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SPRING 2010 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 12 NO. 2

A Look Into the World of Anxiety Disorders

By The National Institute of Mental Health (NIMH)

Anxiety is a normal reaction to stress. It helps one deal with a tense situation in the office, study harder for an exam, or keep focused on an important speech. In general, it helps one cope. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling disorder.

Anxiety Disorders affect about 40 million American adults age 18 years and older (about 18%) in a given year, causing them to be filled with fearfulness and uncertainty. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least 6 months and can get worse if they are not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder.

Panic Disorder: Panic disorder is a real illness that can be successfully treated. It is characterized by sudden attacks of terror, usually accompanied by a pounding heart, sweatiness, weakness, faintness, or dizziness. During these attacks, people with panic disorder may flush or feel chilled; their hands may tingle or feel numb; and they may experience nausea, chest pain, or smothering sensations. Panic attacks usually produce a sense of unreality, a fear of impending doom, or a fear of losing control.

A fear of one's own unexplained physical symptoms is also a symptom of panic disorder. People having panic attacks sometimes believe they are having heart attacks, losing their minds, or on the verge of death. They can't predict when or where an attack will occur, and between episodes many worry intensely and dread the next attack.

Panic attacks can occur at any time, even during sleep. An attack usually peaks within 10 minutes, but some symptoms may last much longer.

Panic disorder affects about 6 million American adults and is twice as common in women as men. Panic attacks often begin in late adolescence or early adulthood, but not everyone who experiences panic attacks will develop panic disorder. Many people have just one attack and never have another. The tendency to develop panic attacks appears to be inherited.

People who have full-blown, repeated panic attacks can become very disabled by their condition and should seek treatment before they start to avoid places or situations where panic attacks have occurred. For example, if a panic attack happened in an elevator, someone with panic disorder may develop a fear of elevators that could affect the choice of a job or an apartment, and restrict where that person can seek medical attention or enjoy entertainment.

Some people's lives become so restricted that they avoid normal activities, such as grocery shopping or driving. About one-third become housebound or are only able to confront a feared situation when accompanied by a spouse or other trusted person. When the condition progresses this far, it is called agoraphobia, or fear of open spaces.

Early treatment can often prevent agoraphobia, but people with panic disorder

see Anxiety Disorders on page 34

Anxiety: The Rust of Life

By Robert M. Lichtman, PhD
Deputy Director, Special Projects Division
Department of Advanced Clinical Practices
Rockland Psychiatric Center

People who constantly worry or complain about how anxious they are can become partially emotionally immobilized and have great difficulty negotiating their lives. Like rust on an iron pipe, it will erode the quality of our lives. Sigmund Freud called this impediment to growth an anxiety neurosis. Others have the ability to take direct action by dealing with the event or object that is causing the stressful or anxious reaction. They employ methods to diffuse or tone down the intensity. Anxiety can be described as an autonomic or automatic response that is not under our direct control, when we are exposed to a present or future stressful event. We begin to experience an uncomfortable sensation within our own skin. The physical presence is akin to a low voltage of electrical current pulsing throughout our bodies. It is usually triggered by a seemingly ever present issue that remains with us until that which is worrying us is resolved. Worry becomes a label applied to an actual physiological arousal that begins in the thinking part of our brains. We interpret information received by any one of our senses and the resulting response will determine whether we feel safe and calm or unsafe and anxious. The process of stimuli input, information processing, perception, interpretation and cortical response is completed in milliseconds by our central nervous system, composed of our brain and spinal cord. Our spinal cord is bicameral, meaning it is divided into two sections, the sympathetic, and the parasympathetic nervous systems. The former is our alarm system, alerting us to take action, or to do something about our unsafe or anxious state. The latter calms us down when we are no longer perceiving ourselves as threatened.

When "The Rust" Becomes Corrosive

Anxiety or 'rust' can reach a level where it becomes corrosive, meaning that it can develop into a more serious problem or in psychological terms a diagnosis. Think about sitting in your car, starting it, placing it in neutral, while you compress the gas pedal and run the engine as if you were going 80 miles an hour, but standing still. If you keep your "pedal to the metal," eventually some part of the engine or transmission will break down. As humans we are kind of the same way. If we keep running our "engines" at high speed, we will also begin to break down psychologically and eventually physically. Anxiety is akin to energy. The diagnostic and statistical manual of mental disorders (DSM-IV TR 2000), says that we qualify for the diagnosis of general anxiety disorder (GAD), if we have excessive anxiety and worry about a number of distinctive events or activities that is debilitating over a period of at least 6 months. Epidemiologists say that the prevalence rate in our population for generalized anxiety disorder is about 3%. That is a lot of people running around excessively anxious and worried. Generalized anxiety disorder seems to run in families, and research (twin studies) indicate that heritability estimates are between 30-40%. Concordance rates for identical twins (MZ) are significantly higher than fraternal twins (DZ) for GAD. Cognitive or information processing factors also play a role. People who feel less able to control events are more likely to be anxious and develop generalized anxiety disorder.

see Rust of Life on page 43

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Deadline	Release Date
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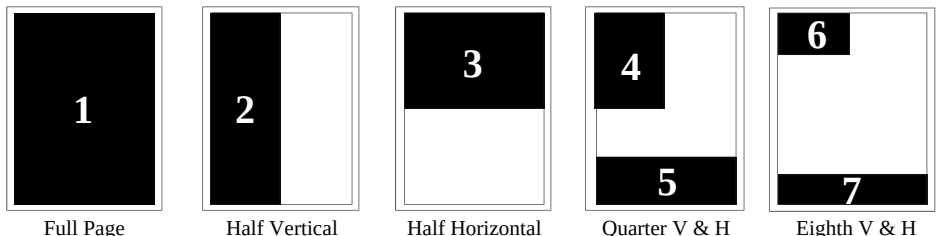
February 1, 2011	April 2011 (spring issue)



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Letters to the editor should only be sent to Mental Health News, and not to other publications. We do not publish open letters or third-party letters. Letters for publication should be no longer than 150 words, must refer to an article that has appeared in our last issue, and must include the writer's address and phone numbers. No attachments, please. We regret we cannot return or acknowledge unpublished letters. Writers of those letters selected for publication will be notified within a week. Letters may be shortened for space requirements. Send a letter to the editor by e-mailing: iraminot@mhnews.org.

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From the Publisher
A Look Into the World of Anxiety Disorders

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

I felt that it would be useful to our readers that we devote this issue of *Mental Health News* to taking a fresh look into the world of anxiety disorders. We last visited this topic in our Winter 2006 issue. At that time The National Institute of Mental Health (NIMH) estimated that 19 Million American adults suffered from anxiety disorders. Today, as reported in our cover story, NIMH estimates that anxiety disorders affect about 40 million American adults age 18 years and older. This represents about 18% of the US population in a given year. That is a substantial increase in only four years. Perhaps this is due to better diagnoses and reporting of anxiety disorders.

In our other cover page article entitled *Anxiety: The Rust of Life*, Robert M. Lichtman, PhD, gives us a good description of the way anxiety feels. "Anxiety can be described as an autonomic or automatic response that is not under our direct control, when we are exposed to a present or future stressful event. We begin to experience an uncomfortable sensation within our own skin. The physical presence is akin to a low voltage of electrical current pulsing throughout our bodies. It is usually triggered by a seemingly ever present issue that remains with us until that which is worrying us is resolved. Worry becomes a label applied to an actual physiological arousal that begins in the thinking part of our brains."

Anxiety disorders are serious and often highly debilitating forms of mental illness. In this issue of *Mental Health News* we had the good fortunate of having an opportunity to interview two highly respected clinicians in the field of anxiety disorders. They are Helen Blair Simpson, MD, PhD, Director of the Anxiety Disorders Clinic at the New York State Psychiatric Institute (NYSPI), and Ann Marie Albano, PhD, ABPP, Director of the Columbia University Clinic for Anxiety and Related Disorders (CUCARD). Both Drs. Simpson and Albano provided a fascinating look into many aspects of anxiety disorders and provide some very useful answers to questions many of us have about anxiety disorders.

Ira H. Minot, LMSW

In my discussion with Dr. Simpson on page eight, she explains how parents detect early warning signs of an anxiety disorder in their children. "Some parents are very aware. Some parents who have suffered with anxiety disorders themselves are very attentive to these issues in their children and are very proactive in alerting us. Unfortunately, some parents who have suffered themselves feel guilty and think "Have I passed this on to my child – have I given them bad genes – are they destined to get my illness?" To me that's very sad, because the parent is suffering twice – for themselves and with worry for their child. The positive side of this is that they know what some of the early warning signs are and if they have been helped by the mental health profession in the past themselves, they are less worried about bringing their child in to early intervention for help, and they are usually less concerned about stigma. Other parents that have no experience with anxiety disorders or have it themselves and have never had it treated, can actually be very frightened of seeing this in their child, and don't often come into the clinic as often as they might, for a whole host of reasons. It might be that to have an anxiety disorder diagnosed in their child may mean it then becomes diagnosed in them. And then there are those parents who don't believe treatment can help or that if they bring their child in, someone will insist that their child be placed on medications. In fact, the first line of treatment for anxiety disorders in kids is Cognitive Behavioral Therapy (CBT) which can be highly effective in many children. I would argue that if CBT isn't enough for your child and your child does need a trial of medication – if it helps keep your child in school with friends and going through normal developmental stages so they don't go off track – you need to balance that against the concerns you have about medications – some of which can be very safe."

