jeopardy. NAMI-NYS urges the legislature to fight to keep these services viable.

Planning and Psychiatric Center Closings: NAMI-NYS applauds the Governor for calling for a new Blue Ribbon Commission to make recommendations about the state psychiatric center system. NAMI-NYS has fought for such a bipartisan long-term planning process for some time. However, the Commission should not be focused solely on psychiatric center closures, as it is now described.

Presumptive Medicaid Eligibility: Persons with mental illness discharged from jails, prisons, and hospitals need access to medications to transition safely into the community. A 45-day gap exists between discharge and re-establishment of Medicaid eligibility. NAMI-NYS fights to close this gap.

Act: Assertive Community Treatment (ACT) is an evidence-based practice proven to work, keeping persons with serious mental illness in their communities for treatment. These teams must be both fully funded and fully staffed.

Employment: Eighty five percent of persons with mental illness do not hold jobs. With training and supported employment, many more can work and be productive members of society. NAMI-NYS fights for 1,500 new supported employment slots in this year's budget, at an additional cost of $3.4 million.

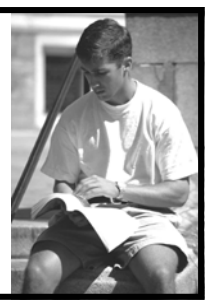
By and large the Governor's Budget was a mixed bag of good news and not-so-good news. However, given the reality of a multi-billion budget deficit facing the State of New York, many mental health advocates, certainly those of us at NAMI-NYS, were relieved and even pleased that the mental health budget faired pretty well. One major item included in the proposed budget that deserves mention here is the proposal to establish a "Bipartisan Commission for the Closure of State Psychiatric Centers." Although NAMI-NYS for years has called for the establishment of a special commission, it was not just for hospital closures, but rather, for a serious, thorough, and fair and balanced long-term planning process for housing and services, including the state psychiatric centers, for New Yorkers with serious mental illness.

see NAMI on page 52

The Campus Report

Discussing Mental Health Issues at College & University Campuses Across the Nation

"Rewards Are High When Effective Services Are Provided"



By David B. Spano, Ph.D.
University of North Carolina, Charlotte

As they have for generations, students bring to college a broad range of developmental issues. Issues of autonomy, interdependence, identity formation, developing a purpose and philosophy of life, and relationship development are among the many exciting—and sometimes bewildering—tasks of late adolescence and early adulthood.

More recently, significant mental and behavioral health issues have become increasingly evident. Major depression, bipolar illness, eating disorders, significant substance abuse problems, anxiety disorders, and other problems are impacting the ability of many students to succeed academically and grow personally and interpersonally.

According to the most recent national survey of counseling center directors, administered by Dr. Robert Gallagher and colleagues from the University of Pittsburgh and published by the International Association of Counseling Services, 81.4% of directors report that their centers are seeing more students with serious psychological problems than they were five years ago. Fully 40% of clients in college counseling centers have "severe psychological problems" according to these directors.

College and university counseling centers have seen a marked shift in students and their problems in the last 10 to 15 years. Most of us who went to college a generation or more ago may have been barely aware of mental health services on our campuses. Now, it is not unusual for college counseling centers to report seeing upwards of 10% of the student body in any given year or 25% of a graduating class sometime during their enrollment. In looking at data from just the past few years, most counseling centers report significant increases in the use of their services by students. According to a 2002 article in the New York Times, Columbia University reported a 40% increase in the use of their services since 1995. The State University of New York at Purchase reported a 48% increase in just three years. During my first five years as director of the counseling center at Ithaca College, we saw a 60% increase in center utilization. Counseling centers around the country report similar trends.

There are several possible explanations for the dramatic increase in students seeking counseling:

1) More students are coming to campus with already diagnosed mental health problems. Some researchers have described an epidemic of depression among teenagers for example. Eating disorders are becoming more common among younger teens. Anxiety and stress-related disorders are on the rise. Across the country, counseling centers report an increase in the number of students who were prescribed psychotropic medication before college, and these students come to college needing psychological support and, often, ongoing psychiatric services. Similarly, an increasing number of older adults, returning to undergraduate and graduate education after years out of school, are also bringing with them the usual stressors of adult life. These students typically seek the support of their campus counseling services in large numbers.

2) More students are enrolling in college who would not have been able to negotiate the demands of college life a decade ago. Students with psychological disabilities who qualify for academic accommodations under the Americans with Disabilities Act or have benefited from improved treatment options are able to get into college and succeed. These students, of course, often need ongoing support in order to remain successful.

3) More students are feeling the stresses of the current world environment. The threat of terrorism, increased violence, war, overcrowding, and changing social norms all contribute to greater levels of stress in the world. For example, colleges in close proximity to New York City saw a dramatic rise in students seeking counseling in the months immediately after 9/11, and those numbers remain high over two years later. Persons who are vulnerable to the development of psychological disorders may in fact develop these disorders as a result of this increased stress.

4) The stigma attached to seeking help for psychological problems is diminishing. Students are coming to counseling centers in increasing numbers because they are more willing to seek help. Students are sharing their experiences with their friends, and that, in turn, encourages others to seek help.

5) Counseling centers have developed into highly professional, expertly staffed clinics. A 2000 survey of counseling center directors found that 94% of counseling center staff have a doctorate in counseling or clinical psychology. Many counseling center psychologists hold licenses and are experts in college mental health. In addition to informing their campus communities about their staff's credentials, counseling centers are working hard to increase their visibility and accessibility to members of the college community. Counseling center staff often spend significant time in consultation with campus faculty and administrators, serving on university committees, and offering educational outreach programs to their campus communities. These activities raise the profile of campus counseling services, promote referrals, and encourage students to use the services offered.

David B. Spano, Ph.D.

The rising numbers of students in counseling today is good news in that colleges and universities are reaching more of the students who need support. Some researchers have argued, in fact, that students may not be not worse off emotionally than they were in past years; they just have better access to services and are more willing to seek help.

There is a downside as well. In this era of spiraling costs and tight university budgets, staffing levels at counseling centers often lag behind the demand for services. Counseling centers often have to make difficult strategic decisions on how to best serve their student clients. Most centers limit the number of sessions a student can attend during an academic year; students who present with more complex or severe pathologies are often referred to resources off campus. Cost, inconvenience, and low motivation make it difficult for some students to follow through with these referrals. While this strategy does allow centers to serve more students, there is also a worry that students who need help the most may be least likely to receive it.

Another issue that complicates things for college and university mental health professionals is the increased degree to which parents are desiring to be involved in their sons' and daughters' lives on our campuses. Issues related to confidentiality and privacy often clash with the desire to keep families appropriately informed about serious mental health concerns. Deans and vice presidents, as well as counseling center administrators, are grappling to strike a balance between communicating with parents and allowing their sons and daughters to learn to make good decisions and take responsibility for their own health care. In cases where the emotional problems become severe, it is sometimes difficult to discern when getting parents involved will be helpful. These circumstances often present college administrators with complex ethical, legal, and practical dilemmas.

Several high profile cases have recently put college mental health services at center stage. A murder at Harvard University in 1998, a suicide at MIT in 2000, a recent suicide at NYU, and similar events at other schools have attracted much attention. In some cases, litigation focusing on the degree to which colleges are responsible for these tragedies is ongoing. The *New York Times*, the *Chronicle of Higher Education, Time* magazine, and other publications have printed major articles on college student mental health and called attention to the problems and dilemmas institutions of higher education face.

These issues are beginning to attract the attention of legislative bodies as well. During the past few months, Congressman Danny K. Davis (D-Illinois) and Congressman Tom Osborne (R-Nebraska), both members of the House Education and the Workforce Committee, introduced HR 3593, "The Campus Care and Counseling Act." This bill proposes an amendment to the Higher Education Act that would include making grants available to campus-based mental and behavioral health services. This bill is intended to strengthen the amount of, type of, and access to mental health services on college campuses.

This bill was written with the knowledge that our country has a major stake in the academic success of the best and brightest of our young people. Mental health issues can significantly impair a students' ability to succeed academically and to grow personally and interpersonally and, thus, to become optimally-functioning members of our society. In the face of growing evidence that our college-age population is suffering more significant stress and emotional difficulty than ever, it is an investment in our future to assist these students in restoring their well-being and optimizing their contributions to society. It is important for all of us who care about the mental health of students on our campuses to call our representatives in Congress and express our support for this bi-partisan bill.

Issues related to the mental health of college students are complex and changing, but they are critical issues to address. The rewards for society, for practitioners,

see Campus on page 53

Latino Health News - Informe: La Salud de los Latinos

"A New Initiative for Mental Health News"

By: Leo Leiderman, Psy.D., CGP
Director of Latino Treatment Services
Saint Vincent's Catholic Medical Center

For over twenty years the U.S. Department of Commerce has reported that Hispanics are the nation's youngest and fastest growing population. In contrast to this population growth, study after study since the 1970's has reiterated that Hispanics underutilize and drop out of mental health and substance abuse services more than any other population with equivalent socioeconomic problems. There is also a void in much needed bilingual/bicultural mental health and substance abuse services for Hispanics. Researchers have pointed out different variables they felt have led Hispanic groups to underutilization and to drop out of treatment. These include factors such as:

- Institutional barriers that inhibit the availability of culturally sensitive and relevant services.

- Differences in social class, cultural belief systems and life-styles between Hispanics and professionals of treating agencies.

- Lack of clear-cut expectations and understanding by Latino patients of what treatment entails, its purpose and intended outcome.

- Institutional racism which has created psychological barriers by practitioners.

- The finding that mental health centers and substance abuse treatment facilities do not meet the needs of Hispanics.

- Many Hispancis are also reluctant and resistant to seek mental health and substance abuse treatment due to the negative stigma associated with receiving treatment and cultural beliefs that inhibit them from obtaining services.

Although resistance to psychiatric and substance abuse treatment is not uncommon, in the case of treating Latinos, on top of these "common" resistances, the practitioner and patient/family are many times separated by linguistic and cultural barriers that contribute to these resistances. One of the main purposes of a bilingual/bicultural approach or knowledge of cultural differences is to dilute these barriers so that a therapeutic relationship can be established. A bilingual/bicultural approach, in addition, enhances engagement especially for those who are resistant to treatment and lowers attrition levels.

Providing bilingual and bicultural services is generally based on the understanding that culture is a strength that will be valued and validated in treatment (Cheung, 1991; Oetting & Beauvais, 1991). A culturally sensitive approach focuses on the factors related to the stress inherent in dealing with two cultures at the same time (Chau, 1992), and the strengths, assets and needs of individuals, families and the community at large (Delgado, 1995).

Leo Leiderman, Psy.D., CGP

Knowledge about how a Latino patient or family may differ from others culturally can not be underemphasized. Understanding the Latino population takes on meaningful significance when one analyzes how individual and environmental problems interact. How immigration difficulties, familial disruption, dislocation, conditions related to poverty and acculturation difficulties are all associated with a greater likelihood of substance abuse and mental health problems (Delgado, 1994; Schinke, Moncher, Palleja, Zayas & Schilling, 1989; Garcia, 1998; Szapocznik & Kurtines, 1980).

Discussing the cultural differences demonstrated by Hispanics is complex. Hispanic families come in many forms, structures, and colors; Hispanic society is not homogeneous. Focusing on an ethnic group as diverse as Hispanics is also complicated by the fact that Hispanics are many times divided between two nations, vary in their use of Spanish and/or English language dominance, have extended families with Spanish, Black and/or Indian heritage, and distinct value and belief systems. The use of generalizations to describe this population is restricted. The danger in pointing out general cultural and contextual characteristics of a particular group of people is that one may stereotype or induce prejudice against that particular group. On the other hand, if sociocultural and cultural differences are ignored, the clinician's effectiveness with Hispanics could be minimized (Rosado, 1980; Pedersen, 1977; Inclan & Hernandez, 1992; Montijo, 1985; Acosta et al., 1982). In addition, without the awareness of the ethnic context of clients, clinicians working with minorities can misunderstand and carry out incorrect decisions and/or treatment interventions (Hines et al., 1992; McGoldrick, et al., 1991).

The cultural barriers, environmental pressures and acculturation stressors that many low-income immigrant Hispanics face leave them without the resources and at times the means to seek appropriate services. Many providers who treat these individuals are ill prepared to address the multilevel needs that exist with this population that are beyond the realms of standard psychiatric and substance abuse treatment models. Often, Hispanics who struggle with mental health and substance abuse problems and acculturation difficulties are unidentified until their problems become acute. Many individuals are never treated or find themselves with legal problems (i.e., juvenile delinquency, foster care, domestic violence, etc.) because they are untreated.

Research has supported not limiting interventions with Hispanics to any one individual treatment approach (Yin, Zapata & Katims, 1995) as well as the need to implement multilevel interventions with Latino individual and families suffering from mental health and substance abuse problems (Comas-Diaz, 1986) and for direct practitioners to engage community services and create more collaboration between professionals and agencies treating Latinos (Delgado, 1995). One such intervention could be carried out by increasing the psychoeducation of the Hispanic population's cultural issues as well as how theses issues interact with mental health and substance abuse problems.

With the aspiration of better serving the Hispanic population's mental health and substance abuse needs, *Mental Health News* has taken on the project of creating a bilingual/bicultural newsletter. This newsletter will target individuals and families at risk for mental health and substance abuse problems as well as those practitioners treating this population. The newsletter will offer psychoeducation and outreach to bilingual, bicultural community agencies, parishes, schools, mental health and substance abuse facilities serving Latinos.

Practitioners would be provided with culturally relevant topics impacting today's Hispanic individuals and families. Such topics are to include: (1) How sex roles have been clearly demarcated: Encouraging a double sexual morality; "hombre de respecto"; "machismo", "marianismo or the martyr complex for females"; how Hispanic females are at times caught in conflicting acculturation roles; single parent families, etc.; (2) Topics related to acculturation and immigration; (3) The cultural value and emphasis placed on the Hispanic family; (4) Intergenerational differences and conflicting cultural values and behaviors within Hispanic families; (5) Effective treatment interventions including engagement strategies for resistant Latino patients and their families; and, (6) Sociocultural factors influencing today's immigrant families.

The bilingual/bicultural newsletter will also reach out to Hispanics in the community. It will reach out to Hispanic consumers already engaged in treatment; as well as those who are not engaged but at risk of mental health and substance abuse problems. Many of those who are not engaged may also demonstrate resistances to services. The goal of this outreach is to reduce the cultural stigma that is many times associated with receiving treatment services. Articles will be written with a grassroots flavor to engage those most in need, educate them about different mental health and substance abuse issues and guide them to appropriate resources within the community.

An Advisory Committee of bilingual/bicultural experts has been formed and met recently in New York City. Some of the members of that committee are David Aquije, Associate Editor, Maryknoll Magazine, Martha Lopez, CSW, Hispanic Liason of the Westchester County Executive's Office, Debra Del Toro-Phillips, CSW, Director, Stepping Together Program of the Mental Health Association of Westchester and Dr. Sharlene Bird, Latino Behavioral Care Network and the Association of Hispanic Mental Health Professionals.

This committee is very interested in your ideas, feedback about the project, or if you would like to support the initiative. Please feel free to e-mail me at lleiderman@svcmcny.org. We are very excited about the project which we are calling "Latino Health News" and look forward to your input.

A native Argentine, Dr. Leiderman has a doctorate and two masters' degrees in clinical psychology. He is a New York State licensed psychologist and is nationally certified as a group psychotherapist. He is the director of the Latino Treatment Service at Saint Vincent Catholic Medical Center. The program is comprised of a multidisciplinary team providing bilingual/bicultural mental health and substance abuse treatment. He chairs the Sound Shore Mental Hygiene Council in Westchester County, is a member of Congresswoman Nita Lowey's Hispanic Advisory Board for the 18th Congressional District, and is a member of the Westchester County Hispanic Advisory Board. He was recently appointed to the Westchester County Community Services Board. He is on the Advisory Council and the Clinical Advisory Board of Mental Health News. He has a private practice in Westchester County and New York City.

the NARSAD *report*

The National Alliance for Research on Schizophrenia and Depression

By Constance E. Lieber, President NARSAD

Constance E. Lieber

I would like to share with you an article which appeared in our Fall 2002 NARSAD Research Newsletter. It is entitled: "Are Eating Disorders Forms of OCD?" This article was written by Ann B. Brown.

Anorexia nervosa is one of the most vexing and dangerous of psychiatric disorders predominantly affecting women. Death rates for this illness from malnutrition and suicide are as high as 20 percent when patients are followed-up for more than 20 years.(1) Increasingly, researchers are focusing on whether eating disorders might be part of the obsessive-compulsive spectrum disorders. Patients with anorexia often exhibit obsessive-compulsive traits such as perfectionism, obsessionality, and compulsivity. Also, researchers have discovered that obsessive-compulsive disorder (OCD) and tic disorders are higher in families of patients with eating disorders—approximately 12 times greater than comparison groups.(2)

Although many people believe that eating disorders are becoming more common due to our culture's preoccupation with thinness, the evidence from systematic surveys is inconclusive. What is clear is that fewer cases are going undiagnosed. One reason is that the average age of puberty in American women has retreated three to four years during this century, probably because of better nutrition and less infectious disease. That means a girl is more likely to develop anorexia while she is still living with her parents, and the disorder is more likely to be noticed and acknowledged as a serious problem.

Anorexia

A typical scenario of anorexia begins when a young girl starts to starve herself and sometimes exercises compulsively as well. Her weight falls and her health deteriorates, but she persists in denying that her behavior is abnormal or dangerous. She may say she feels or looks fat, although everyone else can see that she is gaunt. To conceal her weight loss from parents and others, she may wear baggy clothes or secretly pocket and discard food instead of eating it. Her reasons for rejecting food are a mystery that researchers are still trying to solve.

Often, anorexia may be diagnosed when others notice symptoms such as drowsiness and lethargy which may be affecting schoolwork. Other symptoms may include dry skin, brittle nails and hair, lanugo (fine downy hair on the limbs), constipation, anemia, and swollen joints. Female hormones fall drastically, and sexual development may be delayed. Heart rate and blood pressure can become dangerously low, and loss of potassium in the blood may cause irregular heart rhythms. Other serious long-term dangers are osteoporosis and kidney damage.

Although rare, anorexia nervosa can strike men as well. Recent studies show a 16 percent prevalence rate for men, much higher than was initially estimated (i.e., 5-10 percent).(3)

Bulimia

Bulimia was not even recognized as a distinct psychiatric disorder until the 1970s, and it did not appear in the diagnostic manual of the American Psychiatric Association until 1980. With bulimia, a young girl will typically have two or more episodes of binge eating (i.e. rapid consumption of a large amount of food, up to 5,000 calories) every week for at least three months. The binges are sometimes followed by vomiting or purging (with the use of laxatives or diuretics) and may alternate with compulsive exercise and fasting. The symptoms can develop at any age from early adolescence to 40, but usually become clinically serious in late adolescence. Bulimia is not as dangerous to health as anorexia, but it has many unpleasant physical effects, including fatigue, weakness, constipation, fluid retention (bloating), swollen salivary glands, erosion of dental enamel, sore throat from vomiting, and scars on the hand from inducing vomiting. Overuse of laxatives can cause stomach upset and other digestive troubles. Other dangers are dehydration, loss of potassium, and tearing of the esophagus. A crossover can occur from anorexia, as about 40 percent of the most severely bulimic patients have a history of anorexia.

Irreversible Effects

One potential danger of anorexia is that it can have drastic and irreversible effects on bone function. Relatively rapid and substantial reductions in bone mineral density occur because of both increased bone resorption and reduced bone formation. Therefore, patients should be assessed by dual-energy X-ray absorptiometry (DEXA) starting early in the course of the illness and at regular intervals. Changes occur within months and can result in severe osteopenia (reduced bone mass due to a decrease in the rate of young bone which has not undergone calcification) and even osteoporosis within just a few years. By their mid-20s, women with anorexia have stress fractures seven to eight times more than age-matched controls.(4) Bone loss is particularly severe among purging patients.

Bone density measurements may also have a therapeutic impact. When confronted with their unquestionable low bone densities via DEXA, patients who previously were poorly motivated often shift their thinking and start acknowledging the seriousness of their conditions. This is particularly important because the only intervention known to prevent further bone loss and induce new bone growth is prompt nutritional rehabilitation, starting with hypercaloric diets, together with high calcium intake and vitamin D supplementation.

A second potential danger is that starvation-induced brain changes may not all be reversible. Magnetic resonance imaging examinations in malnourished adolescents with anorexia nervosa have shown that both gray matter and white matter volumes are reduced, and that cerebrospinal fluid spaces increase in these patients. After an average of 16 months following weight restoration, changes in the white matter reverse themselves, but significant deficits in gray matter volume and enlarged sulci (furrows) persist.(5) Conceivably, some of these deficits may improve further with additional time and nourishment.

Occurrence in Children

Although most eating disorders start while patients are in their teens and 20s, earlier and later onsets are encountered as well. In some anorexia patients with early onsets (i.e., between ages 7 and 12), obsessional behavior and depression are common. Children often present with physical symptoms such as nausea, abdominal pain, feeling full, or being unable to swallow; their weight loss can be rapid and dramatic. They may suffer from delayed growth and may be especially prone to osteopenia and osteoporosis. Typically, adolescents with anorexia have better scenarios than adults, and younger adolescents have better prognoses than older adolescents. As for bulimia, children under the age of 12 rarely have this disorder.

Common in Athletes

Many competitive athletes develop eating disorders. Female athletes are especially vulnerable in sports that emphasize a thin body or appearance, such as gymnastics, ballet, figure skating, and distance running. Males in sports such as bodybuilding and wrest-ling are also susceptible. Certain antecedent factors such as cultural preoccupation with thinness, performance anxiety, and athlete self-appraisal may predispose a female athlete to body dissatisfaction, which often leads to the development of eating disorders. Overall, extreme exercise appears to be a risk factor for developing anorexia nervosa, especially when combined with dieting.