In my interview with Dr. Albano on page nine, she discusses how childhood anxieties surface in the classroom. "The thing about school is that it is a wonderful diagnostic laboratory. Every day, kids have to go between eight in the morning until three thirty in the afternoon and through the course of their development they are bombarded with developmental challenges. They have to learn how to raise their hands, ask questions, get along with other kids, become part of the peer group, and how to negotiate multi-tasking. All of these things happen during the course of school and for the kids with anxiety, they are very clear about telling us time and time again, "I sit in school, I watch the clock, and I wait for the bell to ring." They are doing that with their stomach in knots, by trying to avoid eye-contact with the teacher, and they are making themselves as invisible as can be. When a kid comes home and the parent asks "How was school today?" and the child just says "fine," parents really need to find out what that really means. It might mean "fine" because nobody bothered me, and that's something we don't want children to experience in that way."

On page 14, Rachel Goldstein, MD, of NewYork-Presbyterian Hospital discusses *OCD and Anxiety in Postpartum Mothers.* She states that, "Untreated OCD during pregnancy is also a risk factor for postpartum depression as well. Some women do well off medication during pregnancy but may experience an exacerbation post partum. Optimally the women with a diagnosis of OCD will take the opportunity to consider her options and preferences in advance of becoming pregnant while medication reduction or changes can be considered and when CBT skills and other therapy can be introduced if this had not been done before."

In a very interesting article on page 18 from The Jewish Board of Family and Children's Services (JBFCS), colleagues Martha Spital, LCSW, Sararivka Liberman, LCSW, and Susan Trachtenberg Paula, PhD, discuss how *Cognitive-Behavioral Therapy Helps Clients Cope with Anxiety Disorders*. They report that, "The good news is that anxiety disorders are very treatable. Yet only about a third of those who have an anxiety disorder get help. Cognitive behavioral therapy, or CBT, is considered the gold standard for the treatment of anxiety disorders, and is a well-researched, highly effective, and lasting treatment. A large number of peer-reviewed, controlled studies have demonstrated that CBT alone can greatly reduce anxiety symptoms. In some cases, however, CBT with medication produces the best treatment outcomes."

On page 30, Miki Yoshida, LMSW, at the Treatment Center for Trauma and Abuse at Westchester Jewish Community Services (WJCS), tells us that she is helping clients with PTSD through the use of Yoga. "As people practice yoga, they develop skills to pay closer attention to themselves without judgment, and to accept each moment as it comes. People can experience a sense of calmness and contentment with yoga."

As you will see, we have many other wonderful articles of interest in this issue. We also have an exciting lineup of themes on schedule for our upcoming summer, fall, winter, and spring issues. They are listed on page four in our table of contents and on page 43. Our summer issue will take a look at the theme "Addressing the Needs of Caregivers" We are looking for articles relating to the needs of treatment professionals, family members, and the problem of who will continue to care for older people with mental illness when their aging parent caregivers pass on.

I want to thank everyone who helped make this issue of *Mental Health News* possible. I hope you will continue to write to me at iraminot@mhnews.org and tell me what topics are important to you. Your participation is an essential part of the success of this newspaper.

Good Luck in Your Own Recovery
Have a Wonderful Spring Season !

Letter to The Editor

Dear Editor:

This letter is in response to OMHs' Office of Recipient Affairs article promoting Social Securities' Work Incentives as a proven means to self-sufficiency and, outlining their plans to spend some six million dollars given to them by the Social Security Administration. (*Mental Health News*, Winter 2010 issue)

As a consumer/survivor and provider (NYS ED Licensed Business School and Microsoft Office Certified Training Center), in the trenches of direct care, we have trained and placed hundreds of consumers these past twelve years. Sadly, the only ones who have achieved self-sufficiency were recipients of SSDI. None of our SSI recipients were able to overcome the earnings penalties imposed by SSA for earned income, HUD for rent supports and FDA for food stamps.

Last Spring I asked Social Security's Chief Statistician, Clark Pickett, how many SSI recipients had worked their way off SSI in the U.S.? He told me SSA documented five hundred forty-five in 2007 for the total U.S., all disabilities. That's about ten from New York State (see Employment Outcome Report. Appendix at www.economicsofrecovery.org)

This is less than one-half of one percent of the some six million SSI recipients in the U.S. This "success " rate has not changed in the past ten years – regardless of the hundreds of millions of dollars SSA has spent promoting their work incentives.

Instead of using our scarce taxpayer dollars to have the Office of Recipient Affairs tour the state explaining SSAs' fine print, why not help our consumers directly through job skills training and supported employment? You could create a lot of jobs for six million dollars.

Donald M. Fitch, MS

MENTAL HEALTH NEWSDESK

Non-Invasive Technique Blocks a Conditioned Fear in Humans: Recalling Emotional Memory Opens Window of Opportunity to Re-Write It

By The National Institute of Mental Health (NIMH)

Scientists have for the first time selectively blocked a conditioned fear memory in humans with a behavioral manipulation. Participants remained free of the fear memory for at least a year. The research builds on emerging evidence from animal studies that reactivating an emotional memory opens a 6-hour window of opportunity in which a training procedure can alter it.

"Our results suggest a non-pharmacological, naturalistic approach to more effectively manage emotional memories," said Elizabeth Phelps, Ph.D., of New York University, a grantee of the National Institutes of Health's National Institute of Mental Health (NIMH).

Phelps and NIMH grantee and NYU colleague Joseph LeDoux, Ph.D., led the research team that reports on their discovery online Dec. 9, 2009 in the journal *Nature*.

"Inspired by basic science studies in rodents, these new findings in humans hold promise for being translated into improved therapies for the treatment of anxiety disorders, such as post-traumatic stress disorder (PTSD)," said NIMH Director Thomas R. Insel, M.D.

The results add support to the hypothesis that emotional memories are reconsolidated – rendered vulnerable to being modified – each time they are retrieved. That is, reactivating a memory opens what researchers call "reconsolidation window," a time-limited period when it can be changed.

"This adaptive update mechanism appears to have evolved to allow new information available at the time of retrieval to be incorporated into the brain's original representation of the memory," explained Phelps.

Earlier this year, LeDoux and colleagues exploited this potentially clinically important insight to erase a fear memory in rats. They first conditioned rats to fear a tone by pairing it with intermittent shocks. A day later, the rats were re-exposed to the tone, reactivating the fear memory. They then underwent a process to rewrite the fear, called extinction training, in which the tone was repeatedly presented without shocks.

However, the timing of this extinction training proved critical. Fear of the stimulus was erased only in rats trained within a 6-hour reconsolidation window after re-exposure to the feared tone. Fear responses returned in animals trained after the window closed, when the memory had apparently already solidified.

Normally, extinction training suppresses but does not erase the original fear memory. By first reactivating it – sounding the tone – just prior to extinction training, LeDoux and colleagues permanently erased the fear memory.

In the new study, Phelps and colleagues similarly conditioned human participants to fear colored squares by intermittently pairing them with mild wrist shocks.

As with the rats, a day later, the memory was first reactivated by re-exposing participants to the feared squares. A measure of nervous system arousal confirmed that they experienced a fear response. Extinction training – repeated trials of exposure to the colored squares without shocks – followed.

Again as in the rats, a day later, the fear response was banished only in human participants who underwent the extinction training soon after the fear reactivation. Those trained after the 6-hour consolidation window remained afraid of the squares – as did a control group that received extinction training without first experiencing reactivation of the fear memory.

In a follow-up experiment to gauge long-term effects a year later, 19 of the original participants received a potent regimen to re-instate the fear: four shocks followed by presentations of the colored squares.

Remarkably, those who had undergone extinction training within the reconsolidation window were largely spared significant effects. By contrast, those whose training had been delayed 6 hours or who hadn't experienced fear memory reactivation prior to extinction training experienced significant reinstatement of the fear response.

In a similar experiment, the researchers also confirmed that the fear memory was blocked only for the specific colored square for which fear memory was reactivated prior to extinction training. The effect did not generalize to a differently colored square associated with the shocks. This indicated that memory re-writing during reconsolidation is highly specific and that prior reactivation with the specific stimuli is critical.

"Timing may have a more important role in the control of fear than previously appreciated," Phelps suggested. "Our memory reflects our last retrieval of it rather than an exact account of the original event."

Evidence suggests that the behavioral manipulation may work through the same molecular mechanisms in the brain's fear hub, the amygdala, as experimental medications under study for quelling traumatic emotional memories.

"Using a more natural intervention that captures the adaptive purpose of reconsolidation allows a safe and easily implemented way to prevent the return of fear," suggest the investigators.

NCD Calls for Improved Housing for People with Disabilities

By The National Council on Disability (NCD)

The National Council on Disability (NCD) recently released a report titled *The State of Housing in America in the 21st Century: A Disability Perspective* that provides recommendations intended to improve housing opportunities for people with disabilities. This report looks at the state of housing for people with disabilities with the intent to provide recommendations that can improve housing opportunities. The research contained in this report provides a comprehensive overview of the state of housing in the twenty-first century and answers important questions about the current housing needs and options for people with disabilities living in the United States.

NCD undertook this study with three objectives in mind: 1) to evaluate public laws, policies, and program initiatives affecting the housing opportunities available to Americans with disabilities and others who have accessible housing needs for whatever reason, whether due to aging or a temporary disability; 2) to analyze what housing, supports, and other benefits are available through the public, nonprofit, and/or private sectors; and 3) to provide recommendations that can improve housing opportunities for people with disabilities in the United States.

According to NCD Chairperson Linda Wetters, "Affordable, accessible, and appropriate housing is critical and integral to making a community more livable for people with disabilities. In this report, NCD finds that there are unmet housing needs based solely on standard measures of housing affordability. This analysis also reveals a gap between current policy goals and outcomes — even with laws in place requiring a portion of units to be accessible, some developers and property owners do not comply. Whether it is due to ignorance or intent, the evidence suggests we have missed opportunities to increase the supply of accessible, affordable housing."

The findings and recommendations contained in this document are grounded in data and research gathered from federal agencies, either directly or via published reports, and from research completed by academics and disability advocates. This report also provides evidence of what can be effective in meeting the range of housing needs among a diverse group of consumers with disabilities. This includes best and promising practices drawn from real examples, and lessons learned from experts working on housing issues and policy. In reviewing best and promising practices, data was triangulated from different sources — interviews, published reports, and Internet research — to assure a comprehensive assessment. To this end, the research has been reviewed and commented on by a diverse panel of experts and consumer groups that have all provided valuable insights and guidance. Some of the recommendations include: (1) Increase affordable, accessible, and integrated housing for people with disabilities to meet needs and demand; (2) Increase access to existing units; (3) Prevent further loss of affordable, accessible housing; (4) Expand and focus usage of vouchers; and (5) Improve fair housing enforcement of disability rights.

The purpose of NCD, an independent federal agency, is to promote programs, practices, policies and procedures that ensure full inclusion of people with disabilities into all aspects of society. NCD accomplishes this mission by providing advice and making recommendations to the President, Congress, governmental agencies, and other stakeholders.

For more information, please contact NCD's Director of External Affairs, Mark S. Quigley, at mquigley@ncd.gov or by telephone at 202-272-2004.

MENTAL HEALTH NEWSDESK

NYS Department of Correctional Services and Office of Mental Health Open Residential Mental Health Unit at Marcy Correctional Facility

By The New York State Office of Mental Health (OMH)

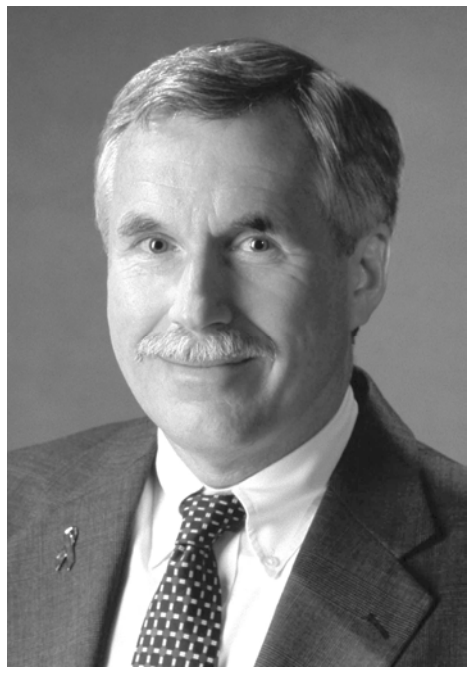
A first-in-the-nation, 100-bed Residential Mental Health Unit has opened at Marcy Correctional Facility in Oneida County for inmates with serious mental illness and disciplinary confinement sanctions.

The new program initiative, developed collaboratively by the Department of Correctional Services (DOCS) and the Office of Mental Health (OMH), will serve inmates with serious mental illness through various treatment interventions and strategies that have demonstrated effectiveness in addressing the unique and difficult issues of this population.

The Residential Mental Health Unit (RMHU) is the hallmark of the 2007 court-approved private settlement agreement the State reached with Disability Advocates Inc., a non-profit advocacy organization.

The RMHU is the most comprehensive and complex mental health prison treatment program developed in the United States in the past 20 years.

It will provide mental health and correctional rehabilitative services in a state-of-the-art correctional residential setting by affording participants the opportunity to develop skills that address their individual needs. Inmate patients will be offered at least four hours per day of out-of-cell treatment and programming, primarily in open group settings. Congregate exercise will be allowed for inmates who have demonstrated treatment progress and will count toward out-of-cell therapeutic programming as determined by the RMHU treatment team.



Michael F. Hogan, PhD

The 57,000 square-foot RMHU program building, which includes office space for DOCS and OMH staff attached to a secure inmate housing unit, was designed to provide treatment in a safe and secure environment to inmate-patients with a serious mental illness and a disciplinary sanction of more than 30 days that otherwise would be served in 23-hour-per-day confinement. The housing unit for these inmate-patients was created by converting two-story, double cell space from the former S-block (Special Housing Unit) site at Marcy Correctional Facility.

Governor David A. Paterson said: "This cutting-edge program represents government at its best by providing a long-term approach to a difficult problem that is both humane and cost-effective. New York is once again leading the nation, in this case by creating a holistic environment for the treatment and care of perhaps the most challenging population within the State prison system."

OMH Commissioner Michael F. Hogan, PhD said: "The RMHU is the latest collaborative step to develop the most comprehensive prison mental health program in the country and through this, to reduce use of special housing/segregation for inmates with mental illness. Earlier steps have included screening on admission for all inmates, a wide array of treatment programs-- including counseling, medication treatment, special day and residential units, and special attention to aftercare when inmates with mental illness are released. The RMHU will provide the highest level of secure treatment outside of hospitalization, emphasizing the appropriate behaviors that will allow inmates to succeed outside of special care institutional settings. It is a collaborative and innovative approach that to our knowledge is the first of its kind anywhere." Commissioner Hogan went on to say, "We worked hard on this program, we think the concept is excellent, and we have high hopes that it will help people. It does remain frustrating that we cannot get similar resources to work on diverting people with mental illness from the correctional system."

DOCS Commissioner Brian Fischer said: "We have met the challenge of caring for the thousands of inmates with mental illness in our State prison system head-on for the benefit of not only the offenders themselves, but our staff and public safety. By working with the Office of Mental Health to create and open this new and first-of-its-kind residential setting, we will provide the environment, treatment and therapy these offenders need to manage their mental illness, make our prison system safer, and better prepare themselves for life not only during incarceration but also back home after their release. This new program specifically concerns itself with offenders who have demonstrated serious problems adhering to prison rules, often as the result of their mental health difficulties. The goal of both DOCS and OMH is to assist the offenders

see Marcy on page 44

Long-term Depression Treatment Leads to Sustained Recovery for Most Teens

By The National Institute of Mental Health (NIMH)

Long-term treatment of adolescents with major depression is associated with continuous and persistent improvement of depression symptoms in most cases, according to the most recent analysis of follow-up data from the NIMH-funded Treatment of Adolescents with Depression Study (TADS). The report, along with a commentary compiling the take-home messages of the study, was published in the October 2009 issue of the American Journal of Psychiatry.

Background: The TADS team randomly assigned 439 adolescents aged 12 to 17 to one of four treatment strategies for 36 weeks—the antidepressant fluoxetine (Prozac) only, cognitive behavioral therapy (CBT) only, the combination of the two, or placebo (inactive or "sugar" pill). After the first 12 weeks, the placebo group was discontinued, while the participants assigned to the active interventions continued treatment for another six months. Overall, the combination therapy was found to be the most effective in speeding up remission. Visit the NIMH website for more information about TADS results.

After the trial ended, the teens who had been assigned to the active treatments were assessed up to four times during the following year to determine if improvements were sustained over time. TADS treatments were no longer offered, but participants were encouraged to continue to seek treatment within their communities.

Participants who had been assigned to the placebo group received open treatment during the one-year follow-up period and were not included in this follow-up assessment. About 66 percent of TADS subjects (not including those who had been in the placebo group) participated in at least one assessment during the follow-up year.

Results of the Study: By the end of the 36-week trial, 82 percent of participants had improved and 59 percent had reached full remission. During the follow-up year, most participants maintained their improvements, and the remission rate climbed to 68 percent. However, about 30 percent of the participants who were in remission at week 36 became depressed again during the following year.

In addition, while 91 percent of participants showed no evidence of suicidal thinking or behavior at the end of the trial, 6 percent developed suicidal thinking during the follow-up year, with no statistically significant differences among the treatment groups.

Significance: The longer-term treatment of TADS, regardless of treatment strategy, was associated with lasting benefits for the majority of participants. However, a significant number of those who had recovered worsened during the follow-up period, indicating a need for continuous clinical monitoring and further improvement in long-term treatment of youth with major depression.

What's Next? The final results of TADS suggest that for most teens with depression, long-term, evidence-based treatments are effective and sustainable. But future research should concentrate on improving treatment strategies to reduce the rate of depression relapse or deterioration. The authors suggest that a randomized maintenance therapy trial would help determine how long active treatment should last to ensure the effects of treatment will endure over time.