Coexisting Illnesses

Impulsivity—manifested as shoplifting, suicide gestures, and laxative abuse—is frequently found in anorexic and bulimic patients. These patients often have the following coexisting illnesses:

- Substance abuse
- Posttraumatic stress disorder (PTSD)
- Mood disorders
- Anxiety disorders

According to one national survey, nearly 37 percent of women with bulimia also had co-occurring PTSD.(6) When the childhood histories of these bulimia patients were examined, physical and sexual abuse was often found.

Personality Traits as Risk Factors

Clinical observations have long pointed toward a link between a type of personality and eating disorders. Aspects of temperament that can contribute to vulnerability for anorexia include:

- Perfectionism
- Obsessionality
- Compulsivity
- High harm avoidance
- Low novelty seeking

Combinations of these traits, together with dieting behaviors and excessive physical exercise, are thought to create potentially volatile mixtures in which risks for developing anorexia increase substantially.

The picture for bulimia is more mixed. Traits such as perfectionism, shyness, and compliance have consistently emerged in some studies of individuals with bulimia. However, other studies have often found bulimic patients to be extroverted, histrionic, and affectively unstable.

Part of Obsessive-Compulsive Spectrum?

Many researchers believe that eating disorders may not be independent disorders but should be considered as part of the obsessive-compulsive spectrum. This hypothesis is supported by a recent study where anorexia patients had a greater probability of possessing the obsessive-compulsive trait.(7) Additional support

see NARSAD on page 17

NARSAD from page 16

has shown that one set of genetic vulnerabilities may predispose a person to develop any type of eating disorder, but anorexia in particular requires the presence of a second genetic predisposition—traits of perfectionism, symmetry-seeking, or perseverance.(8)

The relationship between eating disorders and obsessive-compulsive disorders (OCD) is further supported by studies looking at OCD patients and their risk for developing eating disorders. One study found OCD patients to have a 8.3-12 percent risk of developing eating disorders versus the general population risk of 1 percent for anorexia nervosa and 4 percent for bulimia.(9)

Several twin studies suggest that anorexia and bulimia are hereditary. In one comparison, anorexia was found in 9 of 16 identical twins of anorectic patients but only 1 of 14 fraternal twins. In another study, researchers found that when one of a pair of identical twins had bulimia, the chance that the other would also have it was 23 percent—eight times higher than the rate in the general population. For fraternal twins, the rate was 9 percent, or three times higher than average.

How the Brain Controls Body Weight

One possible cause of eating disorders is abnormalities in the activity of hormones and neurotransmitters that preserve the balance between energy output and food intake. This regulation is a complex process involving many regions of the brain and several body systems. Nerve pathways descending from the hypothalamus, at the base of the brain, control levels of sex hormones, thyroid hormones, and the adrenal hormone, cortisol, all of which influence appetite, body weight, mood, and responses to stress. The neurotransmitters serotonin and norepinephrine are found in these hypothalamic pathways. In starving anorectic patients, serotonin activity is low but higher than average, when their weight returns to normal.

In looking at how parts of the brain control body weight, food intake, and the stress response, Elizabeth M. Bell, D.V.M., Ph.D., of the University of California-San Francisco (a 1998 NARSAD Young Investigator) is investigating how the body's response to stress changes when its metabolism is changed.

Dr. Bell administered either sucrose or water to rats in either a cold or room temperature environment. She found that rats exposed to the cold (a form of stress) and administered sugar water lost less fat and had lower levels of the stress hormone corticosterone than rats exposed to cold who were administered water without sugar. These results suggested that sugar was helping these rats withstand stress better, a finding that may be explained by less secretion of a hormone called corticotropin releasing factor (CRF), which increases the stress response and the mobilization of fat stores.

Other researchers speculate that eating disorders are influenced by enkephalins and endorphins, the opiate-like substances produced in the body. They point to studies that have found the spinal fluid of anorectic patients to contain high levels of these endogenous opiods. Also, when some of these patients are given naloxone (Narcan), a pure opiate antagonist commonly used to treat potential opioid overdose, they gain weight.

When to Hospitalize

The services available for the treatment of eating disorders can range from intensive inpatient settings (in which subspecialty general medical consultation is readily available), through partial hospital and residential programs, to varying levels of outpatient care (from which the patient can receive general medical treatment, nutritional counseling, and/or individual, group, and family psychotherapy). Weight and cardiac and metabolic status are the most important physical parameters for determining choice of setting. Those weighing less than 75 percent of their individually estimated healthy weights are likely to require a 24-hour hospital program.

Prompt treatment is vital. Once weight loss is severe enough to cause the indications for immediate medical hospitalization, treatment may be less effective, refeeding may entail greater risks, and prognosis may be more problematic than when intervention is provided earlier. Knowledge about gray matter deficits that result from malnutrition and persist following refeeding also point to the need for earlier rather than later effective intervention.

Although most patients with uncomplicated bulimia do not require hospitalization, indications for hospitalization can include severe disabling symptoms that have not responded to adequate trials of competent outpatient treatment, serious concurrent general medical problems, suicidality, psychiatric disturbances that would warrant the patient's hospitalization independent of the eating disorders diagnosis, or severe concurrent alcohol or drug abuse.

Treating Anorexia

Because few of the psychological manifestations of anorexia (i.e., obsessionality, compulsive behaviors, conceptual distortions, and symptoms of depression and anxiety) disappear completely with weight restoration alone, patients require specific psychotherapies to help them understand and cope with many slow-to-change, eating disorder-related attitudes and fears. One study found that cognitive behavior therapy was more effective than nutritional counseling alone in helping patients maintain improvements following weight restoration.(10) For younger patients, studies have found that family therapy is more beneficial than individual psychotherapy and should be considered an essential component of treatment in this age group. Because of the enduring nature of many of the psychopathologic features of anorexia and the need for support during recovery, ongoing treatment with individual psychotherapeutic interventions is frequently required for at least a year and may take 5-6 years.(11)

see NARSAD on page 52

VIP Treatment For Mental Health Consumers Returning To Workplace

By Carol Gibney, MSW
The Volunteer Center of United Way

Carol Gibney, MSW

The Volunteer Internship Program serves people who are mentally ill through a volunteer internship position. The interns develop vocational goals and gain work experience. The Volunteer Internship Program (VIP) has been operated by the Volunteer Center of United Way and sponsored by Westchester County's Department of Mental Health since 1994. VIP stands for Volunteer Internship Program as well as Very Important Person. If you are in VIP, you are treated like a VIP. The VIP program is designated as a TEP (transitional employment program). Individuals are referred to the VIP via a mental health professional and internships are set up at nonprofit organizations in Westchester County.

For many, "the journey of a thousand miles begins with a single step". The internship provides the bridge from someone's current situation to the road to employment. Many people with mental illness are at a point in their recovery where they know they are ready for the next step, they want to go back to work, but are reluctant for many reasons to try to make that leap. These individuals often feel isolated, lack confidence in their abilities, and are unsure how to begin. They are keenly aware of the gaps in their work histories and how that appears to a potential employer. An internship provides each volunteer with recent work experience and references. Each internship is based on an individual's skills, interests and goals. VIP is not a training program, but interns are frequently exposed to or taught new skills while they strengthen other skills and an internship often offers many opportunities for growth.

The Volunteer Internship Program provides on-going support, advocacy and coaching by the coordinator, written evaluations by the work supervisor, monthly meetings, socialization and reimbursement for travel expenses. A certificate is awarded when the internship has been completed. The internship frequently provides the volunteers with recent references for a resume.

Whether candidates for VIP come from day programs, IPRT's, club houses or are referred by a private practitioner, they all have one need in common: an opportunity to gain back confidence in a work-setting that supports their goals. That leap to employment mentioned earlier is, indeed, a giant leap without preparation and practice. This is why the Volunteer Internship Program has been helpful for so many people. Past internships have included accounting, art programs, grant writing, childcare, data entry, marketing, outdoor maintenance, hospitals, schools, child and adult care facilities and cultural and human services agencies. Participants must be Westchester residents. Internships run for a minimum of ten or more hours a week for approximately six months.

Please call, Carol Gibney, MSW, VIP Coordinator, at 914 948-4452 to schedule an appointment. Let's take that first step on the journey together!

Mental Health News Message:

You may be feeling hopeless right now... but please realize that these feelings may simply be your illness talking - and with the right help these present feelings can be made to pass.

Never give up hope.
There is a caring mental health community nearby that stands ready to help you get thru this difficult time.

Ira H. Minot, Publisher

What Do We Know About Eating Disorders?

By Katherine A. Halmi, M.D.
Professor of Psychiatry
Director, Eating Disorders Program
NewYork-Presbyterian Hospital
Westchester Division

Anorexia nervosa and bulimia nervosa are the two major eating disorders, which primarily affect adolescent girls and young women. Anorexia nervosa is characterized by a preoccupation with body weight and food, a distorted or peculiar way of perceiving ones body, an intense fear of gaining weight and behaviors directed towards losing weight such as severe food restriction or intense exercise, and amenorrhea, the cessation of menstrual periods. Bulimia nervosa is characterized predominantly by binge eating and the performance of a compensatory behavior to counteract the potential weight gain from calories ingested during bingeing. Patients with bulimia nervosa primarily engage in self-induced vomiting but will also restrict food intake for periods and abuse stimulants and/or laxatives.

Many adolescents and young adults with eating problems do not fit the formal criteria for anorexia nervosa or bulimia nervosa. These patients are treated with techniques that are similar to those used for anorexia nervosa or bulimia nervosa.

It is important to note that many patients are reluctant to discuss their eating habits and their families do not often recognize the seriousness of their problem. For example, self-induced vomiting can lead to a low serum potassium level, which in turn can cause a fatal cardiac arrhythmia.

What Are The Risk Factors For Developing An Eating Disorder

One of the major risk factors for developing anorexia nervosa or bulimia nervosa is having a relative such as a parent, sibling or child with an eating disorder. These disorders tend to run in families. It is likely that both family genetics and family environment play a role in the development of eating disorders. Studies of family interactions involving patients with eating disorders have produced conflicting results. Some studies of families of bulimia nervosa patients show a lack of parental affection, negative, hostile, and disengaged interactions, parental impulsivity, and a family history of alcoholism or obesity. Bulimic patients themselves rate their families as conflictive, badly organized, and lacking in nurturance and caring. Anorexia nervosa patients perceive their families as stable, nonconflictive, cohesive and concerned. These patterns of family interactions are descriptive and at the present time there is insufficient evidence to prove that family environment is a strong positive factor in the development of eating disorders.

More recently some evidence has emerged in collaborative studies among centers in the United States, Canada and Europe of a genetic component to both anorexia nervosa and bulimia nervosa. Changes in a discrete area in chromosome 1 have been associated with anorexia nervosa and changes in an area of chromosome 10 were shown to be associated with bulimia nervosa patients. These findings need to be replicated and the genes in the area under concern need to be studied for specific alterations. The Westchester Division of the NewYork Presbyterian Hospital through its eating disorder program is part of a genetic study funded by the National Institutes of Health. In this study persons with anorexia nervosa who have a sibling or another relative with anorexia nervosa are interviewed and blood is obtained for genetic studies.

Stressful life events may be another risk factor for developing an eating disorder. Approximately 30% of patients with eating disorders may have been sexually abused in childhood, however, this figure is comparable to the rate of sexual abuse found in normal populations.

A perfectionist, obsessive-compulsive personality may be a risk factor for developing the restricting type of anorexia nervosa. The latter are patients who lose weight by restricting food intake and exercising but do not engage in vomiting or laxative abuse.

Anorexia nervosa has the highest mortality rate of any psychiatric illness. Long-term mortality rates are 7% at 10 years and 18 to 20% at 30 years after presentation for treatment. About 25% of patients with anorexia nervosa recover, 25% remain ill and approximately 50% partially improve. The most common causes of death are cardio-vascular failure and suicide. For patients with bulimia nervosa who binge and purge but stay within a normal weight range mortality rates vary between 0 and 3%. The most common cause of death is cardiac arrest due to cardiac arrhythmia caused by low potassium levels in the blood, which result from self-induced vomiting. Ten years after onset of illness about 50% of bulimia nervosa patients will have fully recovered and 20% will remain ill. About 30% of recovered bulimic patients relapse within 4 years after stopping treatment.

Physical and Laboratory Findings

Most of the physical changes that occur in eating disorder patients are due to starvation or purging behaviors. These changes are generally reversible with nutritional rehabilitation and the cessation of purging. Chronic dieting

Katherine A. Halmi, M.D.

can lead to decreased bone density and an increased risk of factures. Even bulimic patients who are not underweight often have decreased bone density after years of intermittent, severe dieting and bingeing.

Eating disorder patients who engage in self-induced vomiting often have tooth enamel erosion with carries and enlarged salivary glands, which give them a chipmunk face appearance. Low blood potassium levels from vomiting can also cause weakness and low blood sugar levels from starvation can be related to fainting episodes.

Treatment

Patients with anorexia nervosa or bulimia nervosa are best referred to a clinic or physician experienced in treating eating disorders. Early treatment is necessary to prevent chronic ongoing illness.

Anorexia nervosa patients need medical management, which includes weight restoration, nutritional rehabilitation, rehydration, and correction of serum electrolyte abnormalities. Patients need to be watched closely for signs of vomiting or drug abuse and for suicidal and impulsive behaviors. Anorexia nervosa patients also need individual psychotherapy based on both cognitive and behavioral therapy principles. Children under the age of 18 will do significantly better if they participate in family therapy, in addition to receiving individual therapy.

Cognitive-behavioral therapy (CBT) has been shown in many controlled studies to be the superior form of treatment for bulimia nervosa. The treatment should be conducted by experienced therapists who have been trained in the use of specific cognitive-behavioral therapy manuals for bulimia nervosa. Antidepressant medications such as the serotonin reuptake inhibitors (Prozac) can also reduce binge/purge behavior. However they are not as effective as CBT. The latter treatment interrupts the self-maintaining cycle of bingeing and purging and alters dysfunctional cognitions and beliefs about food, body image and weight. Usually the treatment consists of weekly therapy sessions over a 20-week period. This treatment will result in complete abstinence from bingeing and purging in about 50% of the patients and a significant reduction of this behavior in over 80%. Another 30% of patients will partially or fully recover a year after therapy. Drug treatment of bulimia nervosa results in only 20 to 30% of the patients obtaining complete abstinence from binge/purge behavior.

Medications are only adjunct treatment for anorexia nervosa. When patients are severely emaciated, a major antipsychotics medication such as Olanzapine may be helpful to reduce the patient's overwhelming anxiety with eating and preoccupations with thoughts of food and losing weight. This medication may also facilitate weight gain. Controlled studies however have not been completed on the use of this drug for treatment of anorexia nervosa. Cyproheptadine, an antihistaminic medication, can facilitate weight gain in patients with the restricting type of anorexia nervosa when given in high doses. It also has a mild antidepressant effect. Fluoxetine (Prozac) has been useful in preventing weight loss relapse in anorexia nervosa patients; however, it is not effective when patients are below 80% of a normal weight.

Today eating disorders have become more prevalent among adolescents and young adults. About 1 in 200 women between the ages of 12 and 18 will develop anorexia nervosa. Bulimia nervosa is more common and is present in about 1% of the population.

The Westchester Division of the New York Presbyterian Hospital in White Plains has had a comprehensive treatment program for eating disorders for the past 25 years. This includes a 20-bed inpatient unit for severely ill patients, a partial hospitalization or day program and an outpatient clinic for those who are less severely ill or are transitioning from inpatient treatment to continuing follow-up care. This program provides individual and family therapy, medical management, nutritional rehabilitation and pharmacotherapy. Outpatient group therapy is available for those patients who have bulimia nervosa. The psychiatrists and psychologists with this program are members of the Weill Cornell Medical Faculty and over the years have conducted many research studies on the eating disorders. Current studies include the genetic study mentioned above and treatment studies for binge eating disorder. For information concerning either treatment or research studies please call 914-997-5875.

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Orange County Eating Disorders Coalition Leads the Cause

By Deborah de Jong,
Associate Executive Director
MHA in Orange County

According to the United States Congress, an estimated 5 million to 10 million Americans suffer from eating disorders, including anorexia, bulimia, and binge-eating disorder as well as eating disorders that are not otherwise defined. As many as 50,000 of individuals affected will die as a direct result of these disorders.

Weight problems are no longer just a personal issue, but a political issue as well. On Feb. 25, 2003, the "Eating Disorders Awareness, Prevention, and Education Act of 2003" was introduced to Congress by Representatives Judy Biggert (R-IL) and Ted Strickland (D-OH). This bill, which is still pending, seeks to amend title V of the Elementary and Secondary Education Act of 1965 to raise awareness of eating disorders and to create related educational programs.

In support of the bill, Congresswoman Judy Biggert, stated: "Despite the social and physical devastation that these diseases inflict on young people, very few States or school districts have adequate programs or services to help children suffering from weight-related disorders. It is not that educators or parents do not realize the problems caused by bulimia or binge-eating or are unable to identify affected students; in many cases, they either do not know how to respond to the problem or are without the resources to help educate our youth about the dangers of eating disorders."

The Orange County (N.Y.) Eating Disorders Coalition, formed six years ago, is ahead of its time. This established team of individuals recognized the need for public awareness, education, prevention and treatment of eating disorders long before it became a hot political issue.

In 1998, under the leadership of the Mental Health Association in Orange County, Inc., Goshen, N.Y., the Eating Disorders Coalition was established to address the critical issue of eating disorders in Orange County. Individuals from mental health agencies, schools, colleges, hospitals and county government joined with individuals recovering from eating disorders to form the Coalition. Their mission is to advance the understanding, prevention, early detection and treatment of eating disorders through education and outreach.

Eating disorders occur when a person turns to preoccupation with food and exercise in an attempt to deal with anxiety and depression. Unhealthy weight loss or gain can result in serious medical problems, poor nutrition, depression, low or high blood pressure, diabetes, osteoporosis, vital organ failure and possible death.

Deborah de Jong, Chair of the Eating Disorders Coalition and Associate Executive Director of the Mental Health Association in Orange County, Inc., said: "The Coalition is concerned about the physical health, psychological and possible life threatening consequences that individuals with eating disorders face. We are a clearinghouse of information and the single point of access for service referrals in Orange County."

The coalition presents an annual conference to inform the public about the cultural and interpersonal factors contributing to the development of eating disorders. On Tuesday, March 16, 2004, the coalition invites the public to attend a conference on "Eating Disorders: Effective Prevention and Intervention Strategies in School," held from 9 a.m. to 3 p.m. at Mount Saint Mary College, Hudson Hall, 330 Powell Avenue, Newburgh, NY. This 4th annual conference targets schools as well as service providers and community members including those with eating disorders.

The keynote speaker, Rebecca Manley, MA, founder and president of the Massachusetts Eating Disorder Association, Inc., has been working in the field of eating disorder prevention since 1988. She is the author of "Teaching Body Confidence: A Comprehensive Curriculum for Girls," published in 2000.

Manley will present on "Body Confidence" and discuss her school-based curriculum in the morning. She will be joined by eight other experts in their fields of social work, law, education, nursing and athletics who will conduct workshops on: "Signs, Symptoms and Causes of Eating Disorders," "Eating Disorders and Athletics," "Schools and Liability Issues" and "Putting Pieces Together and Working as a Team."

de Jong said, "I'm proud of the accomplishments that the committed and dedicated individuals on the Coalition have achieved since fruition. Last year's presentation (in Goshen) on 'Helping Kids to Develop Healthy Relationships with Food' was an overwhelming success." The coalition is recognized as a leader in its field and requests for services are increasing in demand.

Additionally, the coalition provides free online screening for eating disorders. Visit www.mhaorangeny.com for anonymous and confidential test results. Treatment and referral lists, available upon request, include: Comprehensive lists of service providers, healthcare professionals, therapists, nutritional counselors, and support groups for people of all ages with eating disorders.

The coalition continues to serve as a forum for individuals from mental health agencies, schools, hospitals, health organizations, and county government as well as people with eating disorders and their families to access resources, information and support in Orange County and surrounding counties.

The Eating Disorders Coalition is sponsored by Healthy Orange. The Mental Health Association and Healthy Orange are supported by the United Way Agency. For more information, to register for the conference, or to join in the prevention and education effort, contact the Mental Health Association of Orange County, Inc. Phone: (845) 294-7411 or email: mha@mhaorangeny.com.

Understanding Compulsive Overeating

By Janis Voltmer, CSW, Psychotherapist
Putnam Family & Community Services

Compulsive overeating, a behavior associated with anxiety and depression, has been more common among women and now is being seen more frequently among children. Compulsive overeating is often mislabeled obesity or not diagnosed at all since the frequently resulting weight gain or the presenting anxiety and depression are generally identified as the clinical issues. Because the underlying anxiety and depression are most often targeted for treatment as a panacea for treating dysfunctional behaviors, the initial signs of compulsive overeating are often missed and the behavior is undertreated.

Overeating is often seen as one of many behavior problems and barely as an eating disorder. It is a common belief that it results from a lack of willpower or as a result of an underlying problem with food. The belief that food is the problem for overeaters is comparative to concluding that drugs are the problem for the chemically dependent person. It is more accurate that for the compulsive overeater, food is the drug of choice. While there are some theorists who propose that overeating is an addiction or an allergy to sugar, the behavior has a complex cause and effect thinking structure that warrants direct treatment. This compulsive behavior indicates a significant thought pattern that serves to avoid and mask emotional connection and awareness of painful emotions the compulsive overeater believes he/she cannot handle. Until this pattern is treated along with the presenting problems and emotional concerns, any success at treating the underlying emotional issues will be severely jeopardized.

Understanding the implications of this behavior can lead to earlier intervention and healing which can decrease the incidents of morbid obesity, further dysfunctional behavior and emotional suffering. Compulsive overeating is a symptom of a serious underlying thought process that is set in motion by unresolved anxiety and depression, frequently but not always related to trauma, neglect and abuse. It is often used to suppress memories, flashbacks, urges and thoughts about self-injury or self-recrimination. It is a behavior that involves bingeing or overeating to the point of numbness in order to medicate the emotional pain, which results in overwhelming shame. Suppressing this shame becomes the focus of the cycle of thinking. This includes thinking about, focusing on getting, planning around, preparing to eat and consuming food often without conscious awareness.