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An Interview with Helen Blair Simpson, MD, PhD
Director of the Anxiety Disorders Clinic at the NYS Psychiatric Institute

By Ira H. Minot, LMSW
Executive Director
Mental Health News Education, Inc.

Understanding the science and treatment of anxiety disorders can take years of study and the commitment to conduct painstaking scientific research and countless treatment sessions with patients. In a candid interview with *Mental Health News*, Dr. Helen Blair Simpson gives us a unique look into the world of anxiety disorders; both from her perspective as the Director of the prestigious Anxiety Disorders Clinic at NYSPI, but also as a caring and dedicated treatment professional. We are indeed grateful to Dr. Simpson for taking the time to give our readers an up-close and personal look into the world of anxiety disorders.

Q: What is the hardest thing for you to communicate to people when they ask you to discuss anxiety disorders?

A: That's a good place to start and I'll tell you why. One of the reasons I am so pleased that *Mental Health News* has given me this opportunity to chat with your readers is because your publication helps bring vital mental health education directly to people in the community. One of my biggest challenges as a scientist, clinic director and treatment professional, is finding ways to engage patients to work with us so we can advance the science, because without participants in research studies, the science won't move forward. In speaking with you today, I want to be helpful to people who are considering treatment. In addition, forums such as this allow me to talk about advances in the field and the latest research opportunities, I hope your readers might consider participating in research in the future and become our partners in advancing the field.

Q: What are anxiety disorders all about? Why do people get them, and what can people expect in terms of treatment and outcomes?

A: Let me start by making a historical point. The Anxiety Disorders Clinic at NYSPI was founded in 1982 and was the first research clinic in the United States, and probably the world, to focus on anxiety disorders. Before then, anxiety was rarely seen as something important to focus on because in fact, anxiety is a universal human emotion. We all have some form of anxiety, and there was almost a joking notion in the movies and in the media of regarding people with anxiety as "the worried well." Certain kinds of anxiety are actually good for us. Anxiety can alert us to potential threats and motivate us to prepare for certain challenges we might face. However, a surprisingly large proportion of the population experiences excesses of anxiety that is counterproductive and even debilitating. What we've learned over the last 20 years is that this excess anxiety often

Helen Blair Simpson, MD, PhD

takes the form of different prototypical syndromes, and these have been called the "anxiety disorders."

So when you speak to someone like me and say, "What's an anxiety disorder?" I then say back to you, "Well, which one are you talking about?" Our progress over the last 20 years has been to realize that there are many different forms of anxiety disorders – it's not all one thing. Right now in the DSM-IV (our diagnostic manual), all of the following are considered anxiety disorders: Specific Phobia, Acute Stress Disorder, Posttraumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), Social Phobia (also known as Social Anxiety Disorder), Obsessive-Compulsive Disorder (OCD), Panic Disorder – with or without Agoraphobia – and that's the list for adults. Then there is Separation Anxiety Disorder in children. In the upcoming DSM-V, there is a great debate going on about whether all of these should still be considered anxiety disorders. For example, some people are arguing that OCD isn't an anxiety disorder – that it would better fit with Tic Disorders, or that GAD should be grouped with Depression, or that PTSD should be in its own category of trauma related conditions – with anxiety disorders being only for conditions focused on the phobias like height and social situations.

The notion of an anxiety disorder is that at its core is some problem with an exaggerated fear response. Saying that, it's interesting in that the pharmaceutical companies choose Generalized Anxiety Disorder (GAD) as the prototypical anxiety disorder with which to test the efficacy of medications that are being developed – as GAD doesn't usually have that prototypical fear response. All anxiety disorders share certain symptoms, but also have unique symptoms. For example, OCD has repetitive and compulsive behaviors, which distinguish it from the other anxiety disorders. Likewise, with PTSD people can re-experience their symptoms, which is relatively unique to PTSD. Social anxiety patients (not all of them) can have very profound physiological responses like blushing and sweating, which isn't so typical of the other anxiety disorders. What is not unique is a panic attack, which is a sudden surge of intense anxiety with certain array of physical symptoms. You can get a panic attack in Panic Disorder, when it comes out of the blue, but you can also get a panic attack if you have a Specific Phobia, such as a fear of heights, and you are brought up to a high building; if you have OCD you can have a panic attack if you fear contamination and you are suddenly exposed to something you perceive as contaminated; and people with PTSD and people with Depression can have a panic attacks – so panic attacks are not unique to either Panic Disorder or to anxiety disorders in general.

We think, although we don't know, that anxiety disorders share some parts of the brain's mechanisms. But we also find differences among them, which may explain why the symptoms within the anxiety disorders are somewhat different. Our clinic was one of the first to differentiate the anxiety disorders. Years ago we were also one of the first clinics to apply medications to Panic Disorder. The increasing differentiation of each of the disorders over the last 25 years has led to multiple studies demonstrating similarities and differences in what medications are useful for which anxiety disorders. For example, benzodiazepines are useful for some anxiety disorders (like Panic Disorder) but not for others (like OCD). In addition to medications, we also know that a very specific type of psychotherapy, called cognitive-behavioral therapy or CBT is effective for anxiety disorders. At this point, very specific CBT protocols have been shown in randomized control trials to be very effective for individual disorders. Despite this, there is a movement to develop one generic psychotherapy that can treat all of the anxiety disorders, mostly because many people present with multiple anxiety disorders at a time, with overlapping symptoms, and many have accompanying depression. The problem is that the patient who shows up in your clinic isn't that "pure" patient. They may have OCD as a primary problem but they may also have a lot of social anxiety too. So how do you take disorder-specific CBT protocols and make it work in a clinic setting? This explains the thinking within the field to develop a universal CBT program that would make things easier for clinicians in the field to use these effective treatments.

Q: In your own mind, are the anxiety disorders distinct, or is it more like a spectrum of disorders?

A: There are clear differences between the disorders, but there are a lot of gray boundaries as well. What we do know is that for each of the disorders there are differences in what medications work and do not work. Some medications work for some and other medications do not work at all for others. On the therapy side, Cognitive Behavioral Therapy (CBT) is effective in dealing with a patient's "black and white thinking" or distorted beliefs about "risk." The behavioral part almost always utilizes exposure therapy that in a very graduated way exposes patients to the things that they are afraid of. Here's the rub. The way you actually do exposure therapy with individual patients differs a little bit from one patient to another. For example, with a PTSD patient who is a woman that has been sexually assaulted, you don't ask her to imagine the assault happening 15 more times. You work with her to tell you the story of what really did happen, and try to help her realize that this was a horrible event in her life; that not all alleys are dangerous; and that not all men are dangerous. In this case, we are working to expose her to the exact thing that happened to her. On the other hand, when you do exposure therapy with an OCD patient it's exactly the opposite. The assumption is that their fear doesn't make sense, so you are going to work with them to imagine the worst case scenario. For example, for someone with contamination fears who has been avoiding going on the subway, one of your exposure exercises may be to go on the subway with them and purposely make sure they hold the "poles" in the subway car.

see NYSPI on page 45

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An Interview with Ann Marie Albano, PhD, ABPP
Director of the Columbia University Clinic for Anxiety and Related Disorders

By Ira H. Minot, LMSW
Executive Director
Mental Health News Education, Inc.

We are indeed fortunate to have an opportunity to speak with Dr. Albano about her work at the Columbia University Clinic for Anxiety and Related Disorders (CUCARD). In the interview that follows, Dr. Albano takes us into the world of anxiety disorders with a review of many of the clinical aspects of anxiety disorders, as well as some useful information for parents. In addition, Dr. Albano discusses the impact of anxiety disorders on teenagers as they move into adulthood.

Q: What are some of the hallmarks of anxiety disorders?

A: Let me first say that I do not believe that anxiety disorders receive their due respect by our systems of care. Part of the reason for this is because many healthcare systems like the National Institute of Health (NIH) and others often focus on serious mental illnesses such as the psychotic disorders, bipolar disorder, depression, and substance abuse disorders. They do this primarily because in most epidemiological surveys those conditions show a high prevalence as well as a high cost and burden to society.

Anxiety disorders do not always show up on surveys as a drain on healthcare systems or having a high economic burden on society – while the fact is that they do. More people are suffering with anxiety disorders then we might think, and more people suffer with them on a long-term basis.

Anxiety disorders begin very early in childhood. Parents manage them mostly at home as they deal with their child's separation anxiety, their fear of other people, and with social anxiety. As the child ages, they learn ways of avoiding and strategizing to minimize their own anxiety. Over time when those children reach adulthood we see people who have often missed valuable opportunities in their lives and are unhappy because they have not lived up to their real potential in life.

Q: Can you elaborate on how this happens?

A: We're not talking about bad parenting here, but quite often parents will force their child to participate in things they do not want to do or go to, or force separations on their child who will have to endure something uncomfortable. Then during High School, the child will do what is compulsory to get the grades they need and satisfy their parents. However, they will be suffering through these situations. Once they hit adulthood and have their own choice, they learn to avoid the things that cause them stress. A prime example is when a high school senior does not apply to the colleges they might very well get accepted at, because those colleges require a personal interview. Because of

Ann Marie Albano, PhD, ABPP

a fear of being in an interview situation, perhaps due to a social anxiety disorder, they manage their stress by applying to a lesser ranked college because they do not require a face-to-face interview. We see a lot of missed opportunities where students are not living up to their potential because they are avoiding things that they believe they cannot accomplish – and it's all because they have an unresolved anxiety about people, places, or things which have in-turn lowered their own self-esteem.

What the research studies do not show is the fact that young adults are underemployed or undereducated because they made decisions to avoid challenges. These are silent disorders that go on for years. Unless you have savvy parents and adults around the adolescents who can tell whether they are experiencing unbearable stress and are making decisions based on avoidance, it doesn't come to light for a lot of people.

Unfortunately, these situations with adolescents catch up with them as adults. As time goes on and because anxiety comes in multiples, we see their initial anxiety and avoidance behaviors combine with other anxiety disorders and depression. Often we see adults who have made avoidance decisions based on anxiety beating themselves up about their situation, and as a result develop secondary disorders such as depression and substance abuse – and those are the conditions they are seen for treatment in adulthood.

Q: So these unresolved childhood anxieties never go away and re-appear in adulthood in the form of other disorders?

A: It's all about looking back at what people have missed. If you look at the work of Dr. Ron Kessler with the National Comorbidity Survey – what he finds is that anxiety is highly comorbid with many adult disorders. He has also found that conditions like social phobias, the third most common anxiety disorder, are not necessarily the focus of treatment because by adulthood it's the substance abuse or depression that dominates the course of treatments. He has also found that most people with these disorders are not living to their potential, they are not working to their potential, they are in unstable relationships, and they have an overall diminished interest in life. That is the saddest long-term outcome of anxiety – that the person is not living to their potential.

At CUCARD and through some of the organizations we are affiliated with like the Anxiety Disorders Association, we try to educate families to not look at anxiety in childhood as just a phase. It's a hard thing for parents to notice and for pediatricians to wrestle with. Yes, anxiety is a normal emotion. In fact it is a necessary emotion that is evolutionary based in the "fight-or-flight" response. However, abnormal levels of anxiety are problematic and can take a child off their developmental track. With that in mind we educate people to look at how the child is functioning, in light of the anxiety. This helps the parent, teacher and pediatrician to refer a child when the child isn't learning to master the situation – be it separation, speaking in class, handling peer interactions. If they aren't learning to do that on their own by certain ages there's a problem. One of the biggest things that happen is that parents especially, continue to take control and do things for the children and teenagers that these children should be doing for themselves. When the parents manage these anxieties for their children it gives the child and the family the illusion that the child is functioning – but they're not.

Q: Are the schools more willing to address these issues with the children?

A: That depends. We find it varies from school to school. For the most part, children in a classroom who have externalizing issues like ADHD or Oppositional Behavior become the squeaky wheels that get noticed – because they occupy the attention of the teachers.

Q: Haven't we all had a teacher that put so much fear into us that we felt like hiding in the back of the class, hoping they wouldn't call on us or make us figure out a problem on the blackboard in front of the whole class?

A: That's true, and we try to teach parents to listen and read between the lines of what teachers say during parent-teacher conferences. Often a teacher will say, "Oh Mary is such a sweet girl – I don't even know she's in the classroom." Don't feel good about that! Why shouldn't

see CUCARD on page 38

COLUMBIA PSYCHIATRY

-CUCARD-
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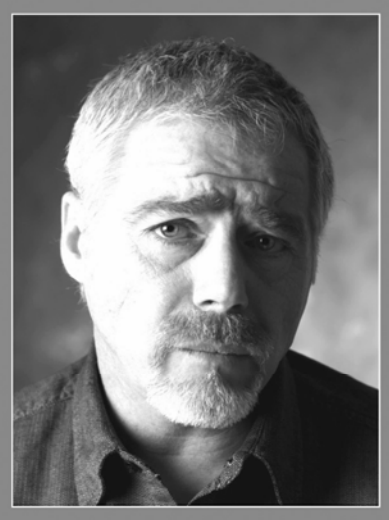

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Point of View:
Paranoia Is a Barrier to Aging in the Community

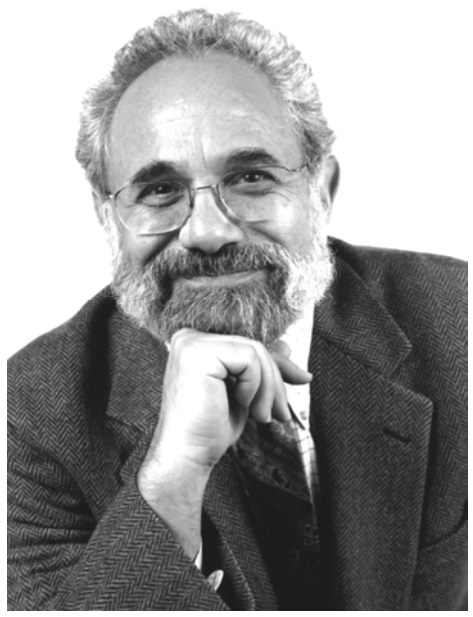
By Michael B. Friedman, LMSW
Lisa Furst, LMSW
and Kimberly Williams, LMSW

Mrs. C lived alone in the apartment in which she and her husband had raised their children. She had always been a bit distrustful. The butcher put his thumb on the scale. A teacher had it in for a daughter who wasn't doing well in school. But after her husband died, she became increasingly suspicious of everyone. She double checked the pills she got from the pharmacist. She refused to hire a new cleaning woman when the one she had had for years retired. Her daughter visited. "You bitch," she screamed, "You stole my diamond ring." The daughter was tolerant to a point but eventually insisted that her mother have help in the home, in part so she didn't have to face her mother's abuse every day. "You say my daughter sent you," the mother yelled through the door when the worker arrived. "Does she want you to kill me?" She did not open the door. Eventually, Mrs. C had to go to the hospital for treatment of pneumonia. Her daughter and the social worker agreed that, given her growing physical disabilities and her refusal of help at home, she should be in a nursing home. Mrs. C did not want to go, but she didn't have the strength to fight. She never went home again.

None of us wants to spend the last days of our lives in an institution. Sadly, many of us do. We don't say this to criticize nursing homes, all of which provide a kind of care that can be very difficult to provide outside an institutional setting and some of which provide very good care that makes life better for their residents. We say that ending one's life in a nursing home is sad simply because it is not what we want for ourselves.

There are many reasons why so many of us do not get to die at home in the company of the people we love. Lack of family or close friends, very severe illness, inability to take basic care of ourselves, lack of wealth—these are all reasons why we may not be able to live out our days as we want.

But—as we have been pointing out for some years now—mental and behavioral problems are among the major reasons for institutionalization. We have learned this from numerous conversations with people who work hard to help older, disabled adults to remain in their homes. Home health aides, personal care assistants, case managers, adult protective service workers, geriatric care managers, and family caregivers have all told us that the people they find most difficult to help to stay in their homes are those with mental and behavioral problems. They also tell us that of all of these, perhaps the most difficult problem they contend with is paranoia.



Michael B. Friedman, LMSW

We want to be clear that they, and we, are not using "paranoia" as a technical diagnostic term. We are using it with its ordinary English meaning—suspiciousness, distrust, the sense that someone is out to get you. We are referring to a range of behaviors from people who are always reading between the lines and looking for ulterior motives on the one hand to people who believe that the CIA is transmitting signals to steal their thoughts and to implant ideas in their minds and who, therefore, cover their heads with aluminum foil on the other. It is a range, that is, from a personality trait to full-blown psychosis.

Paranoia can be a very serious problem even among older adults who are able to manage well enough to survive without much help. They may be able to do their own shopping and cooking, to keep their homes reasonably clean, to get to doctors when they need to see them. But often they become increasingly socially isolated because of their suspiciousness. Some become convinced that their home is broken into when they are out, that family members are stealing from them or, at the extreme, trying to poison them. Family and friends become increasingly scarce under these circumstances. Sometimes paranoid people call the police or aging services programs for protection, but they reject help that is offered because what they are offered is not protection but care and support. They would have to acknowledge their irrationality if they accepted the help offered. Obviously, they become a great challenge to service programs, police, landlords, and others.

For older adults who are paranoid and lack the basic skills they need to survive independently such as the ability to manage their finances, to get out for food and other necessities, to prepare meals, to keep themselves and their homes passably clean, and so forth—for these people, distrust of those who offer help is a life-threatening problem.

What can be done to help people who are paranoid to remain in the homes they want to live in? There is, we are sorry to say, no easy answer. However, there are some steps that could be taken that would make a very big difference.

1) <u>Specialization and training for people who try to provide help in the home</u>: Rejection of help generally is regarded as a problem in the person who rejects help, as of course it is to some extent. But the truth is that some people are better than others at engaging people who are paranoid. People who take accusations, especially abusive accusations, personally are generally not good with people who are paranoid. People who get angry quickly are not so good with people who are paranoid. People who are impatient to get their jobs done, people who want things done the "right" way, people who demand respect—these are people who will have a hard time working with those who are paranoid. Those who understand the emotional root of distrust and abusiveness, who do not take it personally, who have high tolerance for socially inappropriate behavior, whose sense of self-respect comes from within—such people often do better at engaging people who are paranoid.