For overeaters, the idea that they overeat or binge emotionally is initially out of their range of conceptual thinking. When compulsive overeaters can identify their feelings they express deep shame and lack of self-control, fear of exposure, intolerance of emotional tension, poor self-esteem and self image, self disgust and anger, a sense of worthlessness and lingering defeatism, indifference about health and longevity, isolative thinking and unrealistic expectations because of the overeating. The common indicators are bingeing, yo-yo dieting (thinking about and planning to diet, starting and failing repeatedly causing weight gain and loss) and binge/dieting behavior in order to reach and maintain an ideal, often unrealistic weight. This focus becomes an obsession that leads to a series of further attempts to fix what they think is the problem, their weight. Purging and additional substances, such as alcohol or drugs sometimes accompany overeating.

It is not uncommon for the compulsive overeater to be the last to recognize this thinking and subsequent binge/deprive/binge behavior. Most overeaters deny bingeing because they generally do not know what bingeing is, cannot identify feelings and because overeating always appears to occur for no reason or just to satisfy a craving. Bingeing is often misunderstood as overeating to the point of being sick. While this is true for excessive bingeing, bingeing is actually eating when the body is not hungry or calling for food. Overeaters have a great deal of trouble knowing when the body is hungry, such as when the stomach growls or feels empty. They are barely aware that bingeing can occur at any time and in many forms. It can occur at a routine time of day or night or at a particularly stressful time. Most common is night time bingeing or "boredom" bingeing when anxiety and depressive thinking are at their highest. Generally a sense of vague dissatisfaction or tension, usually identified as hunger or a craving previews a binge. This vague feeling generally seems to have no meaning or trigger. Because of this and the shame the unnecessary behavior brings, bingeing is often done in secret or in ways that the overeater thinks goes unnoticed. This may include waiting for others to go to bed or leave, or hiding food where they can get to it at some later time. It can be as subtle as shopping or providing for others, like having candy in the drawer at the office. It includes eating while driving, reading, watching T.V. or waking up at night to get something to eat.

Additionally, bingeing is set in motion by planning for the behavior. It is knowing where all the binge food aisles

see Overeating on page 49

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Inmates from page 1

and the community mental health professionals who support them in over 135 community agencies across New York State.

Based on the very strongly felt personal input of almost 1,000 NYAPRS members in 12 regional forums conducted over the past few months in localities across the state, NYAPRS considers the passage of A.8849 at the top of our legislative priorities for the coming session.

Our members are determined to help speak out on behalf of these 'silent forgotten' members of their community and to ensure that their brothers and sisters behind bars are afforded decent and just alternatives to the inhumane solitary confinement they are currently forced to endure, a system that at this very moment fosters unspeakable suffering that is tragically and unacceptably responsible for almost half of all prison suicides over the past year.

In over 25 years of work and advocacy on behalf of New Yorkers with psychiatric disabilities, no single issue has emerged, in my personal view, with the critical importance and power, than the plight of prisoners with psychiatric disabilities.

Over those 25 years, we have operated in the era of deinstitutionalization, where state officials, advocates, people with psychiatric disabilities and families alike have worked to shift the emphasis of our efforts to support the hope and power of recovery for every individual with a psychiatric disability in productive lives in their home communities.

We've worked to maximize opportunities for recovery, empowerment and employment, we've sought to ensure that all are afforded respect and dignity and are assured fully informed choice of services and practitioners and full protections of their human and civil rights. We've worked to develop progressive new rehabilitative and self-help service models and more effective medicines and we've worked hard to press the state each year to provide a more adequate array of appropriate and diverse housing opportunities.

During this period, state and local hospital censuses have shrunk and we have all hoped that the thousands who otherwise would have languished in outmoded institutional settings have gone on to better lives and enjoyed the advances of the last few decades.

Tragically, this better life hasn't been shared by tens of thousands in our community.

In recent years, we've all learned of the all too often dismal lives endured by 12,000 New Yorkers with psychiatric disabilities who were discharged, not to better lives, but to adult homes that weren't designed, funded and operated to serve them and all too often presented them with deplorable conditions that has bordered on neglect and worse.

We've also had to see, among the explosive rise of homelessness in many of our towns and cities, thousands of people with psychiatric disabilities, unengaged, unserved, forgotten, outside the circle of support offered by our mainstream mental health system.

And perhaps the most tragic plight of all are the thousands in our community who increasingly populate our local jails and state prisons, picked up for a range of criminal offenses that all too often could have been prevented by better care, more skilled and persistent outreach, prison diversion services that until recently simply did not exist and culturally competent services that for the most part still do not exist.

The rising incarceration of unserved or underserved Americans with psychiatric disabilities has resulted in the two largest single mental health institutions in our country being the Los Angeles County Jail and Rikers Island Jail here in New York City.

And it is the terrible inadequacy in our state's ability to properly recognize and humanely treat the mental illnesses endured by thousands who tragically end up in our state prisons that bring us here today, looking for a first glimmer of hope to stop the senseless suffering and suicides of our brothers and sisters with psychiatric disabilities.

For all too many of them, the story has dismally been the same. First you go unserved and untouched by all of the advances I've described above. You grow up all too often in disadvantaged communities, surrounded by the blight of poverty, little hope and educational or economic opportunity. All too often, the growing struggles you face in managing your emotions, thinking and behavior are not well understood and accepted by your family and community: it is poorly understood at best, and at worst you are shunned and isolated. All too often, you have an accompanying second disability, the struggle with drug and alcohol abuse.

You get picked up first due a variety of petty offenses for drug use, public intoxication, disorderly conduct, minor burglaries, you may graduate to episodes of publicly threatening behavior and then worse, sometimes much worse.

Ultimately you wind up in a state prison system which is not adequately prepared to understand and ensure that your basic health and mental health needs are diagnosed, treated and addressed. And then, when your condition and your despair and terror causes you to act out or act up, you're seen as a behavior problem and sent to solitary confinement to learn your lesson.

In a recent account, a Village Voice reporter well captured the terrible fate endured by our brothers and sisters in the SHU.

"On any given day, about 5,000 of New York State's 65,000 inmates are on 23-hour lockdown. Some are left in their own cells; others are taken to a "Special Housing Unit"; still others are moved to a high-tech supermax prison. These forms of solitary confinement go by various names: "keeplock," "the box," "the hole," "disciplinary lockdown," "the SHU."

"None of these words, however, come close to describing the harrowing nature of these prisons-within-a-prison. Imagine spending all day every day trapped in a 70-square-foot room, surrounded by only a toilet, a sink, and a cot.

see Inmates on page 50

Attachment, Metaphors and Behavior: Understanding The Impact of Relationships in the Development of Eating Disorders

By Judy Scheel, Ph.D., Director
Center for Eating Disorder Recovery

"The young child's hunger for (her) (parent's) love and presence is as great as (her) hunger for food." (Bowlby 1973)

"Food is metaphor, a symbol of care." (Bloom, 1993)

At the core of the issues for so many eating disorder sufferers is the need for attachment, the wish to be understood, accepted and loved for who they are. An eating disorder develops in response to the lack of such a primary and critical attachment. The eating disorder and its entire time consuming behavior becomes the substitute attachment.

All human beings crave and depend upon attachments. It is impossible for the human infant to physically survive without attachment to its caregiver. Humans also wither emotionally without stable and reliable attachments. Deprivation and loss in the years prior to the development of an eating disorder are key variables in many of the lives of future eating disorder sufferers. Although traumatic loss (i.e. through death/divorce/physical separation/abuse) are critical events which can significantly contribute to the development of an eating disorder, many eating disorder sufferers describe subtle and chronic experiences of emotional deprivation and loss during the years prior to the development of their symptomatology.

John Bowlby (1907 -1990), primarily responsible for the development of Attachment Theory, saw a child's attachment to caregivers as a fundamental determinant of the strength of the child's later relationships. The strength of the attachment to the caregiver is also later reflected in the manner in which the person comes to feel about her/himself and others. "Where there is a secure core state, a person feels good about themselves and their capacity to be effective and pursue their projects. Where the Core State is insecure, defensive strategies come into play." (Bowlby) The need for a secure base and to feel attached is the sine qua non in the development of a healthy and secure individual.

This type of loss of attachment can manifest in many different ways:

- Living in a household where the child is frequently criticized;

- Child is not valued for who s/he is and is expected to live up to the parent/familial ideal;

- Parent's untreated depression, substance abuse, or eating disorder (which consumes the parent leaving little availability to the child);

- Jealousy, envy by the parent toward the child which often leaves the child feeling guilty and ashamed of their needs and anything good that comes their way or they create or manifest in life.

- Unresolved conflicts from a parent's own childhood which causes and perpetuates problems in their relationship with their own children.

- Absence of an emotional language in the family which leaves a child feeling unable to connect with their emotions and internal states and creates a chasm (detachment) between parent and child. i.e. The family that utilizes the 'pull yourself up by the bootstrap' approach or the 'fix it' approach rather than identifying, feeling and expressing emotions as the means to feel better and maintain safety with and connection to family members.

In each case, there is a loss of the emotional connection to the parent and as Bowlby argues that without this fundamental and ongoing attachment there is a lessening of the ability for a child to form a connection and experience of a stable core self. An absence of identity and absence of self worth in the child is the result of the lack of attachment to the parent(s).

An eating disorder, therefore, creates an identity, an attachment to some 'thing', as well as represents a symbolic container to house all that the sufferer has grown to detest about themselves and feel ashamed of, i.e. needs and wants, hunger for love and understanding, comfort and closeness.

Clearly, there is a multitude of reasons for the development of eating disorders. However, a chronic and a repeated pattern of verbal or interpersonal injury in the relationship by the parent to the child constitute a loss of the attachment by the child to the parent. This type of injury is no less damaging to the individual than other more traumatic or tangible types of loss, as referenced above. This injury can also significantly increase a child's vulnerability to the development of an eating disorder.

What causes one child to be more predisposed to the development of an eating disorder is perhaps the defense of the nature (biological) argument. Although most agree that human beings are born without a developed personality each enters with a unique disposition which awaits experience with caregivers and other environmental exposures and experiences throughout life. At the cornerstone of each unique disposition are unique genes. It is how the caregivers are able to nurture the nature of the individual, which is so powerful in the development of a child's self esteem and self worth. However, the biological model is perhaps exonerating of the parent by not taking the seriousness of parental intra or interpersonal conflicts as seriously impacts the psychological wellbeing of a child. Genes as determinants may be there, but if the parent is ill equipped to parent or psychologically conflicted, the impact on a developing child are significant. The parent may also utilize one child more than another to 'play out' or 'work out' their own conflicts. This partially addresses the argument as to why one child in a family, given the same parents, would develop an eating disorder whereas other siblings do not.

Eating disorders develop when there is no way out of emotional stress. Eating disorder sufferers use the food as metaphor to experience and voice the psychic aspects of their pain. They utilize the abuse or use of food and their bodies to communicate the degree of their distress. The eating disorder symptomatology connects them to their internal world. They use this symbol (food/body) as a means to tell others of their pain, self-loathing, shame, hurt and anger. It is also simultaneously a violent protest against a world of people in which they feel helpless and alone. The eating disorder is also a means to combat feelings and internal states by projecting them on to their body. It is easier, socially more acceptable, and less guilt ridden to say 'I hate my body' than to say 'I hate myself' or 'I am angry, feel hurt or unloved by you' or that 'You have neglected me'.

The types of food suffers restrict or abuse become important metaphors for their wishes or expression of need. Individuals with Bulimia report the vomiting of 'hard' foods like pizza crust to symbolize their rage and need to experience physical pain in the absence of being able to experience emotional pain. (The vomiting of pizza crust is often felt physically in the chest and throat and can scratch and cause bleeding of the throat.) Individuals who cut often describe the relationship to cutting similarly. Individuals who restrict dairy products emotionally typify the inability to allow for comfort. Those who suffer from Bulimia describe the eating of dairy products (i.e. ice-cream) and then needing to vomit it all away symbolically expressing the need for comfort by eating, but the inability to allow for comfort or 'hold on' to it as evidenced by purging the ice-cream away.

In the mind of the eating disorder sufferer, it is safer to rely on food and body than to rely on others. Relationships by now have already proven to be unsafe, unreliable and at best ambivalent.

The implications for treating eating disorder suffers from an Attachment Theory perspective are significant. A secure attachment to the therapist may be part of a new beginning for a patient. It is important to recognize the inherent dilemma in this attachment. The patient may resist any emotional connection in therapy as a defense against the pain and hurt that close relationships have brought in the past. Plus, the therapist must compete with the eating disorder symptom. Why should the patient give up the reliability of the eating disorder in exchange for a relationship? There has been no reliability of the relationships in the past. Yet, the dilemma is that the sufferer is also human and developed the eating disorder in response to needing attachment. It is the therapist's role to say, "Let me help you learn that although relationships can be scary, complicated and imperfect, you have a choice in who you get close to. Food and body obsession can never bring you the joy, understanding and comfort that people can."

Judy Scheel, Ph.D. is the Director of the Center for Eating Disorder Recovery, P.C. (CEDaR) in Mount Kisco, Scarsdale and Nyack and the President and founder of the Eating Disorder Foundation, Inc. a not-for-profit organization for the prevention and education about eating disorders.

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Eating Disorders from page 1

- Intense fear of gaining weight or becoming fat, even though underweight

- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

- Infrequent or absent menstrual periods (in females who have reached puberty)

People with this disorder see themselves as overweight even though they are dangerously thin. The process of eating becomes an obsession. Unusual eating habits develop, such as avoiding food and meals, picking out a few foods and eating these in small quantities, or carefully weighing and portioning food. People with anorexia may repeatedly check their body weight, and many engage in other techniques to control their weight, such as intense and compulsive exercise, or purging by means of vomiting and abuse of laxatives, enemas, and diuretics. Girls with anorexia often experience a delayed onset of their first menstrual period.

The course and outcome of anorexia nervosa vary across individuals: some fully recover after a single episode; some have a fluctuating pattern of weight gain and relapse; and others experience a chronically deteriorating course of illness over many years. The mortality rate among people with anorexia has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population. The most common causes of death are complications of the disorder, such as cardiac arrest or electrolyte imbalance, and suicide.

Bulimia Nervosa

An estimated 1.1 percent to 4.2 percent of females have bulimia nervosa in their lifetime. Symptoms of bulimia nervosa include:

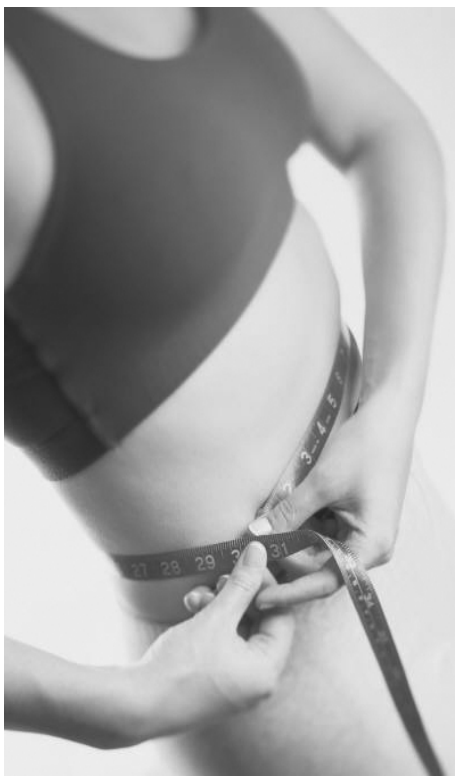
- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a sense of lack of control over eating during the episode

- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting or misuse of laxatives, diuretics, enemas, or other medications (purging); fasting; or excessive exercise

- The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months

- Self-evaluation is unduly influenced by body shape and weight

Because purging or other compensatory behavior follows the binge-eating episodes, people with bulimia usually weigh within the normal range for their age and height. However, like individuals with anorexia, they may fear gaining weight, desire to lose weight, and feel



intensely dissatisfied with their bodies. People with bulimia often perform the behaviors in secrecy, feeling disgusted and ashamed when they binge, yet relieved once they purge.

Binge Eating Disorder

Community surveys have estimated that between 2 percent and 5 percent of Americans experience binge-eating disorder in a 6-month period. Symptoms of binge-eating disorder include:

- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a sense of lack of control over eating during the episode

- The binge-eating episodes are associated with at least 3 of the following: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of being embarrassed by how much one is eating; feeling disgusted with oneself, depressed, or very guilty after overeating

- Marked distress about the binge-eating behavior

- The binge eating occurs, on average, at least 2 days a week for 6 months

- The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise)

People with binge-eating disorder experience frequent episodes of out-of-control eating, with the same binge-eating symptoms as those with bulimia. The main difference is that individuals with binge-eating disorder do not purge their bodies of excess calories. Therefore, many with the disorder are overweight for their age and height. Feelings of self-disgust and shame associated with this illness can lead to bingeing again, creating a cycle of binge eating.

Treatment Strategies

Eating disorders can be treated and a healthy weight restored. The sooner these disorders are diagnosed and treated, the better the outcomes are likely to be. Because of their complexity, eating disorders require a comprehensive treatment plan involving medical care and monitoring, psychosocial interventions, nutritional counseling and, when appropriate, medication management. At the time of diagnosis, the clinician must determine whether the person is in immediate danger and requires hospitalization.

Treatment of anorexia calls for a specific program that involves three main phases: (1) restoring weight lost to severe dieting and purging; (2) treating psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts; and (3) achieving long-term remission and rehabilitation, or full recovery. Early diagnosis and treatment increases the treatment success rate. Use of psychotropic medication in people with anorexia should be considered only after weight gain has been established. Certain selective serotonin reuptake inhibitors (SSRIs) have been shown to be helpful for weight maintenance and for resolving mood and anxiety symptoms associated with anorexia.

The acute management of severe weight loss is usually provided in an inpatient hospital setting, where feeding plans address the person's medical and nutritional needs. In some cases, intravenous feeding is recommended. Once malnutrition has been corrected and weight gain has begun, psychotherapy (often cognitive-behavioral or interpersonal psychotherapy) can help people with anorexia overcome low self-esteem and address distorted thought and behavior patterns. Families are sometimes included in the therapeutic process.

The primary goal of treatment for bulimia is to reduce or eliminate binge eating and purging behavior. To this end, nutritional rehabilitation, psychosocial intervention, and medication management strategies are often employed. Establishment of a pattern of regular, non-binge meals, improvement of attitudes related to the eating disorder, encouragement of healthy but not excessive exercise, and resolution of co-occurring conditions such as mood or anxiety disorders are among the specific aims of these strategies.

Individual psychotherapy (especially cognitive-behavioral or interpersonal psychotherapy), group psychotherapy that uses a cognitive-behavioral approach, and family or marital therapy have been reported to be effective. Psychotropic medications, primarily antidepressants such as the selective serotonin reuptake inhibitors (SSRIs), have been found helpful for people with bulimia, particularly those with significant symptoms of depression or anxiety, or those who have not responded adequately to psychosocial treatment alone.

These medications also may help prevent relapse. The treatment goals and strategies for binge-eating disorder are similar to those for bulimia, and studies are currently evaluating the effectiveness of various interventions. People with eating disorders often do not recognize or admit that they are ill. As a result, they may strongly resist getting and staying in treatment. Family members or other trusted individuals can be helpful in ensuring that the person with an eating disorder receives needed care and rehabilitation. For some people, treatment may be long term.

Research Findings

Research is contributing to advances in the understanding and treatment of eating disorders.

NIMH-funded scientists and others continue to investigate the effectiveness of psychosocial interventions, medications, and the combination of these treatments with the goal of improving outcomes for people with eating disorders.

Research on interrupting the binge-eating cycle has shown that once a structured pattern of eating is established, the person experiences less hunger, less deprivation, and a reduction in negative feelings about food and eating. The two factors that increase the likelihood of bingeing—hunger and negative feelings—are reduced, which decreases the frequency of binges.

Several family and twin studies are suggestive of a high heritability of anorexia and bulimia, and researchers are searching for genes that confer susceptibility to these disorders. Scientists suspect that multiple genes may interact with environmental and other factors to increase the risk of developing these illnesses. Identification of susceptibility genes will permit the development of improved treatments for eating disorders.

Other studies are investigating the neurobiology of emotional and social behavior relevant to eating disorders and the neuroscience of feeding behavior.

Scientists have learned that both appetite and energy expenditure are regulated by a highly complex network of nerve cells and molecular messengers called neuropeptides. These and future discoveries will provide potential targets for the development of new pharmacologic treatments for eating disorders.

Further insight is likely to come from studying the role of gonadal steroids. Their relevance to eating disorders is suggested by the clear gender effect in the risk for these disorders, their emergence at puberty or soon after, and the increased risk for eating disorders among girls with early onset of menstruation.

From: Facts About Eating Disorders and the Search for Solutions, (NIH Publication No.01-4901, Printed 2001, Updated: August 06, 2002). Written by Melissa Spearing, Office of Communications and Public Liaison, National Institute of Mental Health (NIMH). Expert assistance was provided by NIMH Director Steven E. Hyman, M.D., and NIMH staff members Bruce N. Cuthbert, Ph.D., Regina Dolan-Sewell, Ph.D., Benedetto Vitiello, Ph.D., Clarissa K. Wittenberg, and Constance Burr. Editorial assistance was provided by Margaret Strock and Lisa D. Alberts, also NIMH staff members. A full list of references are available at http://www.nimh.nih.gov/publicat/eatingdisorder.cfm#ed1

Letters From Your Teenage Children: Advice and Counsel for Parents Raising Teenagers

By Barbara Greenberg, Ph.D.
Program Director, the "Lodge"
Four Winds Hospital

For 15 years I have worked almost exclusively with adolescents and their caregivers. I have witnessed what could be called an adolescent's most difficult struggle. That being to figure out who they are, while attempting not to alienate their caregivers in the process. The conundrum of adolescence! Adolescence is the period during which our children really need us as role models, and preservers of their self-esteem. Unfortunately, it is also the time period during which they give us, their parents, the impression that they hate us, have little use for us, and that they regard us as utterly clueless!! In fact, they marvel at how we've gotten this far in our lives, flawed as we are! The truth is, that by listening to both parents and their teenagers, our teenagers really do need us during this time whether they know it or not. Maybe more so than they ever will again.