This is why we strongly recommend that home care organizations, adult protective services, and case management programs for older adults develop cadres of specialists to go into the homes of the people who have significant mental and behavioral problems and that special training should be provided regarding mental and behavioral challenges. It's good to find staff who are naturals at engaging people who are paranoid. But training to understand emotions, in the value of patience, in the importance of respect, and in techniques of helping someone quiet down and accept help can make a very big difference. It should be required for all who work in the home.

2) <u>Access to mental health and health professionals with expertise about older adults with mental disorders</u>: Unfortunately, most mental health and health professionals do not have nearly enough knowledge about older adults or about practices that work (aka "evidence-based practices"). This is a very serious problem, which we have every reason to believe will get worse as the population of older adults explodes and the number of geriatric psychiatrists and other mental health professionals as well as the number of gerontologists declines. What is needed is a workforce development initiative that includes appropriate education in professional schools, training for those already in the workforce, a vast effort to recruit new geriatric professionals, and the development of ways to incorporate retired professionals (with updated training) into the service system.

3) <u>Research</u>: More information about paranoia (in the ordinary sense of the word) is also critical. We have been distressed to discover that paranoia receives little attention in the geriatric mental health research community. By far most research focuses on depression, which is very important, of course, and should continue to be supported. But research, we believe, especially research that is funded by the government, should be closely connected with public policy goals. Long-term care reform—largely providing home-based care instead of institutional care—is presumably one of the primary components of health care reform in general—as a matter of both cost containment and basic humanity. It is clear that paranoia is a major barrier to aging where we choose in the community, and research should be organized to help overcome this barrier.

Michael Friedman is Chair of the Geriatric Mental Health Alliance of New York, a project of The Mental Health Association of New York City. Kimberly Williams is Director of the Alliance. Lisa Furst is Director of the Alliance's Training and Technical Assistance Center. The opinions expressed in this article are theirs and do not necessarily reflect the views of the Mental Health Association. They can be reached at center@mhaofnyc.org. For more on geriatric mental health visit: www.mhaofnyc.org/gmhany.

visit the Geriatric Mental Health Alliance of New York online
www.mhaofnyc.com/gmhany/index.html

The Economics of Recovery: The Day the Patients Ran the Asylum

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

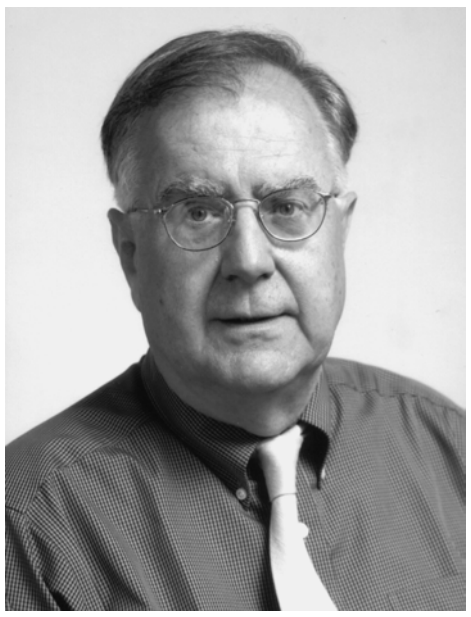
Joanne was smiling as her fellow students congratulated her for passing her Microsoft Word Certification Test. She had to put in eighteen months of class time at the Center in order to pass. Her goal now was to become certified in PowerPoint and Excel, while she held down her new part-time secretarial job.

Just two years earlier, Joanne was an inpatient at St. Joseph's Medical Center in Yonkers, N.Y. where she was being treated for Schizophrenia. She was recalling her time there. She had felt lonely during her stay; there were no visitors or phone calls, she didn't feel like socializing and there was little to do but watch TV, eat & sleep.

She thought, "If I could learn about the computer while I am an outpatient, then why couldn't I learn when I was an inpatient? My diagnosis hasn't changed. Why don't we donate some computers to Saint Joseph's Inpatient and Continuing Day Treatment Units?"

Dr. Barry Perlman, M.D. St. Joseph's Director of Psychiatry, and past President of the New York State Psychiatric Association, thought it was a program worth trying. He was "particularly delighted at the idea of one non-profit agency which serves persons with mental illness helping another." We were thrilled at the thought of our small consumer-run agency being invited to help a two hundred plus bed hospital. But could we deliver?

While we did have twelve years of teaching experience with persons with a broad spectrum of diagnoses, many with



Donald M. Fitch, MS

cognitive deficits; Schizophrenia, Schizoaffective Disorder, Autism, Substance Abuse etc. and at other agencies; Jawonio, three OMH Rockland Psychiatric Centers, The Guidance Center, Open Arms Men's Shelter and others, we had no experience teaching folks at an inpatient unit.

To guide our software selection we searched the databases of OMH, VESID, APA, Columbia, Yale, NYU, etc. and found a number of studies, Centers and Labs involved in Cognitive Neuroscience Research (ccsn.vchicago.edu).

Their findings, combined with our personal and professional expertise helped us to arrive at four criteria:

1) The software programs had to be able to engage a wide spectrum of diagnoses and skill sets.

2) They had to be fun, as well as useful.

3) They needed to include both the patient's and staff's interests.

4) And the toughest; not require staff training, equipment maintenance or an out of pocket expense of more than $1,000 (We got our Board to donate the $).

We refurbished six Pentium Computers with Microsoft Office 2007. Four were placed in an empty office at the CDT site and two were placed in the Arts and Crafts Room of the Inpatient (ILS) Unit.

To ensure a successful launch, three of the Centers' Microsoft Certified Peer Instructors (Peter, Steve & Maria) volunteered two hours a week for four weeks to teach the basics.

On the first day when we got to the ILS site, we had mixed feelings. While the project was an affirmation of how far we had come in our recovery and were now able to give back to our fellow consumers, we couldn't help wondering, when the ILS door closed behind us; "would they let us out?"

Six of the thirteen ILS patients received individual one hour instruction weekly, for four weeks. Following class the patient's had free time to play video games. Most of the patients were familiar with the computer probably because of their youth. Cyberphobia (fear of computers) was observed in only one case. Several patients were accomplished typists (25+ wpm) and enjoyed practicing on the Mavis Beacon Typing Program.

Lisa Sutton, LMSW ILS Staff said she thought "they felt more confident – it gave them hope for a successful recovery and self-sufficiency."

At St. Joseph's Outpatient CDT Program, nineteen of the twenty-five clients enrolled in the computer training course. The CDT students especially enjoyed creating their own business/personal and birthday cards, flyers and letters.

Dianne Rossi, LMSW, the CDT Director, observed, "The clients help one another to learn – the more skilled taking on the role of instructors. It's a self-contained, win-win program. Even the JCAHO and OMH auditors were impressed."

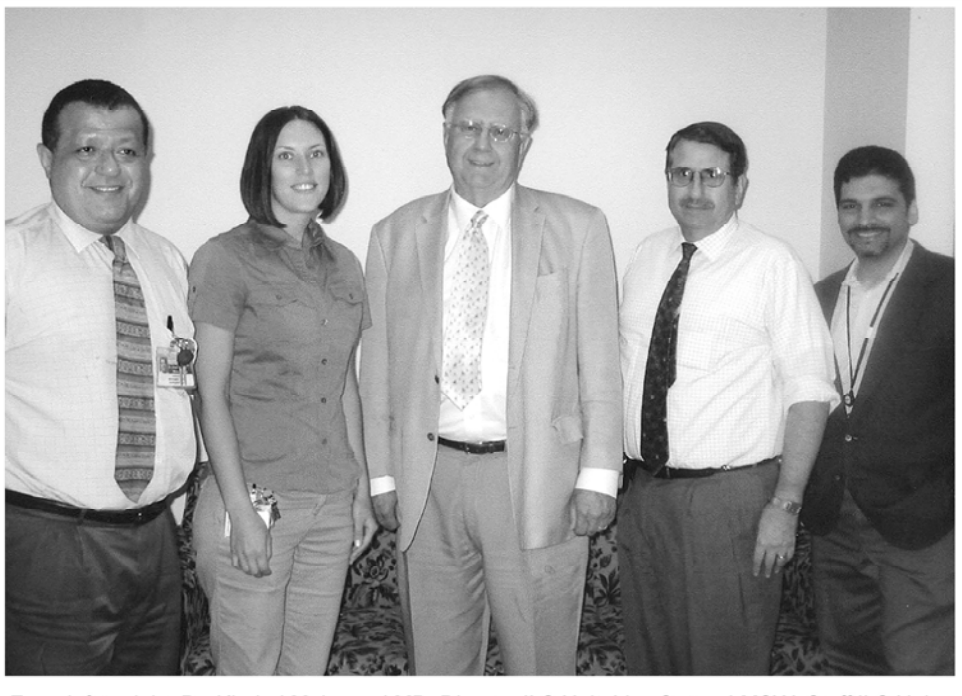
A year and a half later, we conducted four staff interviews to ascertain the programs long-term viability; "were the computers and Nintendo Wii still functioning? Were they an integral and valued part of the programs? Would they recommend them to other CDT and Inpatient Units?" The answer was "yes" to all our questions.

The staff reported the Wii game program was very popular for both the patients and staff with 30 minute blocks of game time given out as rewards. After program hours, the ILS staff played Wii games to relieve their stress!

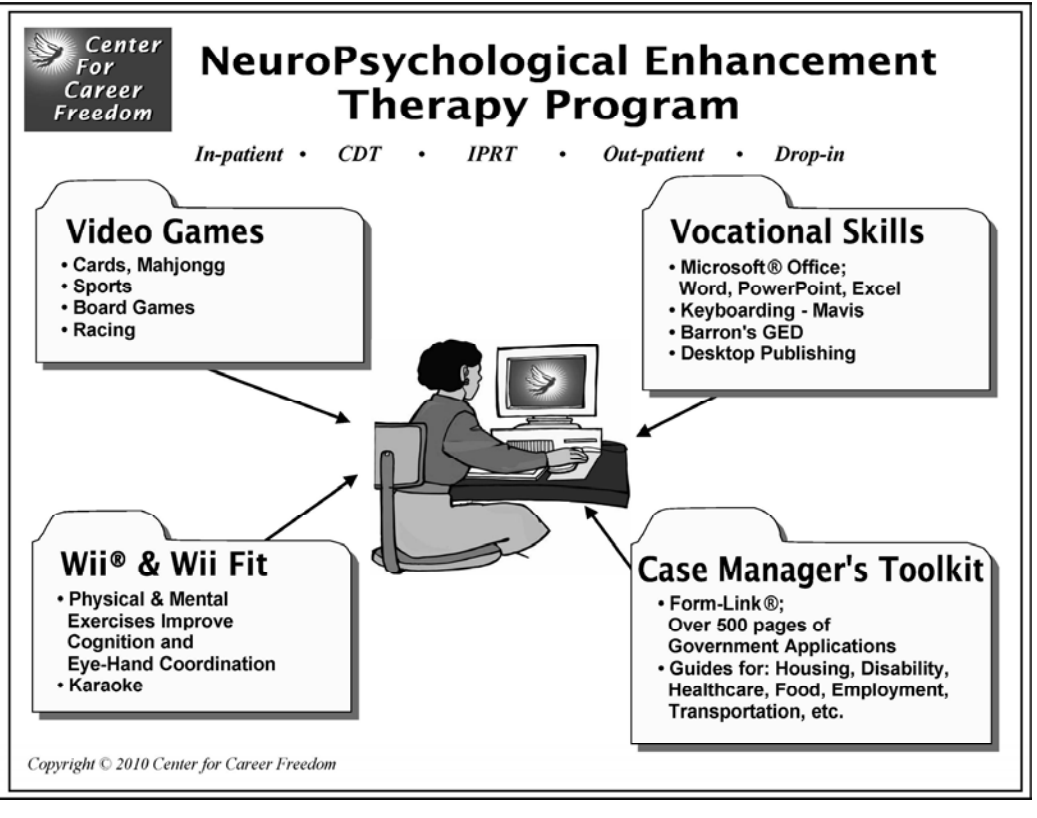
Dozens of patients have utilized these computer programs in the past eighteen months and, no doubt, dozens more will enjoy and profit from them in the future.

Joanne planted a seed that a small consumer-run agency was able to turn into a permanent program enhancement at a major Community Hospital helping hundreds of fellow consumers in their recovery, for pennies.

There was no committee, no government oversight, no grant – just a handful of volunteers at Saint Josephs and the Center with a dream. Just because our budgets get cut does not mean we have to stop being effective providers.



From left to right: Dr. Khaled Mohamed MD, Director ILS Unit; Lisa Sutton LMSW, Staff ILS Unit; Don Fitch MS, Center for Career Freedom; Dr. Barry B Perlman MD, Director Dept. of Psychiatry; Dr. Steve Catanzariti PhD, ILS Unit, Saint Joseph's Medical Center.



visit the Center for Career Freedom online at: www.freecenter.org

The NYSPA Report: A Response to the NYS OMH Report on Inpatient Suicide

By Barry B. Perlman, MD and Virginia L. Susman, MD

Barry B. Perlman, MD

Virginia L. Susman, MD

The poet A. Alvarez titled his book about suicide, "The Savage God" to evoke its lure and horror for its victims and their families. Suicide is one of the most upsetting paths to death for all touched by it. It has been the subject of much study, aiming to understand what drives it and how to diminish it. Changes in public health and education as well as patient care are understood to have contributed to the national incidence of suicide per 100,000 of population in the United States gradually but significantly decreasing from 13.2 in 1950 to 10.8 in 2003. A parallel improvement occurred in New York State where the suicide rate per 100,000 fell from 9.5 during the period from 1980 – 1985 to 6.2 in 2005, the 49th among the 50 states.

No matter the gains for the broad population, it is essential that once a person is hospitalized for mental illness their safety is assured. During June, 2009 the NYS Office of Mental Health released a report about inpatient suicide titled, "Incident Reports and Root Cause Analyses 2002-2008: What They Reveal About Suicides". Their overview addresses inpatient suicide, suicides within 72 hours of discharge, and suicide while on pass or AWOL. During those years the average number of suicides of inpatients was 5 per year and for patients in the 72 hours post-discharge, AWOL and or on pass group the rate was about 12 per year. When presented with positive data such as this, the question arises as to how to further think about it. To consider data and draw conclusions from it, a frame of reference is necessary. OMH's overview, draws on broad numbers about suicide and how it compares to other causes of death, to present a rather gray picture about inpatient suicide. We ask, is that perspective accurate?

The OMH report provides a limited frame of reference when it says that, "…. NYS inpatient mental health treatment facilities operate approximately 3,660,000 bed days each year." The decreased numbers of suicides would be better understood if the report included data on total numbers of admissions or discharges, and on average lengths of stay. For instance, in New York State in 2004 there were 107,271 discharges from general hospital inpatient psychiatric units and the average length of stay (ALOS) was 14.81 days. By contrast, in 1990 the number of discharges 74,563 and the ALOS was 24.77 days. Additionally, state psychiatric centers discharge approximately 7,000 persons per year. Elsewhere, OMH has presented data on where patients are served: in one recent year, general hospitals served 69,939, state psychiatric facilities served 11,288 and private hospitals served 10,378 individuals. These additional numbers flesh out a picture of service delivery and underscore just how infrequent suicide is amongst people served in our mental health system. While we agree that every suicide is a tragedy, 17 deaths (5 inpatient and 12 post-discharge) per 114,000 discharges, a rate of 0.01%, is an achievement to be commended. Another study conducted on all discharges between 2002 and 2007 from a consortium of 6 prominent free-standing private psychiatric hospitals reported 3 inpatient suicides, all by hanging, among 153,552 discharges, a rate of 0.002%. This lower rate adds support to the conclusion that OMH could have more vigorously emphasized - suicide among inpatients has meaningfully declined. In a review of post-discharge suicides among the same cohort, the consortium has preliminarily identified 49 suicides in the first post-discharge month. We suggest that the immediate post-discharge period warrants more careful study and add that study of this higher-risk period should separate planned discharges from patients who were AWOL or on pass at the time of suicide.

The recent OMH review might have benefited by drawing on earlier work by another interested NYS agency. In May, 1989 the NYS Commission on Quality of Care for the Mentally Disabled (CQC) released a report, "Preventing Inpatient Suicide: An Analysis of 84 Suicides by Hanging In New York State Psychiatric Facilities (1980-1985)". Their study focused on a subset of the 131 inpatient suicides during those years. The suicide rate of 48 per 100,000 inpatients was 0.05%. (For purposes of perspective, the odds that a person who auditions for American Idol will win is 1 in 103,000 or 0.001 %.) Thus, over the past 25 years the inpatient suicide rate in NYS psychiatric facilities has dropped from 48 per 100,000 to 5 per 100,000 - clearly, inpatients are far safer now, despite the risks during both eras being very low. A strength of the CQC work was that it studied over 50 variables allowing for data-based conclusions, which providers could incorporate into practice. It recognized, as most scholars have, the unreliability of predicting which persons were likely to attempt suicide. It directed attention to the value of making the environment safer and paid detailed attention to specific matters such as actual times of higher risk and human factors such as making sure safety orders are clearly written and implemented. (We suggest that CQC consider posting their study on their web site.) The OMH report might have been strengthened had it followed up on some important questions it raised, and presented in a fuller context. As an example, the important question of increasingly shorter lengths of stay is raised but not addressed.