All of the teenagers that have invited me into their lives have taught me, and with much support, their parents, how parents can be most helpful, loving and absolutely essential to their teenage lives. Each of the following two scenarios are scripted from actual events, written from the perspective of the adolescent, as they perceived it. The adolescents will explain only their perspective and only their feelings. The parent's viewpoint will then be explained, and a harmonious resolution will be suggested for similar situations that arise in the future. Keep in mind that the ultimate goal in each scenario is for everyone involved to feel, understand, and to retain their dignity, and their positive feelings toward one another. But first, a couple of 'rules.'

Barbara Greenberg, Ph.D.

The Cardinal Rules

Because your teenage children are, at this point, trying to figure out who they are independent of their parents, it is a particularly sensitive time between parents and their teenagers. Your children will often react to your usual behavior and conversation with irritability and/or with unexpected intensity and anger. As parents, these responses are bound to make you feel like you've lost your sure footing and your once-harmonious relationship with your child. Take heart, however, adolescence has a beginning and an ending. In the meantime, there are some well-tested guidelines that will help you and your child sail more smoothly through adolescence. The goals are to keep the lines of communication open to respect everyone's feelings during this time period. Your adolescent may not be able or willing to tell you, but you can be sure they will love you for all of your attempts to support them during their somewhat confusing adolescence.

Rule #1 – Respect Your Teenager's Feelings and Space

Since your children are trying to figure out their own reactions and responses to a variety of situations, they are often in the process of mulling over their own thoughts and feelings when you are inquiring about their days. Hence, the rule is to respect feelings, back off, and return to the conversation at hand when your child gives cues that he/she is ready to speak. Any persistent attempts to force conversation are likely to result in anger, and will further close down the lines of communication. In terms of respecting your child's space, this means making sure that your child not only literally has some private space in your home, but also that your child be allowed to be alone during the times when he/she appears to need to do so. Of course, on the other hand, social withdrawal is an entirely different issue and may require professional intervention or advice.

Rule #2 – Respect Your Teenager's Privacy

Clearly, parents often feel shut out of their teenager's private lives. However, with teenagers, the more you intrude, the less information will be shared with you. Conversely, the more respectful you are of your adolescent's privacy the more likely they are to open up to you. They'll do it when they're ready, and at their own pace. This does not mean you should ignore your teenager. It simply means letting them gently know that you are interested in their lives, but that you will be patient, and wait until they are ready to talk. Again, keep in mind that we are referring to teenagers who appear to be functioning fairly well in their daily lives. For teenagers who appear to be getting into significant trouble, things need to be handled differently and perhaps with professional assistance.

Rule #3 – Listen Effectively

Many parents struggle to understand their teenager and often work harder to "figure them out" than during any other time. It's ironic, however, that it is during this time period that you are most likely to experience abruptly ended conversations and single word non-informative answers when communication seems to be the key! What seems to be most effective is to listen without giving advice (unless this is directly solicited by your child); to encourage continued conversation with non-judgmental cues; and to try to be available, (if at all possible) when your child seems to be in a conversational mode. Paradoxically, during this time period, less talking is more, and more listening will very likely lead to more dialogue.

So, it is with these three cardinal rules in mind that the following two scenarios will be presented. Keep an open mind, and please be patient and kind when reading about the following parent/teenage struggles. You might even see a little bit of yourself here!

Scenario #1

Dear Mom,

Last night when I came home, you asked me why I was upset. I told you I was fine and tried to go to my room. You followed me and kept pestering me by asking me over and over again what was wrong. Finally, I slammed my door and said, "you, that's what's wrong!" "I hate you." Then you wanted to start this whole discussion about why I hate you. Mom, this whole thing had nothing to do with you. I was tired last night and just wanted to get some rest, unwind, and maybe talk to a friend. Maybe in the future you can respect my space.

see Letters on page 30

FOUR WINDS HOSPITAL

MARCH

Special Event

Grand Rounds • Friday, March 26th • 9:30 - 11:30 am

"Childhood Bipolar Disorder"

Joseph Biederman, M.D., Chief, Clinical and Research Programs in Pediatric Psychopharmacology and Adult ADHD, Massachusetts General Hospital; Professor of Psychiatry, Harvard Medical School

Dr. Biederman will review current developments in the diagnosis and treatment of pediatric Bipolar Disorder, particularly its overlap with ADHD and conduct disorders.

- Participants will learn about current concepts in the diagnosis of mania in children and adolescents.
- Participants will learn about therapeutic options in the treatment of mania in children and adolescents.

Fee: $50.00 payable to the Four Winds Foundation, a not-for-profit organization.

2 CME Credits Available

APRIL

Grand Rounds • Friday, April 2nd • 9:30 - 11:00 am

"Executive Functioning: Its Impact on Children's Ability to Learn"

Alan V. Tepp, Ph.D., Director of Consultations and Evaluations, Four Winds Hospital; Private Practice, Mt. Kisco, Katonah & Fishkill, NY

Executive Functioning is the ability to plan, organize, problem solve, develop strategies and inhibit undesirable responses. This informative and educational program will be of assistance to parents and professionals alike.

- Participants should understand that Executive Functioning has become increasingly recognized among educators and mental health professionals as a critical neurodevelop mental construct in facilitating learning.
- Participants should learn the construct of Executive Functioning as it presents across the continuum from children with different learning styles to those children with diagnoses such as ADHD and Aspergers Disorder.
- Participants should understand how Executive Functioning impacts other aspects of learning.

Fee: $10.00 payable to Four Winds Hospital

1.5 CME Credits Available

Grand Rounds • Friday, April 16th • 9:30 - 11:00 am

"Talking to Teens About Sex and Substance Abuse: How to Open the Dialogue"

Cheryl Appel, MD, FAAP, Rivertowns Pre-Teen & Adolescent Medicine, P.C., Tarrytown, NY

- Participants should develop a practical approach to talking to adolescents about sex and substance abuse.
- Participants should better understand the adolescent dynamic to explore sexuality.
- Participants should explore why using alcohol and drugs is so enticing to adolescents in covering up insecurity.

Fee: $10.00 payable to Four Winds Hospital

1.5 CME Credits Available

Save the Date!

Nursing Career Day

Tuesday, April 20th • 4:00 - 7:00 pm

Experience Four Winds firsthand during this informal event.

Join a team that uses a multi-disciplinary approach to treatment.
Your voice will make a difference!

Refreshments, Tours, an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP by April 13th at 1-800-546-1754 ext. 2413

Location:

Four Winds Conference Center, 800 Cross River Road, Katonah, NY

Grand Rounds • Friday, April 23rd • 9:30 - 11:00 am

The Werner and Elaine Dannheisser Memorial Lecture Series

"Our Aging Parents: A Discussion for Caregivers"

Samuel C. Klagsbrun, M.D., Executive Medical Director, Four Winds Hospitals - Westchester, Saratoga

- Participants will learn how to recognize mental health issues and the need for professional intervention.
- Participants will learn how to gain access to resources in the community, and when to ask for help.
- Participants will learn how to take time to care for themselves and recognize their own emotionality as it relates to the issue of their parents getting older.

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

1.5 CME Credits Available

MAY

May is Mental Health Month

Community Service

Wednesday, May 5th, 2004
2:00 - 4:00 pm

National Anxiety Disorders Screening Day

A program for consumers designed to provide an anonymous screening and educational information about anxiety and depressive illnesses.

For information, or to schedule a confidential appointment, please call **1-800-546-1754 ext. 2413.**

Free of Charge • Open to the Public

Community and Professional Education Programs

Special Training

Thursday, May 13th • 2:00 - 4:30 pm

"Child Abuse Identification and Reporting"

Valerie Saltz, 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 any child care worker, school officials, doctors, nurses, dentists, podiatrists, EMT's, 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.

Grand Rounds • Friday, May 21st • 9:30 - 11:00 am

"Music and Mood Disorders: Tchaikovsky"

Richard Kogan, M.D., Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital

- Participants will understand the impact of mood disorders on musical creativity.
- Participants will recognize the criteria for melancholic subtype for major depressive disorder.
- Participants will appreciate some fundamental concepts about the creative process.

Fee: $10.00 payable to Four Winds Hospital

1.5 CME Credits Available

JUNE

Grand Rounds • Friday, June 4th • 9:30 - 11:00 am

"Safety First, Interpretations Later: Treatment of the Self-Harming Patient"

Sharon Klayman Farber, Ph.D., Private Practice, Hastings-on-Hudson, NY; Author, *When the Body is the Target: Self-Harm, Pain and Traumatic Attachments*

Because people who harm themselves (disordered eating, self-mutilation, compulsive piercing and tattooing) suffer from traumatic attachments to pain and suffering, the cornerstone of treatment is a safe and secure attachment relationship that promotes moving from self-harm to self-regulation and self-reflection.

- Participants should understand how to diagnose and assess the patient in order to develop a multi-phased, process-focused approach to treatment.
- Participants should learn how to engage the patient in assuming greater responsibility for maintaining his own physical safety, while creating a treatment environment that the patient can begin to experience as a safe haven.
- Participants should gain an understanding of how to build the therapeutic alliance by engaging the patient in the arena of his inter-personal psychopathology while at the same time managing your own emotional responses and reactivity.

Fee: $10.00 payable to Four Winds Hospital

1.5 CME Credits Available

Four Winds Hospital Now Offers CME Credits

In collaboration with the Albert Einstein College of Medicine, Four Winds now offers Continuing Medical Education Credits beginning with this Grand Rounds Series. Please look for available credits listed under each program description.

Albert Einstein College of Medicine designates this 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, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

Register online at www.fourwindshospital.com

Due to limited seating, registration is limited to the first 100 paid registrants.

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

For those requiring special services, please call no later than two weeks prior to the conference date so that the appropriate arrangements can be made.

Certificate of Attendance available for all programs.

As registration is required, please call **1-800-546-1754 ext. 2413** to reserve your seat today, or mail this registration with payment to:

Four Winds Hospital, Marketing Department,
800 Cross River Rd., Katonah, NY 10536

Letters from page 27

I'll talk to you when I'm ready to talk. Not everything has to do with you. Kaitlyn (Age 16)

Mother's Perspective: Kaitlyn came home from a get-together with friends and looked preoccupied and tense. When I asked her how her evening was, she said fine, but she avoided eye contact and rushed to her room. I was concerned, even afraid, that something had happened to upset her. She subsequently slammed her door and yelled that she hated me. I then got more concerned and needed to follow up with her and get some understanding of why she was upset. Gee, now she even confirmed my worse fear – that I was a bad mother who she not only couldn't confide in and trust, but who she hated. I slept poorly that night, and felt both worried and dispirited.

How This Situation Could Have Been Handled More Effectively: First, it is wonderful that this parent is available to her child and interested in her child's life. It is very important that the child be given this message. However, this situation escalated rapidly when it could have been handled with a much lighter touch. The mother can simply ask the child how her evening was, thereby giving the message that she is available to listen. The mother then needs to respond to her child's cues that she does not want to talk at this moment. The dialogue can end with a "good night" and on a peaceful note. Everyone's space and feelings are respected, and the interaction does not end angrily. Also your child already seems upset, your goal is certainly not to make your child more upset. Your child is aware that you're available. End of story. The evening ends. Dialogue can continue when you get feedback that your child is ready to talk. Keep in mind that nothing significant may have occurred and there may be nothing to talk about. Every disappointment does not need parental involvement. Sometimes you need to back off and be patient and let your child handle things on their own. If something is actually amiss you will see signs of this for several days, so you do not need to acquire information immediately.

Scenario #2

Dear Dad,

You're probably wondering why I didn't talk to you last night. You knew I was bringing my friends over yesterday. They came in to the kitchen to say hello to you, and Mom, and then we were going to go downstairs to watch a movie. First, you started telling jokes that I don't think my friends understood, or thought were funny. I think that they pretended to laugh to be polite. I was so humiliated. I didn't know if I wanted to scream or cry. So I did neither. I just watched you continue to embarrass yourself and me (mostly me). Then you started to ask them a million questions about their social lives and tell them about how many girlfriends you had when you were our age. I think that at this point even Mom started to get embarrassed. Dad, my friends didn't come over to talk to you about your girlfriends. In fact, they didn't come over to see you at all. They came over to hang out with me. Would you please keep your conversations with my friends shorter, much shorter??? Matt (Age 15).

Father's Perspective: I noticed that yesterday after Matt's friends left, he seemed very upset with me. He wouldn't talk to me and wouldn't even make eye contact. In fact, I think I overheard him telling my wife that I had acted like a jerk with his friends. Well, the way I see it, I was just trying to be friendly. I really like Matt's friends and I was just trying to be one of the guys. Matt's friends seemed to be laughing and looked happy to me. I don't know why Matt is so darn sensitive. I've got to break him of this.

Mother's Perspective: Matt's friends are very polite kids. They come in to say hello to me and my husband whenever they come over. They clearly have been taught by their parents to have good manners and good social skills. Matt knows that we appreciate his friends' politeness and that we expect him to be equally polite at his friends' homes. Yesterday, when Matt's friends came in to say hello to me and David, I could immediately tell that David was getting a little too chummy and that Matt had started to blush and get uncomfortable. I tried to reengage David in conversation with me so that the boys could move on, but to no avail. David was on a roll. He even began to talk about his own high school days. I would have liked to end this conversation but I couldn't figure out how to do it without being impolite to David. Really, I know that David has a good heart and was just trying to make sure that the boys like him. Sometimes it's hard to know what to do in these situations.

How This Situation Could Have Been Handled More Effectively: Let me first say that the father in this situation probably did have good intentions. He very likely wants his son's friends to like him, and to find his home to be a friendly place. However, that father must remember that he is not 'one of the boys.' He was an adolescent boy once, but he is an adult now, and a father to an adolescent boy. As such, his role is different now. He is expected by his children, and for that matter, his wife, to behave as an adult. This means making polite, brief, and mature conversation with his children's friends and not attempting to behave like one of them. Although he wants to be 'liked' he is actually more likely to achieve this goal if he assumes his role as an adult. His son will appreciate this, and will be much less likely to experience embarrassment. After all, isn't it uncomfortable and sometimes painful for all of us to watch someone strive to be something that they are not? Also, keep in mind that these are the son's friends, not the father's friends. The son may experience his father as slightly competitive in his attempts to engage his friends in conversation. In the future, this father would do well to continue to be friendly and warm but to do it briefly, and without getting into personal topics and his own teenage experiences. Your teenagers have a very hard time watching you step out of your role in front of their friends. On the subject of assuming appropriate roles, this would have been an excellent opportunity for the mother to gently redirect her husband. Perhaps in the future, she can help terminate the conversation by moving forward. Send the boys to watch the movie and get her husband involved in different and unrelated conversations. The mother would be appreciated by everyone if she is able to make such an intervention.

In summary, these two different scenarios only begin to address some of the most sensitive aspects of adolescence. Parents will unintentionally stumble and be accused by their children of all sorts of bad intentions when they usually mean well and are just trying to facilitate safety and happiness! It is a balancing act knowing when to be available to listen and knowing when 'just asking' and not getting an answer is enough, and your child isn't being intentionally disrespectful.

Embarrassment is a major issue! Keep in mind that your very self-conscious teenager is viewing you as a reflection of him/herself. Be alert for cues from your child, spouse, etc. that the conversation is heading downhill – that you are approaching embarrassment (or perceived embarrassment) and gently get out of the conversation. It is up to your child to sustain his/her friendships. Your job is to provide a safe, warm, loving home that they know they can come back to when "things get rough on the outside". Keep good boundaries as a parent and an adult, and they'll keep coming back to you! Take solace in the fact that they, too, will be adults one day, and they will have had you as role models for successful parent-teenage interactions! You made it through, so will they!

Dr. Greenberg is the Program Director of the "Lodge" Adolescent Unit at Four Winds Hospital. She maintains a private practice in Weston, Connecticut, and Katonah, New York. Dr. Greenberg can be reached by calling 914-763-8151, ext. 2482.

The Mental Health News

New York City Section

Treatment of Anorexia Nervosa in Adolescence: Is Direct Parental Involvement Harmful or Helpful?

By Katharine L. Loeb, Ph.D.
Assistant Professor of Psychiatry
Director, Weight and Eating Disorders Program, Mount Sinai School of Medicine

Tracey Lion-Cachet, Clinic Coordinator, Weight and Eating Disorders Program
Mount Sinai School of Medicine

Anorexia nervosa is a serious psychiatric illness that, albeit rare, boasts among the highest mortality rate of any psychological disorder. Although many girls and women have anorexic symptomatology (symptoms are 9-10 times more common in females than in males; Lucas, Beard, O'Fallon, & Kurland, 1991), only 0.05 percent actually has the illness. Of the 0.05 percent approximately 10 percent die (Steinhausen, Rauss-Mason, & Seidel, 1991,1993), half from medical complications associated with starvation and half from suicide. Symptoms are typically marked by a pathological refusal to maintain body weight at or above a minimally normal weight for age and height. This is fortified by an intense fear of gaining weight or becoming fat. The undue influence of body-weight/shape on self-evaluation often leads to a deterioration of self-esteem as the elusive self-defined target weight continues to plummet over the course of illness.

Anorexia nervosa is a notoriously difficult illness to treat, as evidenced by its chronic nature and precipitously high relapse rates. McKenzie (1992) reported that about 40 percent of hospitalized patients are readmitted at least once. Not only are relapse rates high, but individuals with the disorder are also resistant to entering into treatment altogether, and if they do initiate treatment they often terminate prematurely. Furthermore, health care practitioners are repeatedly confronted with the challenge of motivating patients towards a process of change. This is primarily due to the ego-syntonic nature of the illness whereby the illness has become deeply naturalized and entrenched into the person's identity. Because some of the symptoms of self-starvation (such as amenorrhea) are considered an achievement for the individual with anorexia nervosa, the illness is often revered and almost viscerally protected, like a hard won prize. Consequently patients avidly deny having the illness, which further attenuates the therapeutic process.

Typically anorexia nervosa begins in adolescence (with a prevalence rate of 0.48 percent for girls between the ages of 15-19; Lucas et al., 1991) and assiduously becomes an intractable illness. In a seminal study of outpatient family-based versus individual treatment for adolescents and adults with anorexia nervosa at the Maudsley Hospital, London (Russel, Szmukler, Dare & Eisler, 1987), recovery was most likely for adolescent patients with a short duration of illness (less than 3 years) receiving family treatment; these results were reconfirmed in a

Katharine L. Loeb, Ph.D.

5-year follow up whereby 90 percent of patients were still fully recovered (Eisler et al., 1997). This study, along with other research on course of illness, underscores the fact that early intervention is a key determinant of prognosis. Most importantly, it has inspired a growing body of research on family-based treatment for adolescents with eating disorders, all with exciting results. The success of family-based treatment for anorexia nervosa, often referred to as the "Maudsley Method," is reflected in high retention rates and the impressively low relapse rates.

The Rationale for Family-Based Treatment

Traditional models of anorexia nervosa posit that this illness represents a maladaptive attempt at autonomy and control. By extension, direct parental involvement in the refeeding process would be harmful, not helpful. Such clinical lore has at times lead to the recommendation of a "parentectomy," or removal of the parents from any targeted treatment efforts. As noted above, however, research suggests that parents are a vital ingredient in the recovery process and can serve as agents of change until the child is well enough to assume developmentally appropriate levels of independence regarding food and eating.

Notably, there is good fortune in discovering an approach that does not merely appear to be effective – in both the absolute sense and relative to alternative interventions – but can be administered on an outpatient basis. The high cost of inpatient care has prompted insurance carriers to limit stays; sadly, thirty days is rarely a sufficient time period in which to fully weight restore a patient with anorexia nervosa. Relapse is an inherent risk in the disorder, and this is likely exacerbated by premature discharge from structured treatment settings, thereby contributing to the characterization of anorexia nervosa as a disorder replete with recidivism.

see Parental on page 51

"Casa Renacer" in East Harlem Opens For 60 Formerly Homeless Men and Women

Staff Writer
Mental Health News

Casa Renacer, a newly constructed supportive housing project providing safe, affordable permanent housing for 6O formerly homeless men and women today celebrated its official grand opening. Located at 158 East 122nd Street, Casa Renacer ("reborn" in Spanish) combines affordable housing with on-site social services including substance abuse counseling, job training and mental and physical health care. Manhattan Borough President C. Virginia Fields, Deputy Mayor Dennis Walcott, and a host of community leaders and service providers welcomed Casa Renacer into the community at an opening ceremony. Jazz composer Gabriel Jodorkovsky performed a new work in honor of the occasion.

Built by Weston United Community Renewal, a non-profit serving the Harlem community since 1985, Casa Renacer is the agency's first permanent housing program. It boasts 60 fully furnished efficiency apartments with a full bath; kitchenette equipped with a 2-burner gas stove, a microwave-convection oven and a half-size refrigerator; living quarters furnished with a captain's bed, chest of drawers and table and chairs; an air conditioner and start-up kit of linens and kitchen and bath supplies.

Tenants are supported with 24-hour staff, including social workers, case managers, a nurse and half-time psychiatrist. Tenants pay only one-third of their income for rent.

"Our mission is to change people's lives by giving them the support and the resources they need to overcome their disabilities," said Jean Newburg, Chief Executive Officer of Weston United. "With this project we are really seeing the attainment of our vision."

"When you come into your apartment and you see it clean and beautiful, it feels like home. It's bad to be homeless, but Weston United helped me," said Miriam Perez, a Casa Renacer tenant who previously lived at the Weston House Transitional Living Community, a shelter for those with mental illness. Roseanna Saccomannoa, another tenant at Casa Renacer added, "It's very nice here, the people are nice. I love it."

Casa Renacer, a newly constructed building, was funded by NYC Housing Preservation and Development's Division of Special Needs Housing. The Federal Home Loan Bank also contributed capital funds through Carver Federal Savings Bank. The building was designed by Richard Dattner and Partners, PC and was built by BFC Construction, headquartered in East Harlem. Operating subsidies and social supports are financed through HUD's Shelter+Care program, the NYC Department of Health and Mental Hygiene, and the NYC Department of Homeless Services.

Weston United began in 1985 as a grassroots response to the needs of the mentally ill and homeless by Harlem

see Casa on page 48

the mental health association of new york city, inc.

Healing from 9/11 Remains a Challenge for Many New Yorkers And There is Help for Those Directly Affected

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

Giselle Stolper

We are well past the second anniversary of the attacks of September 11, 2001. We have come a long way toward rebuilding the space where the World Trade Center towers once stood. Most New Yorkers look forward to the new site, with its sweeping architecture and poignant memorial, hoping it will give them some closure to the events of that unforgettable day. Yet for some, the emotional effects of the 9/11 attacks remain a continuing source of sadness, anxiety and traumatic memories that interfere with their ability to heal and move on.

The Mental Health Association of New York City monitors the trends among New Yorkers' emotional post-9/11 recovery through its multicultural information and referral services hotline, LifeNet. The MHA of NYC also administers the 9/11 Mental Health and Substance Abuse Program on behalf of the program co-sponsors, and the American Red Cross and The September 11th Fund, which has helped thousands get the mental health treatment they need.

LifeNet Hotline Caller Trends: 9/11 Still on New Yorkers' Minds

- "My husband is drinking more than ever."
- "I lost my job after 9/11 and I've been out of work ever since."
- "Our son is having trouble in school."
- "I have headaches all the time."
- "9/11 feels like ages ago. Now I worry about what's going to happen next."

These are some of the concerns that callers voice when they speak with LifeNet professionals. LifeNet, New York City's 24/7 crisis, information and referral hotline, serves as a primary point-of-entry for all mental health services, and was designated by the City to serve as central resource for 9/11-specific mental health issues in the wake of the disaster. LifeNet staff assess the caller's problems and provide referrals to appropriate providers based on the caller's needs and geographic location.

To help us spot caller trends and identify unmet needs, the MHA of NYC uses LIFENET's caller statistics to track New Yorkers' mental and emotional states. Among the recent trends noted, call volume to 1-800-LIFENET remains more than double the volume before the disaster, averaging approximately 6,000 calls per month. Up to one in 10 of these calls reference 9/11-related issues. And among all problems reported this year, one in 10 problems indicate post traumatic stress and anxiety-related disorders as compared to pre-9/11 levels, in which one in 200 problems indicated the same.

While fewer callers have reported symptoms of PTSD in the last two months, the volume remains quite high as compared to pre-9/11 levels, which is not surprising. The call trends are consistent with what was documented after the 1995 bombing in Oklahoma City, where more people sought counseling the second and third years after the attacks. While someone may have recovered emotionally from 9/11 on the surface, the exposure to such a high level of trauma can lower his or her threshold to withstand future crises.

Contributing stressors such as job loss, economic stress, death of a loved one, a relationship ending, or the fear of war and bioterrorism, can trigger the onset of symptoms of PTSD years after the initial tragedy. Symptoms of PTSD can include sleeplessness, unwanted or intrusive memories or flashbacks, irritability or anger, guilt for having survived, fear of places or situations that can trigger memories of the event, and a pervasive feeling of imminent danger.

Financial Assistance for Mental Health Treatment Still Available for Those Directly Affected

While many 9/11-related programs have shut down, the American Red Cross, The September 11th Fund and the MHA of NYC continue to offer the 9/11 Mental Health and Substance Program to ensure that individuals who were affected by the attacks can still get mental health treatment at little or no cost, regardless of their financial situation.

People who are eligible to enroll in the program can choose their own licensed practitioner, and can receive the assistance wherever they live, even if they have since left the New York area. Treatment can include individual or family therapy, medication, inpatient hospital treatment, auricular acupuncture and substance abuse services.

Financial assistance for treatment costs is retroactive to September 11, 2001. That means those who sought treatment immediately after the attacks may be eligible for reimbursement through the program. To date nearly 7,000 people have enrolled, and, true to the findings from Oklahoma City, nearly one-third of those individuals enrolled in just the last four months, though the program was launched in August, 2002, just before the first anniversary of the disaster.

This program is open to a broad range of individuals who experienced the attacks first-hand. Those eligible include family members or roommates of people who were lost; people physically injured at an attack site; employees who worked in the World Trade Center area or the Pentagon; employees who worked below Canal Street and lost employment or wages; residents below Canal Street in Lower Manhattan; officially deployed rescue or recovery workers at any of the attack sites or morgue workers; children who went to school near the World Trade Center and employees who worked at Ronald Reagan National Airport. In most instances, assistance is available to the individual who was affected, his or her immediate family members, and anyone who lived with that person at the time of the attacks.

Many people who were affected may be experiencing symptoms they don't even attribute to the events of 9/11. We urge anyone who was impacted by the 9/11 attacks and may be suffering emotionally – whether they can tie their current situation back to the attacks or not – to use this benefit to get mental health treatment for themselves or their loved ones.

If you, or someone you know, may be eligible for the 9/11 Mental Health and Substance Abuse Program, please contact the MHA of NYC at 1-800-LIFENET (1-800-543-3638) or visit the program Web site at www.9-11mentalhealth.org.

Dr. John Draper, Director of Public Education and LifeNet hotline, and Dr. Gerald McCleery, Director of the September 11th Mental Health Benefit Program, contributed to this article.

Nobody's stronger than New Yorkers.

In the terrible wake of 9/11, we said, "Things will never be the same". And they won't be. But as we go about our days, working, walking the dog, arguing about ball games, most of us are feeling something new -- and good: a fresh appreciation for all the ordinary, normal, daily things that make a life. But while we are getting along with our lives, some of us may continue to feel sadness, anxiety and fear. If you have problems coping, be assured that you can always get help by calling 1-800-Lifenet.

1-800-LIFENET, or dial 311 and ask for Lifenet.

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Peventing Eating Disorders in Girls and Young Women

By Kathy Rosenthal, CSW, Assistant Vice President, Family Services F·E·G·S

Don't Let Them Slip Through The Cracks

In a middle school on Long Island, there is a *Double Digit Club*, a non-sanctioned club whose members pledge to keep their weight below 100 pounds.

Eating disorders have reached frightening proportions, with conservative estimates indicating that 5-10 million American girls and women and one million boys and men struggle with eating disorders including anorexia, bulimia, and binge eating disorder (National Eating Disorders Association, 2002).[1] Younger and younger girls are becoming vulnerable. The number one wish of 11-17 year-olds is to lose weight.[2] "Literature suggests that the incidence rate for bulimia among college age women is as high as 25%." [3]

To address this burgeoning issue, F·E·G·S, one of the largest not-for-profit health-related and human services agencies in the Country, secured funding from The Hadassah Foundation and UJA-Federation of New York in 2000, to bring the Harvard Eating Disorders Center's (HEDC) curriculum to girls and professionals, particularly in the Jewish community on Long Island and in the New York metropolitan region. The cutting edge curriculum, *Full of Ourselves,* was developed by Dr. Catherine Steiner-Adair and field-tested in 33 schools with nearly 500 girls. Over the last three and a half years, F·E·G·S has reached more than 4,000 girls, parents, teachers, social workers, guidance counselors and other professionals with eating disorders prevention programming.

As girls go through adolescence their self-esteem drops, they lose self-confidence and a sense of efficacy, their school work suffers, and their education and career aspirations get side-tracked, overshadowed by a disproportionate emphasis on looks, weight, clothing, make-up and other superficial attributes.[4] Media images and the continuous parade of frighteningly thin role models in magazines and on popular television shows, drives pervasively home messages about the value of being thin; messages that often lead to dangerous, life-threatening obsessions with diet, excessive exercise, and compulsive control over and restricting of food intake.

Marilyn Monroe, with her curvaceous figure, was the epitome of beauty in the 1950s and 60s. By comparison, the average model today is 5'11" and weighs 117 pounds --- making it virtually impossible for the average American woman, at 5' 4" and 140 pounds, to compete. According to Jean Kilburne, producer of the *Slim Hopes* video series, today's fashion models weigh 23% less than the average woman; in the Marilyn Monroe era, they weighed only 8% less. These models set a standard of beauty that is impossible for most women to achieve – no matter how much they diet, exercise and purge. Yet, they continue to try, using risky, highly self-injurious behaviors.

While issues such as substance abuse, suicide, sexuality, relationship violence, etc. are effectively addressed head-on with teens, educators have found that telling girls about eating disorders -- especially survival stories told by those in recovery -- has the reverse effect. Girls, particularly those at-risk, become more adept at anorexic and bulimic behaviors. As one young woman put it an article about her experiences as an anorexic and bulimic in an in-patient mental health facility, "For eating disorder patients especially, listening to others recount their worst times can lead to a dangerous race to hit rock bottom." [5] These factors are among the driving forces behind the HEDC curriculum – a model that focuses not on eating disorders, but on healthy development, personal power, nutrition, media and values education, and standing up against "weightism" (prejudice against individuals based on body size). It takes the emphasis off of appearances and helps girls see and value attributes beyond physical beauty. *Full of Ourselves* is an eight-week program, full of creative, interactive exercises, role plays, meditations and action assignments that resonate with participants. The program targets 8-13 year-old girls and includes a mentoring component that gives girls the knowledge, tools and skills to take these important messages to their younger peers. The program has resulted in positive and maintained changes in knowledge and attitudes about weight satisfaction among adolescent girls.

The psychological and physical/medical complications of eating disorders that lead to excessive weight loss or gain can be life-long and are often life-threatening. Eating disorders have the highest mortality rate of any mental illness --up to 20% (Susan Ice, M.D., Medical Director, The Renfrew Center).[6] The best and most effective cure is prevention. It is vital to expose young girls – ideally before they become vulnerable to the pervasive messages about the importance of appearance and the value of being thin – to creative educational programs that help build their resiliency, self-esteem and confidence.

For more information on the eating disorders prevention/education that F·E·G·S is providing, please call (516) 496-7550, ext. 133.

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2 Maine, Margo, Body Wars: Making Peace with Women's Bodies.
3 Pipher, Mary, 1997. Hunger Pains. Ballantine Books, NY
4 Steiner-Adair, Catherine, *Full of Ourselves Curriculum,* Boston
5 Brennan, Leah. "Girl Reconstructed" *Hartford Courant*
6 http://www.eatingdisorderscoalition.org/reports/statistics.html

Women With Eating Disorders: My Story

By Shirley Francis
F·E·G·S Brooklyn Day Program

Shirley was diagnosed with a mental illness when she was 22. Since 1987 she has been a client at the F·E·G·S Coney Island Continuing Day Treatment Program where she participates in daily groups which help her to manage her illness. She also struggles with severe symptoms related to an eating disorder. Shirley is also a member of the F·E·G·S Consumer Advisory Board, a group that is helping to shape the F·E·G·S Wellness Initiative.

At this writing I am proud to say that I am a woman who has begun to successfully conquer my food demons. At the age of 53 I couldn't stand, walk, or participate in life the way I wanted to. As I did with my mental illness many years ago, I got information, set a goal and have lost well over 100 pounds in the past year. My conflict with food goes on but I am a step ahead now.

Women with eating disorders…there is so much to say. My own struggle started, as many in my generation, with the Barbie Doll and then Twiggy. Too many women are celebrated for their bodies, even if they have brains: actresses, singers, even news personalities. Are Madonna or Britney Spears really celebrated for their talent or for how they look and shake that thang? I have heard people say that girls today are not as influenced by what they see on TV and in magazines as women of my generation. They say that there are so many good role models for girls today. I say bull. Eating disorders are on the rise, girls as young as 8 and 9 think they are too fat and are developing eating disorders. Nothing has really changed.

Like many other women, I was a slave to the scale. The needle on the scale was my addiction. I ate lettuce and rabbit food with my bony friends but snuck sweets behind closed doors and vomited into the garbage. I have had bulimia and anorexia and many beautiful women share my shameful secret.

In the 60's, I was a knockout weighing 115 pounds, wearing a Betsy Johnson mini-skirt and thigh-high boots just like Twiggy. When I was in high school I had big dreams--I wanted to be a mover and a shaker, an editor, a politician, but I became a wife and mother and put my dreams on the back burner. I felt I had to be perfect: the perfect daughter, perfect bride, and perfect wife. I was far from perfect and there was nothing I could control, except food. Food didn't talk back, or boss me around; food was always there. I had starved myself to be that perfect bride, to look the way I thought everyone, my mother, my husband, the world, said I should look. When I lost the battle with skinny I went whole hog. I ate Junior's cheesecake and Haagen Dazs ice cream. Who could resist? I ate cookies up and down the aisle of the super market. After I lost my grandmother and later my mother, I ate extra hard and I felt terrible. Terrible about everything.

I have gotten tremendous support and help from my program, the F·E·G·S Coney Island Day Program. When I decided I wanted to work on my weight issues my counselor and I talked about what I could do to regain my health and self-esteem. The first step in my plan was to meet with a doctor and I went for some physical therapy too. In the program I was in, lots of groups helped me focus on what I wanted to do: a Self-image group, a Wellness group and a dual recovery group helped me face my addiction--food. Without the program I couldn't have stuck to my goals. I have to give credit to all the staff and my peers for helping me stay on track.

Another thing that saved my life was something I learned from William Shakespeare-- "to thine own self be true." Admit you have a problem, turn yourself over to whatever your higher power might be and get help. You can get therapy, or go to Overeaters Anonymous but you need to accept help, not just diet. Diets don't work; they punish and don't heal or help. I have lost weight this past year because of a change in my attitude and a change in the way I view food and myself. You have to face yourself, your problems and who you are. We were not all designed to wear a size 2 dresses, but we can all be healthy, fit, happy and beautiful. You can save your life. I saved mine.

A Review of the Eating Disorders Continuity Hypothesis

By DeMecia Wooten-Irizarry
Institute for Community Living

Several researchers have proposed the concept of an eating disorder continuum. This eating disorder continuum construct is use to aid in the understanding of similarities and differences among various types of eating disturbances and disorders. The purpose of this article is to review the literature.

Introduction

The developmental perspective asserts that the differences among individuals with eating disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, fall along a continuum of severity. It asserts that there are not different types of eating disorders but eating-related behaviors that share similar underlying psychological characteristics. The frequency or severity of eating problems have normal eating at one end of the continuum and bulimia or anorexia nervosa at the other end with sub-clinical forms of eating disorders at intermediate points along the continuum.

Eating Disorder Continuum

The organizing eating disorders continuum, was originally proposed Nylonder (1971) and it was further developed by Rodin, Silberstein, and Striegel-Moore (1985) It asserts that the fundamental differences among individuals with eating disorders who meet the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev. [DSM-III-R]; American Psychiatric Association, 1987) criteria and individuals with milder forms of eating disorders are a matter of degree and not of kind. Although individuals with different types of eating disorders differ in eating-related behaviors, the continuum hypothesis suggests that the groups on the continuum share similar underlying psychological characteristics. (Scarano & Kalodner-Martin, 1994).

Recently, the eating disorder continuum identified by Mintz et al. (1997) placed unrestrained eating at one end of the continuum (i.e., asymptomatic group), clinical eating disorders at the other end of the continuum (i.e., eating disordered group), and milder forms of disturbed eating at an intermediate point (i.e., symptomatic group). These three groups illustrate operational definitions of the eating disorder continuum hypothesis. They represent increasing levels of disturbed eating behaviors that are proposed to occur along common behavioral and psychological dimensions, so that group differences are a matter of degree and not kind (Mintz & Betz, 1988 ; Scarano, 1993 ; Scarano & Kalodner-Martin, 1994).

The Developmental Perspective

The continuum hypothesis from the developmental perspective asserts that the differences among individuals with eating disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, fall along a continuum of severity. It asserts that there are not different types of eating disorders but eating-related behaviors that share similar underlying psychological characteristics. The frequency or severity of eating problems has normal eating at one end of the continuum and bulimia (BN) or anorexia (AN) nervosa at the other end with subclinical forms of eating disorders at intermediate points along the continuum. The continuum is thought to begin on one end with dieting as a response to the physical changes and psychosocial challenges of puberty. Further, along the continuum are the unrelenting patterns of compulsive eating associated with certain personality characteristics. According to developmental approaches, these characteristics are a reflection of a failure to resolve significant development tasks (e.g., enhanced autonomy, modulation of impulses and of expressions of mood states, and integration of changing images of the body and self). At the far end of the continuum are the more serious psychosocial impairments and eating disturbances seen in adolescents with eating disorders (Attie & Brooks-Gunn, 1989). Viewing eating disorders within the context of this developmental perspective raises questions with regard to the individual, familial, or sociocultural factors that move an individual along this continuum to developing AN or BN. (Smolak, Levine & Striegel-Moore 1996, p. 22)

Developmental approaches have been used to understand the etiology of pathology; and, it is believed that they are especially complementary to the study of eating disorders. For instance, several eating disorder symptoms appear to represent the extreme end of a continuum that is at least partially grounded in normal functioning and behavior (Polivy & Herman, 1987), pointing to a relationship between normal and abnormal development. The diagnosis of AN or BN is approximately 9 to 10 times more likely to be given to women than to men (American Psychiatric Association, 1994). Diagnoses of Eating Disorders-Not Otherwise Specified (EDNOS) and Binge Eating Disorder (BED) also appear to be somewhat more common among women. There does not appear to be an inherent biological difference between men and women that can explain this gender difference. It is believed that something about female development that is potentially problematic. Smolak, Levine & Striegel-Moore (1996) argue, that this factor is contextual rather than intra-individual. They contend that the emphasis on contextual issues is consistent with a developmental model. Finally, they assert that eating disorders, especially AN and BN, show distinct developmental trends, with onset typically occurring during a restricted period of adolescence or early adulthood (see Smolak, Levine & Striegel-Moore 1996, p. 185)

Multiple factors operate in a pathological process of development and do so through a hierarchy of dispositions (see Cicchetti & Schneider-Rosen, 1986). For example, a genetic diathesis to the early onset of pubertal changes may create a predisposition to control food intake through the emergence of dieting behavior, but only given the action of certain psychological mechanisms such as perfectionist strivings, depressive symptoms, feelings of ineffectiveness, or self-regulatory deficits (Johnson & Maddi, 1986). The dieting behavior may in turn lead to the development of body image disturbances and other problems in self-representations and self-esteem, but only given a particular pattern of socialization such as that found in families with high achievement standards, blurred interpersonal boundaries, and little support for autonomy. The relative importance of each of these potential factors may vary over time, as well as with regard to the onset or maintenance of a pathological process. (1996, p. 15)

Variables along the Continuum

Studies on the construct validity of the eating disorder continuum generally have supported its theoretical construct in that characteristics of clinical eating disorders such as body dissatisfaction, food and weight preoccupation, feeling fat, and the fear of becoming fat increase and self-esteem decreases as the severity of an individual's eating pathology increases (Dykens & Gerrard, 1986; Mintz & Betz, 1988; Scarano & Kalodner-Martin, 1994). Initial research suggests that women with various eating disturbances share similar behavioral and psychological characteristics differing only in their severity (Scarano & Kalodner-Martin, 1994).

The results of two studies reviewed by Tylka & Mezydlo Subich (1999) support the construct validity of the eating disorder continuum. Several variables that are significant characteristics of clinical eating disorders varied meaningfully as a function of women's placements along the eating disorder continuum. Their analysis showed that variables explored—relationship between the five factors of personality proposed by Costa and McCrae (1992) and psychological and behavioral variables: body dissatisfaction (Thompson, 1990), ineffectiveness and inadequacy (Garner & Bemis, 1985), beliefs that only the highest standards of personal performance are acceptable (Slade, 1982), alienation and reluctance to form close relationships (Selvini-Palazzoli, 1974), confusion and mistrust related to affective and bodily functioning (Garner & Bemis, 1985), fears of maturation (Crisp, 1980), belief in the virtue of oral self-restraint (Garner & Bemis, 1985), poor impulse regulation (Casper, 1990), and beliefs that social relationships are insecure and disappointing (Strober, 1981) -- showed the expected linear relationship to eating disorder continuum placement, thereby supporting the construct validity of the eating disorder continuum hypothesis for women. These results also extend prior work that showed a variety of psychological, behavioral, and cognitive characteristics related to clinical eating disorders (Brookings & Wilson, 1994; Fairburn, 1995; Garner, 1991; Skodol et al., 1993; Stotland & Zuroff, 1990) to be related as expected to women's continuum placement. (Tylka, & Mezydlo Subich, 1999).

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Helping Mothers Help their Daughters: Preventing Disordered Eating and Eating Disorders

By Judith Ruskay Rabinor, Ph.D.
Faculty Member, JBFCS
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Judith Ruskay Rabinor, Ph.D.

It is Halloween, an unusually warm evening for late October, and not yet dark. Answering my bell, I open the front door to find two adorable young girls costumed in long evening gowns and rouged cheeks. A large shopping bag is held firmly between them. The girl wearing long blond braids speaks first.

"I'm Sleeping Beauty," she says.

"And I'm Barbie," chimes in the second.

I tell them how wonderful they look.

"Your choice," I say, pointing to my selection of candy. "M&M's or Tootsie Rolls."

'Barbie' speaks up. "Candy?" she says, "Oh no – No candy for us! But do you have anything not fattening?"

"Not fattening?" I repeat. "Why?"

"I don't want to be fat like my mom and my older sisters, so I'm starting to diet early."

* * * * *

Children mirror the world around them. My neighbor's daughters, Sleeping Beauty and Barbie, are typical of normal weight young girls who are doing what children do: taking cues from the behavior of the adults they admire. While these eight-year-olds have no diagnosable eating disorder, such as anorexia or bulimia, they are good candidates for developing one. At younger and younger ages, girls are becoming anxious about food and their bodies, leaving themselves at risk for serious eating problems.

Many parents encourage their daughters to diet – overtly or covertly. In the hopes of making their daughters more attractive and saving them from the rejection that often accompanies being overweight, parents may overemphasize weight loss. Ironically, these efforts may backfire and push their daughters into a lifelong battle with food and a never-ending struggle with their weight.

So, what's wrong with dieting?

Dieting is damaging in many ways. Dieting teaches girls to disconnect from their bodies. Dieting teaches girls to starve rather than feed themselves – first nutritionally and then emotionally. Dieting leaves one feeling deprived, and deprivation leads to binging and binging leads to weight gain which leads to dieting. A vicious cycle becomes easily established where one is programmed to disconnect from their inborn hungers, appetites and desires. Dieting lays down a template that says: "Let others tell you what to eat, how to feel, how to nourish, nurture and feed your hungry self." Most women spend a lifetime feeling fat, hungry and deprived.

I am a clinical psychologist who has specialized in working with eating and body image problems for over 25 years. While we have learned a great deal about treating eating disorders in these past decades, we have not learned how to prevent them. In fact, the epidemic of eating disorders continues.

Recently I have been inundated by mothers worrying about their daughters who, at younger and younger ages, are "feeling fat."

When I talk with mothers I attempt to share the lessons I have learned in my office. Innumerable psychological issues – concerns and struggles with identity, connection and relatedness—are masked and expressed in the constant chatter about dieting and pounds lost. In exploring the inner worlds of my patients, I have learned that our deepest hungers are too often and too easily twisted into a fear of fat. Beneath the words "I feel fat" lie deep needs, appetites, desires and hungers.

Clinical example: A young mother recently came to my office concerned about her six-year-old daughter. Becky had begun a diet and was suddenly "feeling too fat to go to school." Our conversation revealed that this diet began shortly after the birth of Becky's new brother, Ben, now three months old. In our session, I invited the mother to talk about the stresses a newborn inevitably brings to the family. "I'm so exhausted," she said and started to cry.

see Helping Mothers on page 40

Helping Mothers from page 38

I gently suggested that her daughter might benefit by simply hearing her mother name her feelings – the negative as well as positive – about Ben's birth. My goal was to help this mother understand that her daughter's dieting might be expressing some feelings that could be better expressed verbally. By teaching her to tease out the meaning of her daughter's dieting, I was empowering her to be more empathic and connected to her daughter. In talking with her about her own feelings, I hoped to normalize the negative as well as the positive emotions and enable her to make more room for her daughter's mixed feelings.

When children develop eating and body image problems, often parents wonder if their own dieting or exercising is to "blame." Therapists tread a thin line, for while it is necessary to pay attention to family dynamics, it is important to remember that parents are not the only force in children's lives. To minimize guilt and remind parents of their limitations, I quote Mary Pipher, who said that if she were to raise her children again, she would eliminate television from her home. Most parents, reminds Pipher, are not their children's enemies and will do "battle to save their daughter's true selves." With Piper's remarks in mind, I attempt to enlist parents as allies and offer these guidelines:

You are your child's most important teacher. Although there are many influences on your daughter – including peers, other adults and the media, you are your child's most important role model. Be aware of your own eating habits. Eat when you are hungry and stop eating when you are satisfied. Don't diet and don't talk about dieting. This is hard to do in our diet crazed culture. It requires a deliberate consciousness. Honor your own hungers- for nutritional, emotional and spiritual satisfaction. If you do this you will teach your daughter to tap into and honor her internal cues.

Be a better listener. Listen to your daughter. Become a more available parent. Eating disorders are about far more than food and losing weight: Become a translator. Complex messages are encoded in the three little words, "I feel fat." Stop, look and listen.

Listen to how you talk about yourself...and about others. What do you say to yourself about your body? About your appearance? About your daughter's appearance? About others?

Minimize food, dieting and appearance as important conversations. Think about what really matters to you in life. Be mindful. Talk to your child about what you really believe in.

Teach your daughter to listen to the wisdom of her body. Teach her to nourish her emotional, spiritual and psychological hungers as well. Teach her to distinguish between an emotional desire for food and a true physiological hunger. Help your daughter learn to talk about and resolve conflict and differences. Conflict and differences are inevitable and a normal part of growing up. Avoid conflicts over food which can easily become the focus of adolescent rebellion, but invite conflict and differences into your relationship. Talk to her about the conflicts you experience in your life and how you resolve them.

Help your daughter learn to live with disappointment. People use dieting to cope with disappointment and difficulties. Talk to your daughter about your coping style.

Remember: It takes great strength to nourish our inner hungers. Share your own hopes, dreams and disappointments with your daughter. Teach her to cope with life's challenges, disappointments and inevitable stress—without food or dieting. Teach her to nourish her own dreams and withstand life's inevitable difficulties.

What nourishes mind, body and soul are good relationships.

Among its 185 mental health and social service programs, the Jewish Board of Family and Children's Services helps adolescents facing a range of problems through a network of outpatient, day treatment and residential settings. For more information on these services, call (212) 582-9100.

For more information on the training and education programs of the JBFCS Martha K. Selig Educational Institute, contact Rick Greenberg, Ph.D., Director, at (212) 632-4633 or e-mail rgreenberg@jbfcs.org.

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The "New" Eating Disorder A Topic of Concern at Connecticut's Renfrew Center

By Douglas Bunnell, Ph.D., Director
The Renfrew Center of Connecticut

The growing public concerns about obesity and health risks have forced the field of eating disorders to reconsider the relationship between eating disorders and obesity. Binge eating disorder (BED is increasingly recognized as a distinct eating disorder with unique demographic and clinical features. Recent research indicates that BED may occur in 2 – 5% of community samples. BED is by far the most common eating disorder.

Clinical Features

BED is characterized by a recurrent pattern of binge eating that occurs a minimum of twice weekly for six months. The binge consists of an inordinate amount of food, eaten in a discrete time period, and accompanied by a sense of loss of control. Unlike individuals with bulimia nervosa, individuals with BED do not regularly engage in compensatory behaviors such as vomiting, laxative use or overexercise.

How do those with BED compare with individuals who are overweight, but who are not binge eaters? In general, those with BED have higher levels of emotional impairment and lower quality of life than obese non-bingers. Rates of comorbid psychiatric disorders such as depression, anxiety and substance abuse are comparable to rates in those with bulimia nervosa. Medical comorbidity also appears to be high in patients with BED.

Etiology and Risk Factors

Many of the factors associated with the etiology of anorexia nervosa and bulimia nervosa may also be associated with BED. These include childhood trauma, family histories of depression, sociocultural idealization of thinness and genetic vulnerability to obesity. The latter may be particularly significant suggesting that individuals vulnerable to weight gain and obesity may also be at increased risk for developing binge eating disorder.

Treatment of Binge Eating Disorder

The most extensively studied treatment approach with BED is cognitive behavioral therapy (CBT). CBT with BED focuses on the normalization and moderation of regular eating, addresses patterns of restrained eating and then works to help patients manage dysfunctional thoughts about their eating, weight and shape. CBT, in general, is an effective treatment, but the data indicate that while the vast majority of patients have a significant reduction in binge frequency by the end of treatment, only 60% of patients remain binge free at one year follow up.

The only other psychological therapy for BED with an extensive research base is Interpersonal Psychotherapy (IPT). IPT, an effective treatment for bulimia nervosa, appears to be effective for BED as well. IPT does not focus on eating, weight and shape cognitions but, rather, on the interpersonal and relational factors associated with the onset and maintenance of binge eating.

Psychopharmacological treatment of BED appears to be a useful adjunct to the psychological therapies. Studies of SSRI anti-depressants have shown that these medications can reduce binge eating frequency (Arnold, McElroy, Hudson, Welge, Bennett, Keck, 2002). There are also some data to suggest that overweight patients with BED may benefit from anti-obesity medications such as the appetite suppressant sibutramine (Appolinario, Godoy-Matos, Fontenelle, et al., 2002).

see BED on page 51

Celebration Honors People in Recovery who Staff "Peers Reaching Out" and "Peer Engagement Programs"

By Karen Kangas, Ed.D., Director of Recovery, SWCMHS/DMHAS

Southwest Connecticut Mental Health System: Connecticut Department of Mental Health and Addiction Services

I recently attended a standing-room only celebration at the Greater Bridgeport Community Mental Health Center. This celebration was in honor of people in recovery who serve as staff in the Peers Reaching Out (Pro) and Peer Engagement Programs (PEP) which currently operate in the greater Bridgeport and Stamford/Norwalk areas. These programs were designed after the Ellis Hospital Program in Schenectady, NY, and the idea of bringing them to Connecticut was introduced by the Consumer Action Group in Stamford under the leadership of Gabrielle Kitchner, Office of Consumer Affairs at the F.S. DuBois Center. The programs were then developed and implemented by OmiSaide Ali, Regional Director of the Office of Consumer Affairs, DMHAS South West CT Mental Health System (SWCMHS).

Peers Reaching Out and Peer Engagement Programs are designed to employ peers to provide companionship, an empathetic ear and the experience of their own recoveries to other consumers who may be struggling. They act as role models for their fellow consumers and a source of hope for recovery and a meaningful life in the community. The peers are hired, then trained by experts in the field and are paid stipends based on an hourly rate. The programs also focus on recruiting African-origin and Latino consumers to address the health disparities in the mental health and substance abuse fields.

Another unique aspect of the program is that it is a collaboration between the public and private hospitals. Norwalk Hospital officials were instrumental in promoting and implementing the program at their facility. Alan Barry, Administrative Director at Norwalk Hospital's Department of Psychiatry, likes the program because it focuses on care that is recovery oriented. "It means giving the patient the opportunity to be a part of a community again," Barry said, "and showing them that people who have been hospitalized for mental illness can work again."

Bruce, one of the Team at Norwalk Hospital's Peer Engagement Program and a former corporate accountant before he became ill stated recently, "I never thought I would work again and now, three months down the road, my weeks contain healthy work." Amina, a college student working part time at Norwalk Hospital in the Peer Engagement Program states, "They (the consumers on the inpatient units) feel more relaxed around you, that they can trust you. It gives a lot of people hope."

OmiSaide Ali, Regional Director of the Office of Consumer Affairs, SWCMHS/DMHAS, remarked that "it's not about challenging the existing healthcare system. It's about enhancing it. It's about being there, reducing anxiety and feelings of isolation and loneliness. If a consumer is cold, we get him or her a blanket. If they are feeling lonely, we provide them with conversation and an empathetic ear. The difference is that the person on the other end of this is an expert in that pain and that experience as the Peer has lived it him or herself. The Peer Engagement Program demonstrates all that is good about collaboration between our State agency, DMHAS, and our private providers. Working together as a team with people in recovery, we have developed a program that is a win/win situation for us all."

Based on my personal experience and the positive feedback I have received about these programs, I know that they make a difference in our lives. Peers helping peers is certainly a vital component of a recovery-oriented system of care. Your comments are welcome and may E-mailed to Karen.Kangas@po.state.ct.us.

Connecting To Feelings Key With Eating Disorders

By Meg Weissmann, LCSW
Norwalk Hospital

Mary sat with her head down staring at a large bowl of cottage cheese that her mother put on the table in front of her face. She was fighting back the tears welling up inside. She had just come home from school and was not hungry. She felt forced and as if she was betraying her body by eating.

She had stopped eating regular breakfast and lunch months ago and only ate some dinner because she had to sit at the table with her new stepfather, stepbrother and mother. She knew there would be a problem if she refused to eat. She was always trying to make or keep the peace. She could get away with no lunch at school since because nobody saw her. The most would be an ice cream sandwich or a plate of the rice. She was thin and wanted to be thinner. She knew she wasn't too skinny yet and would layer her clothes to prevent it from being noticeable.

And so goes the story of many women, especially teenagers in our society. They are exposed to images that prevent them from accepting what a normal or healthy body looks like. In all aspects of the media, TV, magazines, movies and ads on the radio, one sees the tall, thin and (usually) blonde model or actress one is suggested to strive for and look like for ones 'success'. The ads are saturated; selling diet pills programs, exercise plans, equipment and the right food. Peer pressure is another strong influence. If ones self-image is not strong and at least reasonably clear, it can be overwhelming and devastating to those who do not fit the advertised image. One's self image is continually being chipped away and challenged by these messages.

Mary was one of the lucky ones. It was noticed that she was getting thinner and thinner. As she was being encouraged to eat, she also was getting the needed support and attention she had missed. The new marriage and yet another move and new school were too much. It had not really been addressed. This, however, was just the tip of the iceberg. She had many years of impaired self-esteem and had been constantly invalidated by two controlling parents. They were not nasty; that would have made it easier. They could be loving and kind and were good people who cared; however their own needs and control took over.

As we know, she is far from alone. Eating disorders are getting more and more recognized and addressed by therapists, doctors, and other professionals. It is no longer for the white, middle class teenage girls. It extends to men, all classes, and races. Famous singers, such

see Key on page 51

In June 2001, Hall-Brooke Behavioral Health Services opened a new 58,000 square foot, residential style treatment center on its beautiful 24-acre main campus in Connecticut

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Men and Eating Disorders

By Sheila Cooperman, M.D., Director
Eating Disorder and Adolescent Programs
Silver Hill Hospital

Eating disorders have long been considered a "woman's disease". More recently, however, more and more men are being diagnosed and treated for their eating disorders. Men and women with eating disorders have symptoms that are observed to occur along a broad continuum. There are similarities and differences between the sexes in the way in which these symptoms are expressed. Making the most accurate diagnosis can facilitate the most effective treatment.

Eating Disorders affect 5-10 million people in the United States. The lifetime prevalence rate for Anorexia Nervosa is 0.5-3.7% and the male to female ratio is 1:6-1:10. This is the same ratio as in Bulimia Nervosa. Bulimics make up approximately 4% of the population. The prevalence of Binge Eating Disorder is 2%. In people seeking treatment in a University based treatment center, 30% of those with Binge Eating Disorder were men.

Currently, the most common eating disorders that people are aware of are: Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. The American Psychiatric Association has developed diagnostic criteria and practice guidelines for their treatment.

The identifying features
of Anorexia Nervosa are:

- Body weight 85% below that expected for age and frame
- Fear of becoming fat despite low body weight
- Body image distortion
- In women, loss of menstruation for 3 cycles in those who previouslyMenstruated

There are two subtypes, which are:

- Binge-Purge who vomit, use laxatives, enemas, and diuretics
- Restricting who withhold food

The identifying features
of Bulimia Nervosa are:

- Recurrent episodes of binge eating, which consist of consuming within 2 hours, a greater amount than most people
- Feeling out of control of how much food they consume
- Engage in behavior, which they believe compensates for the calories consumed during a binge, like vomiting, laxative use, diuretics, restricting calorie consumption
- The binges and compensatory behavior occurs at least 2 times a week for more than 3 months and does not exclusively occur during periods of anorexia. Body image predominates how they see themselves.

There are two subtypes of Bulimia:

- Purging – regularly engages in vomiting, laxatives, diuretics, enemas
- Non- purging – compensates by over exercising and bingeing

Binge eating disorder is currently a diagnosis that is being debated about and being looked at as a discrete diagnostic category. This does seem to be a relevant behavior among the obese and may be a variant of bulimia. It is binge eating without compensatory behavior. The binges are episodic and there is a greater than normal speed of consumption of calories. The person eats until they are uncomfortable, consuming large amounts of food when they are not hungry. People with Binge Eating Disorder tend to eat alone because they are embarrassed by how much they eat. They usually feel depressed, disgusted and guilty after a binge. These binges average 2 times per week for more than 6 months. In order to fit into this category, the behavior does not occur only when the Anorexia or Bulimia is active. The person with Binge Eating Disorder may or may not be obese but they usually have low self-esteem and are dissatisfied with their body image.

It is estimated that 10% of patients with eating disorders are men and some medical experts believe this is an underestimation. It may be that men are more reluctant to come for treatment out shame, thinking that an eating disorder is only a woman's issue or it may be that they may not even be aware that they have an eating disorder. Traditionally, eating disorders have been seen by most professionals as a woman's issue and not suspect their patient has an eating disorder.

It has been observed that eating disorders begin in adolescence in males and that they begin several years later than in women. It may be triggered by a wish to lose weight or to change their body shape. It appears that men's motivation for dieting may be connected to a wish to excel in sports, achieve an ideal body, gain peer acceptance, to prevent weight gain following an injury or to avoid medical complications like heart dis-

Sheila Cooperman, M.D.

ease. In contrast to women, men who develop eating disorders are more likely to be obese.

Some research reports have noted that men with eating disorders are unhappier about their upper bodies rather than lower bodies, face and thighs, which preoccupy most women with the same conflict. Men may become more obsessed by developing larger and larger muscles and repeatedly measure their size and strength. Men are more likely to engage in intense compulsive exercise and athleticism.

There are several vulnerable male groups, which appear to develop a higher rate of eating disorders. This includes actors, runners, gymnasts, models, bodybuilders, rowers, wrestlers, swimmers and weight lifters. Athletic pursuits that depend on weight criteria can intensify the pressure to perform at a particular level and trigger an eating disorder in someone who is susceptible.

It does appear that men with eating disorders struggle more with gender identity and appear to have lower levels of sexual activity but are less likely than women with eating disorders to respond to negative emotions like anger, frustration and anxiety by engaging in their eating disorder behavior. Men are less likely to have been victims of sexual abuse. As with women who have eating disorders, men appear to have the same rates of anxiety, depression and alcohol depenence.

It appears that men respond to intensive treatment similarly as women, and have similar outcomes. It is believed that men and women can benefit from being treated together in groups and may enhance their therapy by participating in some groups with men only. Men with eating disorders can be successfully treated if professionals are aware of these diagnoses and guide their patients with effective strategies.

It is important to identify the most appropriate level of care in order to have the best chance for successful outcomes. Clinicians need to evaluate their patient's weight, height, cardiac status as well as metabolic status. Their Psychiatric assessment should include an evaluation for suicidality, substance abuse, and other comorbidities. Goals of treatment are to focus on achieving and maintaining a healthy weight, stabilizing any abnormal medical conditions and motivating patients for recovery. Education about the disease, which includes: information on healthy nutrition, short and long term physical complications and a healthy weight range can undercut some of their self destructive behavior.

Hospitalization may be necessary if the person is medically or Psychiatrically unstable. Medical status can be compromised by inadequate oral intake, abnormal vital signs or electrolyte loss through vomiting. Suicidality may require emergency care for stabilization. Failure to gain weight or break the binge-purge cycle can be signals for hospitalization.

In the hospital, patients are hydrated, restored as closely as possible to a healthy weight and provided nutrition to preserve bone. A Psychiatric evaluation can pinpoint other coexisting disorders like anxiety, depression and addiction. At that time, medication may be started to reduce the risk of relapse. Families can be enlisted to learn about ways they can help in the recovery process. Clinicians can assess the family dynamics and make appropriate therapeutic interventions.

Professionals can provide patients and their families with important information about the chances for recovery if they are clear in their expert assessment about how motivated the patient is for treatment. Patients entrenched in not wanting to change and not seeing their symptoms may require a different intensity of treatment than those who are seriously thinking about changing behavior and are actively working on changing their symptoms.

Coordinating care, whether in or out of the hospital is essential and should include medical supervision with regular weigh-ins, family involvement and nutritional consultation that encourages trying a wide variety of foods with judicious exercise. Various forms of therapeutic interventions may be helpful. Encouraging a firm commitment to recovery will lead to the best outcome.

Dr. Cooperman is Director of Eating Disorder and Adolescent Programs at Silver Hill Hosptial and has been on the staff at the hospital for more than 10 years. She is a former voluntary faculty member of NewYork Presbyterian Hospital Westchester Division. For more inforation about the programs at Silver Hill Hospital, please call 203-966-3561.

Medical Management of Eating Disorders in Adolescents

By Marcie Schneider, M.D.
Director, Adolescent Medicine
Greenwich Hospital
Assistant Clinical Professor of Pediatrics
Yale University School of Medicine

Eating disorders affect up to 5 % of females and a much smaller number of males. In fact, eating disorders are the third most chronic illness in adolescent females. Many teens first start treatment with a therapist to address the psychological issues. Although eating disorders are psychologically based diseases, they have significant medical consequences. Comprehensive and adequate care for teens with eating disorders requires a team effort including a mental health provider, nutritionist, and medical provider with expertise in adolescent health. It is essential for the team members to be in close communication with each other so that the treatment goals are clear and unified. Each member of the team has a clearly delineated role. The purpose of this article is to outline the role for the medical provider in the evaluation and treatment for teens with eating disorders.

Eating disorders in adolescents include anorexia nervosa, bulimia nervosa, and binge eating disorder. Anorexia nervosa occurs in 1/200 adolescents. Ten percent of cases are in males. The peak ages of onset are 13 – 14 years, and 17 – 18 years. Bulimia nervosa is about ten times more common than anorexia nervosa, peaking between 17 and 25 years. Binge eating disorder occurs in up to 4 % of adults, and most report the onset of bingeing in their teens. Most teens do not fulfill the criteria for any of the above, and are categorized as "eating disorder not otherwise specified." For a complete description of these disorders you may consult the *DSM IV, Diagnostic Criteria,* published by the American Psychiatric Association.

The medical provider must rule out any medical causes of the presenting symptoms. Once that is determined, he/she assesses any medical complications and consequences. Next, a treatment plan is delineated, including setting a goal weight and time frame in which to attain the goal weight, and determining the best treatment setting. Medical complications of eating disorders were discussed in a previous issue of Mental Health News (winter 2001) and are listed in the table *located on the following page.* Teens with eating disorders can be treated as outpatients, as inpatients on medical or psychiatric units, or in day programs for full or partial days.

The initial evaluation includes a full history and physical examination. Blood work is sent including hormonal studies. For boys with anorexia nervosa, the hormonal evaluation includes thyroid studies and testosterone levels. For girls with anorexia nervosa, hormonal evaluation includes thyroid studies, leutenizing and follicular stimulating hormones, estradiol, and prolactin. Complete blood counts, blood chemistries and fasting

Marcie Schneider, M.D.

lipid profiles are also sent. Cholesterol may be elevated even when teens are malnourished and eating no fat due to the livers response to starvation. In those with anorexia nervosa purging type, or bulimia nervosa, blood chemistries may be abnormal, and even life threatening. If the purging is from vomiting or diuretic use, potassium may be low and dehydration may be seen. If purging is from laxatives, dehydration may be seen. Treatment for these is dependent upon the level of abnormality. Again, optimal treatment is normalizing eating behaviors including eating a well balanced diet and refraining from any purging behaviors.

Adolescents gain half of their adult weight, one fifth of their adult height, over half of their bone mineral deposition, and progress through puberty during these years. Their nutritional requirements are great, and second only to that of an infant. At each yearly physical examination, teens are measured, weighed and assessed for pubertal stage during their visit. Their height and weight are plotted on their growth curve, and compared to prior years. Unlike adults who need to lose weight to meet criteria for anorexia nervosa, adolescents do not necessarily need to lose weight; maintaining weight while growing ultimately leads to falling off the growth curve and slowing perhaps even stopping further growth and pubertal development. For girls who have not yet started menstruating, malnutrition can delay the onset of menstruation. For older girls, malnutrition may cause cessation of menstrual cycles.

For those girls who have lost their periods, or who have delayed their puberty and never menstruated, or for those whose periods were normal and now are erratic due to their nutritional status, bone density studies are done. This is to assess if there is bone loss due to malnutrition, lack of fat in the diet to absorb Vitamin D and in turn calcium, and a lack of the necessary estrogen to make bone. It is essential in dealing with teens that the bone densities are done at a facility that has a bone density machine with the software to interpret bone density compared to age matched controls. When teens, particularly young teens, have bone densities that are compared only to adult norms, they look worse than they are, as they have not yet reached their peak bone density. When the results show bone loss it can be interpreted as osteopenia (1 – 2.5 standard deviations from the mean for age) or osteoporosis (more than 2.5 standard deviations from the mean for age). The ideal treatment for osteopenia or osteoporosis in an adolescent is weight restoration, with a diet including enough fat, calcium and vitamin D, and restoration of menstrual cycles. The combination hormonal pills often used around menopause have not been scientifically proven to increase bone density in anorexic osteopenic or osteoporotic adolescents. There has been some evidence that using combination hormonal pills may be helpful to avoid losing more bone, and it is therefore reserved for those older chronic anorexics that are close to reaching their peak bone mass and have little hope for gaining weight and restoring menses in a timely enough fashion.

Goal weights are based on several criteria. The most important criterion is based on the patient's growth curve, estimating where the patient's weight and height should be based on their heights and weights from the age of 2 years. Another criterion to consider is the weight that is 10 % below ideal body weight for their expected height (the lowest weight considered normal for that height). The majority of girls lose their periods while dropping weight, and usually need to be 2 or 3 pounds higher to get their periods back. (For those who lose periods before weight loss, that is not a useful number.) The goal weight changes as teens grow taller and will need to be changed over time. Discussing this process is essential.

Rate of weight gain is also an issue. The expected rate of gain changes depending upon treatment setting. Weight gain can be 0.5 pounds per day on an inpatient unit, while 1 – 1.5 pounds per week is the expected rate of gain in outpatient settings. Teens will often ask to wait to gain weight until they are psychologically ready. As puberty, growth, and peak bone mass are time limited processes, and as brains when malnourished look shrunken on MRI leading to poor reasoning, one must be nourished to work well in therapy. For these reasons, therapists are involved from the beginning of treatment to help support the process. If the physical criteria for hospitalization are met including weight of less than or equal to 75 % normal for age and height, heart rate less than 50 beats per minute, blood pressure that is too low or too great a difference in blood pressure from the lying to sitting position, or electrolytes are abnormal, the patient can be medically hospitalized, hopefully not using up their psychiatric inpatient benefits. A treatment protocol and a staff trained to deal with teenagers and with eating disorders are imperative on any unit where a teen is hospitalized. Because of this, there are few medical hospitals that hospitalize teens with eating disorders.

Due to the strong influence of insurance companies, recovery can no longer be accomplished during a hospitalization. Rather, the hospital is seen only as a place to gain medical and psychological stability. Short stays can be a major problem as it has been shown repeatedly that the need for readmission is minimal if an anorexic can remain in the hospital long enough to attain their goal weight. At this time, readmission is extremely common as insurance companies do not allow patients to stay until that point. As a result, intensive outpatient programs have arisen where teens can attend Monday through Friday 9 AM – 5 PM. In these programs, teens typically spend time eating in a supervised manner and working on the psychological issues both individually and in a group. To date, there is only one full day adolescent eating disorders day program in the tri-state area, the others being either for all ages, or not a full day. Some of these day programs offer a less intense level of care, by meeting mid-day or early evenings a few days per week, and often include a meal or snack. The least intensive level of care is as an outpatient. Teens who need to gain weight and are medically borderline unstable should see a medical provider weekly. At each visit, weights are checked in a consistent manner (same time of day, same scale, patient wearing a gown). Urines are checked for markers of hydration and starvation. Vital signs are checked and bloods are drawn if deemed necessary. In addition to the medical provider, teens see a nutritionist weekly, mental health provider at least weekly and possibly a psychiatrist for psychiatric evaluation. If available, group psychotherapy may be helpful. Thus even this level of help is intense, with each professional having a different and clearly defined role to play. As weight and medical issues stabilize, the medical provider's role decreases and the teen works primarily with the nutritionist and the mental health provider.

One of the biggest challenges in dealing with the medical issues of teens with eating disorders is engaging them in treatment. It is extremely important that the parents and mental health providers support and encourage the patient to take the necessary steps toward medical health. Unless they have had a stress fracture, even if teens with bone loss cannot developmentally appreciate that they have a problem. Involving the parents as partners in helping their teen regain their medical health is essential. This means keeping the parents abreast of and invested in the treatment plan, but

see Medical on page 47

Medical Complications For Adolescents with Eating Disorders

Anorexia Nervosa

- Hair loss
- Lanugo (downy-like hair on back and limbs)
- Cold extremities
- Dry skin
- Bruised skin
- Constipation
- Delayed gastric emptying
- Fatigue
- Muscle wasting
- Decreased concentration
- Decreased coordination
- Irritability
- Pubertal delay
- Growth failure
- Loss of menstrual periods
- Low body temperature
- Low blood pressure
- Slow heart rate
- Rhythm abnormality on EKG
- Low voltage on EKG
- Anemia
- Low white blood cell count
- Low platelet count
- High cholesterol
- Blood chemistry abnormalities
- Hormonal abnormalities
- Bone loss on bone density test
- Brain shrinkage on brain MRI

Bulimia Nervosa

- High or low blood pressure
- Chemical abnormalities including low potassium
- Dehydration
- Erosion of dental enamel
- Calluses on the back of the hand
- Enlargement of the parotid gland
- Dilatation or rupture of stomach
- Bleeding from stomach and esophagus
- Irritation of stomach and esophagus
- Gastric esophageal reflux disease
- Barrett's esophagus (precancerous lesion)
- Aspiration pneumonia
- Diarrhea, constipation, fatty stools
- Heart muscle abnormality from ipecac use
- Menstrual irregularity
- Polycystic ovarian syndrome

Medical from page 46

does not necessitate that parents supervise meals. The medical provider must have expertise in working with teens and in turn in working with their parents. The issues around buying food, preparing meals, eating family meals will be determined with the teen, parents and providers. Working with parents is essential even when the teen is over 18 years old. Even then, parents have financial control and emotional ties such that their words, actions and support still have great power.

After all is said and done, the outcome of having an eating disorder is that about a third recover, a third get better but not totally recovered, and a third remain chronic. The mortality for this illness, excluding suicide is 5 – 10 %. It is believed that primary prevention and early identification will help to improve the odds. As 3 – 4 professionals are required to adequately treat a teen with an eating disorder, it is clear that this is a complex set of problems. As such, it requires a multidisciplinary team with professionals skilled with eating disorders and with dealing with this age bracket and their parents. The program at Greenwich Hospital has two medical providers, a psychologist and a nutritionist on site. We have a group for teens with eating disorders and have the ability to medically hospitalize teens with eating disorders, if medically necessary. We work with many therapists and nutritionists outside of our program to best serve the needs of our patients.

For further information please call 203 863 4224.

MHA of Westchester Training Institute Inaugurates New Courses for Mental Health Professionals

Staff Writer
Mental Health News

The Mental Health Association of Westchester Training Institute presents four new courses for mental health professionals, beginning in February 2004.

Course #1: "Treatment of Interpersonal and Psychological Trauma" teaches the skills of assessment and diagnosis of psychological trauma and associated disorders and current evidence-based treatment models for trauma related disorders. Covering Phase Oriented Trauma Treatment, Cognitive Behavioral treatment, Exposure therapy, Eye Movement Desensitization Reprocessing (EMDR) and psychopharmacological interventions specific to trauma treatment.

Instructor Betty McCorkle, CSW, senior clinician with the Northern Westchester Counseling Center (NWCC), has 15 years of experience working with child, adolescent and adult victims of domestic violence, sexual abuse and other traumas, and is trained in EMDR-Level II. She earned her MSW from Columbia University. *The course is scheduled for the 3rd Wednesday of each month, from 9:30 – 11:30 a.m.*

Course #2: "Treatment of Children" presents the most recent research on the etiology and treatment of childhood disorders. Emphasis is on identifying early stages of development, learning how children are impacted by disorders differently depending on their age, identifying symptoms manifested by children suffering from mental illness and specific interventions e.g. play therapy, family therapy, cognitive behavioral treatment and psychopharmacological approaches. Emphasis is on best practice models for assessment, diagnosis and treatment.

Instructor David Wall, PhD, is clinical coordinator of Crossroads and Partners in Parenting (community) programs at MHA. With more than 10 years of experience in clinical treatment, Dr. Wall is a clinical supervisor and provides therapy to children, adolescents, adults and families from a cognitive-behavioral perspective. He earned his PhD in Clinical Psychology from the State University of New York at Buffalo. *The course is scheduled for the 2nd Thursday of each month, 9:30 – 11:30 a.m.*

Course #3: "Treatment of Mood and Anxiety Disorders" offers research on the etiology and treatment of mood, anxiety and associated disorders. The course will address assessment and differential diagnosis of mood and anxiety disorders and best practice models for the treatment of mood and anxiety disorders, including psychopharmacological approaches and developing treatment plans utilizing specific Cognitive Behavioral Techniques.

David Wall, PhD, is the course instructor. *The course is scheduled for the 3rd Thursday of each month, 9:30 – 11:30 a.m.*

Course #4: "Treatment of Psychotic Disorders" focuses on the assessment and diagnosis of psychotic disorders, the etiology of schizophrenia, and the roles of psychotherapy and psychopharmacology in the treatment of psychotic disorders. Included are information on the range of psychosocial issues that affect people with psychotic disorders, the impact on the family and the role of these disorders in substance abuse, homelessness and the criminal justice system. Specific attention is directed to best practice models of rehabilitation and recovery, including wellness interventions, vocational, housing and social supports.

The instructor is Carla Quail, CSW, clinical director of the Sterling Center, a clinic of MHA in Elmsford and a satellite clinic in White Plains. She has extensive experience treating serious mental illnesses. Ms. Quail earned her MS in social work from Columbia University. *The course is scheduled for the 2nd Tuesday of each month, 9:30 – 11:30 p.m.*

Each course has been approved for 18 hours of continuing education under the auspices of the National Association of Social Workers New York State Continuing Education Recognition Program. Tuition is $990 per course that includes course materials. Courses are offered to certified social workers, doctoral level psychologists and professionals in related disciplines. Courses meet monthly between February 2004 and January 2005. Case presentations by participants are an essential part of the course. All courses meet at MHA of Westchester, 2269 Saw Mill River Road, Bldg. 1A, Elmsford, NY 10523.

MHA also offers courses required by New York State for Designated Professions:

"School Violence Prevention and Intervention" (Project Save) and "The Identification and Reporting of Child Abuse and Maltreatment" are required by New York State for people licensed in designated professions, who must provide documentation of having completed both courses. MHA is an approved New York State provider for both courses, which are offered throughout the years.

For course dates and to register, or to arrange a presentation, please contact Katharine Swibold at 914-345-3993, Ext. 222 or by e-mail to swiboldk@mhawestchester.org. The MHA of Westchester's web site www.mhawestchester.org provides information on additional educational opportunities.

Casa from page 31

residents who were leaders at St. Philip's Church and Harlem Hospital. The organization operates Bishop House and Weston House, licensed community residences for the mentally ill; Weston House Transitional Living Community, a unique shelter for the mentally ill homeless, Community Focus, a housing program for people with HIV/AIDS; and Supported Housing in rented apartments throughout upper Manhattan. Employment-centered programs are Club United and Casita Unida which are certified clubhouses, Gallery M and Visionary Bookstore which employ clients, and the Career Development Program which helps them find and keep jobs. Treatment programs include Blended Case Management, which has teams of workers supporting at-risk clients throughout the community; and the new Assertive Community Treatment (ACT) team, a mobile psychiatric clinic serving the Washington Heights community.

For more information contact Jean Newburg at (212) 866-6040 x220

Overeating from page 23

are in the grocery stores, where all the delis and candy stores are located, what time they open and close. It is planning how to alternate going to each store for different binges to buy foods, believing it will avoid raising the scrutiny of the staff. It is planning the time, day and place to binge in private. It is avoiding, lying, hiding, stealing to make sure there is enough food at all costs for the binge. The pursuit of the food becomes the obsession that goes uninterrupted until the binge and consequent let down.

Consuming the food often involves a numbing and dissociative experience in which the overeater barely remembers the food, how much was eaten, how his/her stomach feels and what the food tasted like. The experience generally is remembered as "inhaling" the food. This lack of awareness sets up further bingeing because of the dissatisfaction of the experience, the brevity of it, the sense of not having any more and the initial emptiness and vague emotional discomfort that still lingers. This is generally followed by self-recrimination that exacerbates the emotional state further and triggers more bingeing. When periods of deprivation of food are attempted in an attempt to quell shame and regain a sense of control, anxiety levels become intolerable. Unrecognized anger is accompanied by the need for further acting out or rewarding oneself. Thoughts that "it doesn't matter anyway," that any attempt to change is hopeless and that dieting, purging or starvation can be used at any time in the future are common when the overeater finally gives into a binge and the momentary sense of relief from the tension of deprivation and being "good." This cycle continues unless it is recognized, understood and dealt with.

For compulsive overeaters, the effort to connect with the feelings that spur the behavior seems impossible to accomplish until the behavior is recognized and validated as a survival and coping method, but one that may no longer work for them. Compulsive overeaters commit to treatment when they recognize the desire to find relief from the tension of the compulsion. They begin to acknowledge that the results and aftereffects no longer provide the relief and resolution they thought it did. They realize that the overwhelming anxiety each binge causes and the exhaustion of the resulting depression are increasingly more debilitating. It becomes clear that they perpetuate the same emotional tension they had originally tried to suppress.

In treating the compulsive overeater, it is important to recognize that compulsive overeating engenders such a degree of shame when it is finally acknowledged, that the overeater tends to want to hide it further. Most often the opposite action to this inclination, such as group therapy can be the most effective form of treatment. Universalizing the feelings which the overeater is trying to avoid, education and radical acceptance appear to provide the most benefit. Support groups, groups with a dialectical behavioral approach and therapy groups show significant positive results. These modes of treatment have allowed for further therapeutic intervention on deeper issues to occur. Workshops given by experts such as Geneen Roth, literature and expressive therapies have been effective in using opposite action and one-mindfulness to help with increasing awareness, encouraging empowerment and decreasing shame.

It is important to consider that medications can be both helpful and harmful for compulsive overeating problems. Some anti-anxiety and anti-depressant drugs can help with reducing mood states so the behavior can be managed more effectively. However, some medications such as certain SSRIs contribute to weight gain and the inclination to overeat by adjusting brain chemistry levels. When considering this eating behavior, it is important to conference with all coordinating treaters to help make an informed plan that will not counteract the effort to stop overeating. Most important, helping professionals need to consider the behavior important enough to warrant an approach that addresses it directly. Compulsive overeating, like other eating disorders, is generally one of the last things the individual talks about, thinks about or knows about except that it is causing suffering that no words describe.

For the compulsive overeater, once the pattern of thinking and behavior is identified and acknowledged, significant work around coming to terms with this behavior can begin. This includes what it means to regain control, lose weight and the feelings that this allows to surface. Vulnerability to danger and hurt, loss of a dependent coping method, and anxiety about getting better are some of the subsequent experiences. With appropriate support, education and healing approaches that reduce shame, treating compulsive overeating can result in an ability to be more adaptive, self-accepting and empowered. This can provide a crucial opening for treating and healing the underpinnings of painful issues that have affected the individual from the start.

For further information about trauma sensitive groups, treatment for compulsive overeating and other disorders and literature, call Janis Voltmer at Putnam Family and Community Services at 845-225-2700 extension 147.

Summer 2004
Cover Story Theme
"Sleep Disorders"
Deadline May 1st

Fall 2004
Cover Story Theme
"Cultural Diversity"
Deadline August 1st

Social Work p.r.n.
A Resource for Settings & Social Workers

Staff Writer
Mental Health News

In today's world, human service providers face a multitude of challenges to delivering quality services. Increasing complexity of consumer needs, cost-containment, heightened accountability to funding sources, and staff recruitment and retention concerns all call for creative solutions. Social Work p.r.n. has partnered with thousands of settings nationwide to help them meet their most challenging social work staffing, recruitment, and support needs.

Ellen Brodsky, CSW, New York Coordinator for Social Work p.r.n., explains that more and more businesses rely on the professional services provided by companies like Social Work p.r.n. "There are temporary employment agencies for accountants, architects, lawyers, physicians and nurses, for instance, and Social Work p.r.n. provides this service for social workers."

When an agency needs social work coverage to fill gaps in permanent staffing due to vacations, leaves, resignations, hiring, census fluctuation, work overload, and program start-up, help is now just a phone call away. Social Work p.r.n. is able to draw upon a pool of highly skilled and dedicated social workers that come to us looking for flexibility in employment, the opportunity to work in a variety of settings, and the support of a professional social work company that promotes their interests and talents.

Settings often rely on Social Work p.r.n. to provide temporary help while engaged in hiring a social worker. Because the hiring process is expensive (on average settings spend $3,000 to $6,000 to hire a new worker), finding the right match crucial. Social Work p.r.n.'s temp-to-hire option is a great way for both the setting and the social worker to decide if a "fit" exists between the worker and the job before making a commitment. When you are looking to hire a social worker for a permanent position, Social Work p.r.n. can do all the preliminary work for you and provide expert screening, interviewing, reference checking, and understanding of who would make a good "fit" for your setting. The moderate fee that Social Work p.r.n. charges a setting for permanent placement is often less than the cost of advertising for a position.

Social Work p.r.n. serves across fields of practice including medical and behavioral health care hospitals, addiction treatment centers, outpatient, partial hospitalization and day treatment programs, community mental health centers, government agencies, residential facilities, and many other settings that utilize social workers. "Mental health is a very large area of practice for our office," notes Ellen Brodsky, "and our professional social work training and experience definitely aids our understanding of service delivery at the practice level, which in turn, helps us provide the best services to settings and consumers."

In addition to our staffing services, we offer clinical supervision and training and continuing education workshops for community agencies and social work professionals alike.

Inmates from page 24

Time slows to a near halt. The passage of minutes is marked by the drip of the faucet, the jingle of keys on a guard's waistband, the screams of other inmates, the scraping of a food tray through a slot in the door."

"Punishment here takes on a new, more extreme form. It's not just boredom and monotony, the usual banes of prison life. For mentally ill prisoners, life in the box can quickly become an invisible torture as their minds fill with delusions. And there is no limit to the number of months—or even years—a prisoner can be locked up this way."

"Solitary confinement is the penalty for a wide range of transgressions, everything from failing a drug test, to refusing to obey an order, to assaulting a guard. Between 1997 and 2000, New York State opened 10 new facilities specifically to hold inmates in 23-hour lockdown. (For the Mentally Ill, Solitary Confinement Can Be a Death Sentence The Stories of Two Men Who Never Made It Out Suicide in the Box by Jennifer Gonnerman Village Voice December 17 - 23, 2003).

Who suffers? All too often, the inmates sent to the SHUs are not hardened criminals but people with often complex medical/mental health problems that go undiagnosed, untreated or under-treated; a vulnerable needy group whose difficult, disruptive or non-responsive behavior is all too often dismissed as defiant, oppositional, explosive or anti-social behavior. Those on whose behalf we are here today are not the hardened criminals who have chosen a path of violence and malevolence; we're here to speak out on behalf of those vulnerable New Yorkers who suffer with a severe mental illness.

I have personally visited with some of these individuals last year, during a visit on the tiers at Sing Sing. I sat with and listened to some of these prisoners; they looked, talked, acted just like many of the folks we see every day in community mental health services across New York State.

These are our people, our brothers and sisters, an important part of our community, lost by us, lost to us…and they desperately need and deserve our help.

The New York Association of Psychiatric Rehabilitation Services strongly supports the legislation that Assemblyman Aubrey has proposed and Assemblyman Rivera and the members of this panel so strongly support, Assembly Bill A.8849.

This bill will begin a critical process of making mental health treatment available to prisoners who have a serious mental illness and create a meaningful mechanism to prepare prisoners for release into the community. Increasing the responsibility of the New York State Office of Mental Health for the treatment of prisoners with mental illness and developing a stronger oversight process through the participation of the Commission of Quality of Care will bring additional and needed expertise to the development of quality mental health services to prisoners.

Your legislation represents an essential step towards righting terrible wrongs we have visited on this desperate group.

We routinely fail them at three critical junctures:

- At the outset, we fail to properly educate and engage them in the beginning and to provide the kinds of outreach and support, particularly in communities of color, that might have diverted them from a life of trouble and eventually of criminal behavior.
- Then, during a prison sentence that all too often could and should have been prevented, we fail to properly and promptly recognize their disability and vulnerability and instead require them to take their depression, delusions and despair into the dark, alone and isolated for 23 hours a day. And then, when they don't respond, we sentence them to even more time in torment rather than the treatment they need and deserve.
- And finally, all too often we fail to provide them with adequate and appropriate discharge planning, which denies them appropriate follow up community support and frequently re-starts the cycle of recidivism that will lead them back to prison.

As a first step in seeking to end this terrible cycle, NYAPRS will work tirelessly to get this legislation supported and passed by both houses and signed by the Governor. We pledge our full support and will come back for our Legislative Day on January 27 and again and again until these folks get they humane treatment and true justice from New York State they are denied and deserve.

Thank you once again for your strong and wise leadership on our behalf.

You may follow the advocacy efforts of NYAPRS in their regular column in Mental Health News, or call them directly at (518) 436-0008.

Parental from page 31

Financial constraints typically prevent families from covering the remainder of inpatient care out-of-pocket. Another benefit to the discovery of a viable alternative to hospitalization is that outpatient care is less disruptive the patient's life (e.g., school participation) and psychosocial development.

The Maudsley Method

The Maudsley method is an amalgamation of various family based therapies that blend together to form a highly successful, albeit controversial, style of treatment. Philosophically the approach minimizes ruminating on the causes of the illness and focuses instead on the importance of the family as a vital component in the treatment process.

The treatment is divided into three phases that encompass approximately 20 sessions over 6-12 months. The aim of Phase 1 is for the therapist to assist the parents in taking charge of the situation and gaining control over their child's eating habits. The approach emphasizes how in the face of the illness the adolescent has lost control of his/her eating, and the parents are needed to reinstate eating appropriate to the child's state of starvation. Potentially this could be seen as problematic considering firstly how adolescence is a time of self-assertion and autonomy and secondly that anorexia nervosa is typically viewed as being caused or perpetuated by a controlling parental environment. Ironically, the effect is a therapeutic one, and can even result in a sense of relief for the patient when painstaking decisions regarding food are no longer left up to the adolescent.

One of the fundamental components of the approach is to eliminate any blame on either the parents or the patient's behalf. Because the treatment advocates a lack of etiological focus (which often implies that anorexia nervosa is a byproduct of controlling parenting), a parent's sense of personal blame for their child's illness is alleviated (which is emphasized by the fact that the treatment advocates more parental control). Conversely the adolescent is relieved of blame in that the treatment attempts to separate the illness, conceptually, from the patient. Consequently the patient is perceived as having been usurped by the illness and no longer in control of his/her decision making and behavior regarding food. This form of externalizing the illness into a separate entity from the patient helps reframe how the family perceives the illness. Research has shown that parental criticism toward the patient is associated with poorer prognosis (Le Grange, Eisler, Dare, & Hodes, 1992). Therefore treatment intends to refocus the family's perception to one that is less accusatory and more sympathetic.

Considering the arguably distinct parenting styles of Britain and the United States it is seemingly counterintuitive that the Maudsley method would make such a smooth transition from its base in London to the Unites States. In American families, parents tend to advocate less authoritative control and encourage a more self-autonomous expression. However, preliminary results from this country indicate that this family-based treatment is as successful here as abroad.

Gaining the physical weight is a prerequisite to ameliorating the psychological disturbances typical to anorexia nervosa, including associated symptoms such as depression. Phase I is thus referred to as the "refeeding" process, whereby the parents come together as a unit and decide on the best method to get their child to eat. The therapist initiates this by creating a shift in the parent's thinking from feeling powerless in the face of the illness to being in control and proactive. During the second session, parents bring in a family meal to consume in the therapist's office. This is used as a diagnostic tool and helps the therapist initiate the refeeding process for the parents. Parents often ask what they should bring for the meal and can expect the response "what you think is appropriate to feed a starving child." Interestingly some parents will still bring in an abstemious list (consisting of vegetables and fat free products), which represents the few foods the child will eat. It is this pattern of thinking that keeps the illness alive and which the therapist helps restructure. The remainder of Phase I is devoted to maintaining a focus on the refeeding process. Parents implement this with a blend of firmness and kindness.

Once the patient has physically gained weight and psychologically lessened the battle with his/her parents, Phase II begins, which helps transfer independence and control of eating back to the child. In all phases, it is important that parents do not assume excessive control in areas other than those related to food, eating, and inappropriate compensatory behaviors, such as purging. In the second phase, the child can once again eat autonomously, at a developmentally appropriate level. For instance, younger adolescents will be able to participate in slumber parties, eating dinner outside of their parent's view; older adolescents will be able to go out for pizza with friends. Phase III, the final phase of treatment, addresses both the issue of relapse and the broader concerns of normal adolescent development. It is important to be sure that the child is back on track in all developmental domains.

Conclusion

There is no time to waste in commencing effective treatment for an adolescent with anorexia nervosa. Research indicates that the Maudsley Method, a family-based intervention that puts the parents in charge of the refeeding process, is a viable and effective outpatient approach for weight gain and long-term resolution of the eating disorder. This method is also being adapted for adolescents with bulimia nervosa and with obesity.

For further information on the Mount Sinai program please call the general psychiatry referral line at 212-659-8760 and ask for Tracey Lion-Cachet, Clinic Coordinator of the Weight and Eating Disorders Program.

BED from page 41

Studies of anti-convulsant medications such as Topiramate are now underway. Open label studies have shown that these medications may also reduce binge eating frequency (McElroy, Arnold, Shapira, et al., 2003).

Treatment of BED
at The Renfrew Center

The unique features and treatment needs of this group of eating disordered clients suggest that it would be optimal to treat them in a specialized treatment program. The Renfrew Center of Connecticut ran a pilot one night per week intensive group program for women with binge eating disorder earlier this year. The three-hour program consisted of an opening psychotherapy group, which addressed relational factors associated with the binge eating symptoms and worked to decrease the often profound feelings of shame and isolation reported by the patients. The second hour consisted of a structured, nutritionally planned meal and focused on issues such as pace of eating and increasing recognition of satiety signals. The final group of the evening was experiential in nature, alternating between art therapy and movement therapy. Patient feedback was positive and Renfrew is resuming this group program this month.

The goal of treatment is symptom improvement through the development of interpersonal connections that help the patient manage, contain and tolerate the anxieties and distress associated with the binge eating. In creating a unique and safe space, specialized treatment can help to reduce shame and isolation, help to soften body focused self-loathing and help patients identify the interpersonal antecedents to binge eating.

Conclusions

We now know that a subgroup of people who are overweight have a contributing psychiatric diagnosis of BED and are aware of how to begin to treat this group. Increased sensitivity to this diagnosis on the part of physicians, mental health clinicians and nutritionists may allow for earlier detection, treatment and, ideally, the prevention of the medical risks associated with excess weight gain.

Douglas Bunnell, PhD, is Director of The Renfrew Center of Connecticut and President of the National Eating Disorders Association. He maintains a private practice in Wilton, CT, specializing in the treatment of eating disorders.

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Key from page 42

as Karen Carpenter, had to die and actresses, such as Jamie Lee Curtis, who are willing to expose their personal life and history before it became more accepted and conscious in our society. As Jung would say, our collective unconscious has to catch up. What many don't realize, is that no one looks like the pictures we see in magazines, much of which is altered by air brushing, make up and lighting. As professionals we realize that when a person is emotionally vulnerable they are susceptible to the ads and constant barrage of pictures, comments and images. It does not take much or long for it to influence and diminish ones self esteem. It can become harder and harder to resist and not buy into the images.

The most important piece is to start to connect to the feelings and to the 'void' the behaviors are filling. There are many theories and techniques including personal journals, food journals, individual and family work, and group therapy. The more one can identify the thoughts and feeling the behaviors protect, the closer to recovery one can get. Food can become ones best friend, or ones worst enemy. It is something one can eventually control.

Treatment generally comes with the ability to allow the patient to discover and heal the pain, losses, and trauma, to learn how feel worthy and that it is all right to take care of themselves. They can find healthy ways to get what they need or learn how to accept and allow themselves permission to be healthy. They do not have to remain the scared, hurt, angry, anxious, suppressed or depressed person. Society and family expectations do not have to rule their beliefs and behaviors. They can learn to have internal controls and improve their negative self esteem and body image that was controlling their thoughts and behaviors.

Time is our biggest ally. One can not force the patient to change their perspective and while this is true in all work, it is important here since control plays has such a major role. Patients have to learn how they can let go and allow themselves to feel their own connection and control. Often learning other ways to fill the void and identify the feelings helps as they work on the issues and start to develop more balance in their lives. Food no longer has to be the focus and they can start to gain some internal controls and expand their perspective. Time is an important factor, since by forcing the issues behaviorally, we reinforce the negative behaviors and impede the therapy. If we can help patients see that the images are not real or realistic for people in general, we have a good start. Others need to support the patient as well as urging that our society not put so much emphasis and value on the image in stead of the person.

NARSAD from page 17

Some researchers speculate that pharmacological treatments of anorexia have been unsuccessful due to an untreated hypothyroidism seen in all patients with anorexia. Dr. Adelaide Robb of the Children's National Medical Center (a 2001 NARSAD Young Investigator) is studying whether this hypothyroidism contributes to the maintenance of the disease by altering the physiology, thinking, and behavior of the individuals with anorexia. Dr. Robb is administering the thyroid hormone, levothyroxine, to adolescent patients admitted to an inpatient adolescent psychiatry unit.

Treatment-Resistant Anorexia

Unfortunately, a substantial minority of patients with anorexia nervosa can be resistant to standard treatments and develop a chronic course. These patients often have debilitating concurrent mood, anxiety, and/or personality disorders. Patients with purging subtypes of anorexia often have worse outcomes than others.

Several studies suggest that novel uses of medications may help some treatment-resistant patients. Selective Serotonin Reuptake Inhibitors (SSRIs), administered in doses ordinarily used to treat obsessive-compulsive disorder, may help some otherwise treatment-resistant patients. One study found that weight-restored patients who receive fluoxetine (Prozac) in addition to ongoing counseling have better 1-year outcomes than those not receiving medication.(12) Patients taking fluoxetine show less subsequent weight loss, fewer rehospitalizations, and fewer symptoms of depression during follow-up. The antidepressant, citalopram (Celexa), should not be prescribed as it has been associated with increased weight loss in adolescents with anorexia treated in outpatient psychotherapy.

Some clinicians have started to use atypical neuroleptic medications, such as olanzapine (Zyprexa) and risperidone (Risperdal) for treatment-resistant patients, either to augment SSRIs or occasionally as single therapies.(13,14) A recent case report found female patients who were chronically ill and had been refractory to multiple treatments responded to olanzapine by gaining weight and experiencing reduced agitation and resistance to treatment.

Treating Bulimia

Since most patients with bulimia nervosa are of normal weight, nutritional restoration is not a central focus of treatment as with anorexia patients. Initial treatment strategies for bulimia include:

- Nutritional counseling and rehabilitation;
- Psychosocial interventions including cognitive behavior, interpersonal, behavioral, psychodynamic, and psychoanalytical approaches) in individual or group format;
- Family interventions;
- Medications.

Additionally, support groups and 12-step programs such as Overeaters Anonymous may be helpful. Although these programs may be beneficial as adjuncts to initial treatment and for subsequent relapse prevention, they are not recommended as sole treatments.(15)

The role of medications remains enigmatic in treating bulimia nervosa. Although antidepressants can be effective in treating bulimia, some studies have found that their withdrawal more often leads to relapse than with cognitive behavioral therapy treatment alone.(16) As such, antidepressants may be especially helpful for patients with substantial symptoms of depression, anxiety, obsessions, or certain impulse disorder symptoms, or for patients who have failed or had a poor response to previous attempts at psychosocial therapy.

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NAMI from page 13

Such a process would begin with a statewide needs assessment, continue with a thorough capacity evaluation and conclude with specific numbers, recommendations and timetables for any changes to the state system, including closures or consolidations, if called for by the commission's analysis. If the proposed Commission's role can be expanded in that direction, then NAMI-NYS will offer its full support and participation. As now proposed, however, even the Commission's name presupposes just what the commission should examine and study.

We at NAMI-NYS applaud and thank Acting OMH Commissioner Dr. Sharon Carpinello, her staff, Division of Budget staff and the Governor's staff for doing what they could to help preserve badly needed mental health services and spare them from more Draconian cuts in this toughest of budget years. Yet everyone must be reminded that the unmet needs across the state of persons with serious mental illness and their families are huge. As the economy continues to improve, one would hope that the State of New York can and will redouble its efforts to meet the basic humanitarian needs of its most sick and vulnerable citizens.

And in that way, maybe the ice from the blizzards will finally melt and we will see the spring.

Campus from page 14

and, especially, for students are high when effective mental health services are provided on our campuses.

It is my pleasure to present to you this first report on the mental health needs of today's college students, and wish to thank Mental Health News for its vision to provide its readership with this new column. We hope that you will contact us to express your interest and support, and invite your participation. You may call Mental Health News at (914) 948-6699 or by e-mail to mhnmail@aol.com.

If you wish to write to me directly please send me your email to dbspano@uncc.edu.

Dr. Spano is a licensed psychologist and Associate Vice Chancellor for Health Programs and Services and Director of the Counseling Center at the University of North Carolina at Charlotte. He was the director of the Counseling Center at Ithaca College from 1995-2003 and is the former chair of the Mental Health Services Board in Tompkins County, New York.

Testimony from page 12

Trended Rate Increase For
OMH's New 'PROS'
Licensed Program Model

To ensure that current state plans to convert $50 million of community rehabilitation services to Medicaid do not, over time, destabilize the recovery of thousands of New Yorkers with psychiatric disabilities by failing to keep up with steadily rising costs, we strongly seek a trended increase for 'PROS' programs, effective 2005.

A major source of state savings that was approved last year was the conversion to Medicaid of over $50 million of OMH-funded community mental health rehabilitation, employment and support programs through the introduction of a new Medicaid outpatient license called 'PROS' (Personalized Recovery Oriented Services).

PROS represents the most sweeping reconfiguration of community mental health services since the inception of the deinstitutionalization movement of the 1970's.

After PROS is fully implemented (scheduled to begin this summer), services that over forty thousand New Yorkers with psychiatric disabilities rely on to support their recovery will be forever changed, moving from a guaranteed, fixed grant-funded arrangement to the more regulated, less flexible and less fiscally certain Medicaid environment.

Conversion to Medicaid under PROS brings additional costs to comply with Medicaid, as well as exposure to Federal and State Medicaid audits, so adequate resources need to be available on an ongoing basis to ensure proper compliance and optimal consumer services.

The legislature can ensure the future stability of core community services!

While we are hopeful that 'PROS' has the potential to improve service delivery with its emphasis on recovery outcomes and individual service planning, we urge the Legislature to ensure that the funding for these essential community mental health services continues to keep pace with growing demands and pressures. Accordingly, we strongly urge you to ensure that a *trended rate increase* be instituted beginning in 2005, the second year of the new program's implementation.

We are asking the State Legislature to add statutory language in the appropriate Budget Bill to provide this trend. Technically, language could be developed for PROS services that is based on the current COLA language for other DOH-licensed Medicaid services.

NYAPRS strongly urges the Governor and Legislature to ensure the future stability of core community rehabilitative and employment services by building in a trended increase, to begin in the program's second year of operation (2005-6). No cost is required during this fiscal year.

Meeting the Needs
of Adult Home Residents

The Executive Budget provides $10 million for adult home services, starting with a $2 million fund for resident clothing, air conditioning and other personal needs, with the remaining monies to fund resident assessments, case management/peer support, social/recreational, medication assistance and related services for residents of some adult homes.

NYAPRS supports the new funding allocation for adult home initiatives, especially the resident 'quality of life' fund to address urgent needs for residents identified by them in numerous forums and meetings, including clothing, air conditioning and basic necessities.

The proposal, however, leaves 3 major outstanding areas of concern: It does not tie any of the 1,800 OMH-funded community mental health housing slots coming online this year, nor any of the 2,600 OMH slots coming online over the next few years directly to adult home residents seeking an alternative community setting they have a legal right, under the Supreme Court's Olmstead decision, to have. The initiatives will only touch the lives of several hundred residents, while thousands more wait for relief that continues to evade them. It leaves unfunded the QUIP fund adult home operators rely on to maintain solvency and basic plant improvements.

We therefore urge the Governor, during the 30-day amendment period, and the Legislature thereafter, to: Provide more funding to allow proposed case management/peer specialist, medication assistance and assessment initiatives to reach more residents; see that a portion of 4,400 new community alternative mental health housing beds coming online in the next 3-4 years are expressly dedicated in law for current residents, especially those who indicate a preference and readiness to leave, per recently conducted assessments; and restore funding for the QUIP program to help support the efforts of qualified operators to sustain their housing and resident services.

Funding/Mandating Human Alternatives
to the Disciplinary Segregation of State
Inmates with Psychiatric Disabilities

Nationwide, Americans with psychiatric disabilities make up a growing number of our nation's incarcerated. According to the NY State Office of Mental Health (OMH), 12% of State prisoners are identified as having severe psychiatric disabilities. In addition, OMH reports an increase in the complexity and severity of psychiatric disabilities among state prisoners.

Severe psychiatric disabilities interfere with many inmates' ability to conform to prison rules. Inmates who violate prison rules are frequently segregated for months, or even years, in disciplinary lockdown, sometimes known as Special Housing Units (SHU), keep lock, or simply the "Box." Research has shown that lack of adequate mental health care and the stressors of incarceration make it more likely that an inmate with a psychiatric disability will serve time in isolated confinement.

Nearly 25% of the 4,000 inmates confined in disciplinary segregation are people with psychiatric disabilities – more than two times the incidence of psychiatric disability found in the general prison population. (NYS Department of Correctional Services)

Sensory deprivation and social isolation are well known to have serious damaging effects on a person's mental health. Increasingly, experts are documenting significant psychiatric deterioration including self-injury, suicide, delusions, manic activity and paranoia among inmates with psychiatric disabilities held in disciplinary lockdown.

Distressed inmates suffering from psychiatric symptoms often violate prison rules leading to even more time in "the Box." Because NY State law does not limit the amount of time inmates can spend in lockdown, hundreds of prisoners with psychiatric disabilities have spent years in disciplinary housing. Tragically, the length of sentence for inmates with psychiatric disabilities is on average six times longer than that reported for the general disciplinary population. (NY Correctional Association).

Shocking suicide rates exist among prisoners housed in disciplinary lockdown. From 1998 through 2001, between 30% and 50% of prison suicides occurred within the 7% of the population confined in disciplinary segregation. Investigations by the State Commission on Correction, have determined that psychiatric disability aggravated by disciplinary confinement contributed to many of these deaths.

NYAPRS members strongly support the Executive Budget's $13 million allocation for new Office of Mental Health and Department of Corrections treatment and security staffing as a good first step in expanding appropriate prison mental health facilities. We strongly seek the passage this year of A.8849 (Aubry) and an identical Senate version to legally eliminate the use of solitary confinement for inmates with severe psychiatric disabilities.

Again, given time restrictions and today's focus on budget-related mental health policy, I will not provide detail on other NYAPRS positions, but will instead attach a copy of excerpts from last week's Legislative Day briefing book.

Please note that NYAPRS continues to be a strong supporter of: legislation approved by both houses last year to boost state reporting and oversight into the use of electroshock treatment (vetoed by the Governor), Timothy's Law, ending mental health insurance discrimination in New York, Adult home legislation mandating proper state oversight and enforcement efforts to assure adequate safety, housing and service assurances for residents of the state's adult homes, and Legislation establishing an OMH Housing Waiting list.

We continue to be very grateful to the NYS Legislature for their very strong support. In recent years, for examples, your passage of several incarnations of the Community Reinvestment law, the MTA Half Fare Fairness law, Medicaid Buy-In legislation, Most Integrated Settings Council authorizing legislation, ECT reporting legislation, approval of the New York/New York program and your rejection of last year's efforts to deny SSI recipients a cost of living adjustment have been critical to our joint efforts to improve services and social conditions for people with psychiatric and other disabilities here in New York State.

We hope that once again you will be able to help us to achieve our objectives this year. Thank you.

Losing Weight: A Lifetime of Trying

I was the first born child to Jewish parents in 1937. I was a healthy weight of a little over 8 lbs at birth but soon plumped out with all that pureed foods my mom made special for me until I was a year old and my arms were so fat you couldn't see the bracelet I was wearing.

Food was Love and so it was as I got older and 4 more siblings arrived in our home. I was the only one that was fat. When I was about 10 I was very tall and bigger than all my peers but not fat. My Mother made my weight the bane of her existence and my Father joined in the battle. She started to take me to diet doctors when I was about 13 and was put on amphatamines (black beauties) in my early teens. My heart would beat so fast I was sure everyone could hear it, I passed out in school one date. I would lose 10 lbs, gain back 15.

My parents did everything to make me lose weight from putting me in a psychiatric hospital in NY for intense therapy to the Rockefeller Institute where they weighed my input and output. I was even sent to a fat farm in Punta Gorda, Florida where I was fed grapes and grape juice 3 times a day for a month and lost 30 lbs but when I ate anything other than the grapes I gained.

I was hypnotized, hospitalized pillized and even had a ring inserted in my earlobe to pull when I got hungry. In 1971 after I gave birth to my daughter I was given a shot of the extract of the placenta. I lost 100 lbs, divorced my husband and started dating again. All the men wanted my body and I couldn't adjust to that so I gained it back and met my second husband.

I am now 66 years old, a widow and living in Boca Raton, Florida. I am the heaviest I have ever been and it is affecting my entire life. I have diabetes, lymphodema and am in remission from three bouts with Non-Hodgkins Lymphoma. I have to use a walker to get around because I have stenosis of the spine and 2 herniated discs. I have had 3 epidurals but to no avail.

I am now going for bariatric surgery (laproscopically) to hopefully restore the quality of life I deserve. I have tried every diet conceived and have lost some and gained more. I feel this surgery is the only answer to my problem.

Those close to me are saying a prayer that all goes well and I hope you will too. Their support helps me have hope.

Gloria

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