The OMH report based its recommendations on the results of root cause analyses. While this methodology is designed to identify system failures, it also is dependent on self-examination, introducing the risk of subjectivity and bias. To counter that risk OMH requests re-investigation when they feel an institution has overlooked something. We do not dispute the value of fostering rigorous scrutiny of processes, and we feel there are important and generalizable lessons to be learned from their summary of root cause analyses. However, it should be recalled that these lessons emanate from reviews of very rare occurrences, and they are unavoidably anecdotal and subjective. The OMH report highlights "communication" deficiencies and makes particular note of a parallel conclusion drawn in a 2005 Joint Commission report. While this certainly may be a contributory problem, the likelihood that similar communication occurred in tens of thousands of other cases where suicide was not the outcome, must not be overlooked. We must not return to the approach of believing we can predict who among a high risk population is most likely to attempt suicide. Identifying faulty communication as something to eradicate stops significantly short of outlining processes and practices based on data, which if adhered to could further improve outcomes. Once we understood the frequency and means of suicide by hanging, including where and how it

see Inpatient Suicide on page 42

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OCD and Anxiety in Postpartum Mothers

By Rachel Goldstein, MD
Assistant Attending Psychiatrist
NewYork-Presbyterian Hospital

I spotted them in the waiting room easily. She was wearing crisp khakis and a clean white shirt, short hair neatly combed, touches of makeup on her cheeks alongside a tight expression. Her husband was clean cut and looked athletic though his blue jacket was slightly rumpled. He looked tired as a small infant slept in the baby carrier next to him. They both rose up quickly as I approached and Mr. J. extended his hand as he said, "We are so glad you could see us today. We are not sure what to do."

Once inside my small resident's office, Mrs. J. shared that she had been having thoughts of harming her baby, now three months old. She explained that these thoughts flashed into her mind and caused her a great deal of distress. When she was working with a knife in the kitchen, she thought that she could cut the baby and would see images of her bloodied child in front of her. When she was changing the baby she imagined it careening off the table and had the thought that she could intentionally drop the infant. While she and her husband had wanted a child and planned carefully for the right time, she now wondered if she had made a mistake. Feeling ashamed and disgusted with herself, she said 'I want those thoughts to go away.'

The notion of a mother harming their own child stokes strong emotions in most people. As a resident many years ago, I could feel myself tense up as I continued the assessment of her symptoms, taking care to note if she had signs of psychosis, depression or suicidal ideation, trying to make certain that the baby was not at risk. She was clear that she had no intention of harming the baby, had no hallucinations or delusions and she did not want to die, although she said she was becoming discouraged. Fortunately, during my prior year of residency I heard a lecture by a Dr. Sichel who was a specialist in women's mental health and had a come across a series of women in her practice who presented in a very similar way. Dr. Sichel described their symptoms in an article for the Journal of Clinical Psychiatry as all experiencing an onset of intrusive, aggressive obsessions during the first postpartum weeks. These women did not want to harm their babies, but they were very distressed by the intrusive aggressive thoughts they were experiencing. None of these women engaged in visible compulsions or rituals but they avoided stimuli that triggered the obsessions (e.g. the knife or the baby). In her lecture she explained that the women she had followed did not act on their obsessions, though they feared that they would. She characterized their presentation as consistent with obsessive compulsive disorder (OCD).

Obsessive Compulsive Disorder is defined as having obsessions or compulsions that are distressing and interfere substantially with a person's usual functioning or take up a lot of time (over an hour a day). Obsessions are thoughts, images or impulses that occur over and over

Rachel Goldstein, MD

again and feel out of the person's control. The person does not want to have these thoughts, and recognizes them as inappropriate or disturbing, knowing they do not make sense. Sometime the obsessions are associated with feelings of fear, disgust or needing to act in a particular way that feels 'just right'. Compulsions are repetitive behaviors (e.g. excessive washing or checking) or mental activities (e.g. praying, counting, saying a particular phrase or mantra in a specific way) that a person does to neutralize the obsessions or make them go away. The compulsions do not help permanently but can ease the person's anxiety for a brief amount of time.

Obsessive Compulsive Disorder is estimated to have a general population prevalence of 2%. Men and women experience the disorder in roughly equal numbers, although some think women have a slightly higher prevalence of 3.1 %. Men have an earlier average age of onset (15 years) while women have two peaks of onset with the larger one occurring between 22 and 32: prime childbearing years. Early studies looking at people' s recollections for major life events that corresponded with the onset of OCD symptoms found high percentages of people citing pregnancy or the birth of a child. However, these retrospective types of studies are not always reliable. More recent studies looking at non- clinical groups of post partum women have found ranges of 2-9 % of women meeting criteria for Obsessive Compulsive Disorder, confirming the sense that there is a high prevalence of OCD at this time, but certainly larger and more comprehensive studies need to be done.

Many reports and studies confirm that OCD that starts during the peri-natal period frequently include obsessions which are aggressive, sexual involve fear of contamination. The obsessions often include fears related to the fetus or baby. Compulsions commonly include checking as in the mother who could not sleep because she was checking her baby every 10 minutes to see if she was breathing, or cleaning to neutralize fears of contamination or illness that might befall the baby. Some women begin to avoid caretaking as an effort to avoid intrusive thoughts, or due to anxiety that they may act on the obsessions. When symptoms include aggressive obsessions women are often are secretive about these thoughts and imagine that other people or the authorities would think they are unfit to care for their children.

Ms. J. reported that she had been increasingly fearful of being around her daughter and had been relying more and more on her mother who had been visiting to care for the child. She had not shared the thoughts she was having with her mother, as she was worried that she was not the good mother she had thought she would be and concerned that others would see her as unfit. What her mother and husband observed was that Ms. J. was worried about the baby, and was very concerned about keeping his room and belongings clean and germ free. Mr. J. explained, 'It seemed a little overboard but _____ was always a little bit of a neat freak.' Ms. J. elaborated that she had in fact been quite successful at work because of her organizational skills and she also liked things to be planned. She thought that at times that tendency might have been a bit excessive–explaining how in the course of general cleaning she liked to touch up the baseboards with paint when she found a wayward scuff.

Ms. J. had also felt anxious about breast feeding and found it overwhelming to know if her baby was full or getting the right amount of nourishment despite repeated reassurance from the pediatrician that her daughter was growing beautifully. She did not tell them that she was also alarmed by the intrusive aggressive thoughts she sometimes got while nursing. After about two months she decided to wean the baby and use formula. Her mother often fed the baby for her as Ms. J. described feeling more and more anxious about her ability to care for the baby and spent ore time engaged in keeping the house and baby supplies organized. She tried to keep up appearances and would spend time around her daughter provided her mother or husband was close by. Things came to a head when her mother needed to return to the West Coast and her husband was supposed to be at work. Panicked on the prior Sunday night she had begged him to stay home with her the following day. He had reassured her that she was doing a fine job, that she was very capable and that she could call him if needed. It was only then that she talked more openly about the thoughts she had been having.

In reality, unwanted intrusive aggressive thoughts are actually fairly common. A paper by Jennings and Pepper compared 100 women with postpartum depression with 41 post partum women who were not depressed. They found that 41% of the depressed and 6.5 % of the non-depressed women experienced obsessive-compulsive symptoms. (OCS) Other investigators have found that more than 50% of a sample of new mothers reported thoughts of unwanted, intrusive thoughts of intentionally harming their newborns and all of the 91 women reported some intrusive thoughts of accidental harm. Another study showed community samples of new parents of both genders with high percentages having some intrusive aggressive thoughts. As with the non-postpartum population with OCD, the key feature in those who manifest OCD is not the existence of intrusive thoughts but the way they interpret them. Typically the women with OCD give these thoughts greater significance, are more alarmed by them and take steps to neutralize them through avoidance or various compulsions. For example, they would try to avoid care taking, or would try to suppress these thoughts which in turn actually serve to increase the severity of the obsessions. Clinically the difference in subjects with an OCD diagnosis is that the obsessions are longer lasting, more frequent and cause greater distress or discomfort.

It is not clear why so many women experience OCD after childbirth. Perhaps the high prevalence of these types of aggressive thoughts occurring at the same time as the heightened sense of responsibility for a child creates the right environment for OCD to emerge in certain people. There is some evidence in animal models of OCD that symptoms fluctuate in association with estrogen levels with symptoms worsening with withdrawal of estrogen, similar to the quick reduction of estrogen levels in postpartum women. There may be a subset of women in whom the hormonal changes around childbirth lead to the emergence of OCD. It has long been recognized that the serotonin system is involved in OCD pathology and reproductive hormones such as estrogen modulate serotonin in the brain. However, the fact that some men also develop OCD or exacerbation of OCD in this setting bolsters the recognition that there are multiple factors involved.

Treatment for OCD during the perinatal period currently follows recommendations for OCD at other times with a few modifications. A mainstay of OCD treatment is a form of Cognitive Behavioral Therapy called Exposure and Response Prevention (ERP). In that form of therapy, the person with OCD is guided to expose themselves to the feared object or situation (germs, uncertainty, disturbing images or thoughts) without engaging in the types of neutralizing behavior or mental activity mentioned above. When the obsessions are of an aggressive or sexual nature this is sometimes done with the use of scripts that describe the dreaded scenarios or images or exposure to objects associated with the obsession that the person may have been avoiding. Patients are also trained to tolerate the discomfort of having certain kinds of thoughts and to learn to recognize their discomfort as a component of their OCD. Medications are also helpful in OCD treatment with first line medication being agents that enhance serotonin such as serotonin reuptake inhibiters. Obviously given the possibility for transmission of medication through breast milk, a discussion about the risks and benefits of medication treatment needs to include a consideration or whether or not to breastfeed. It should be assumed that all medications are transmitted via breast milk. There is limited data on the long term impact of these medications on the child. Fortunately, many of the medications used for OCD treatment

see Postpartum on page 42

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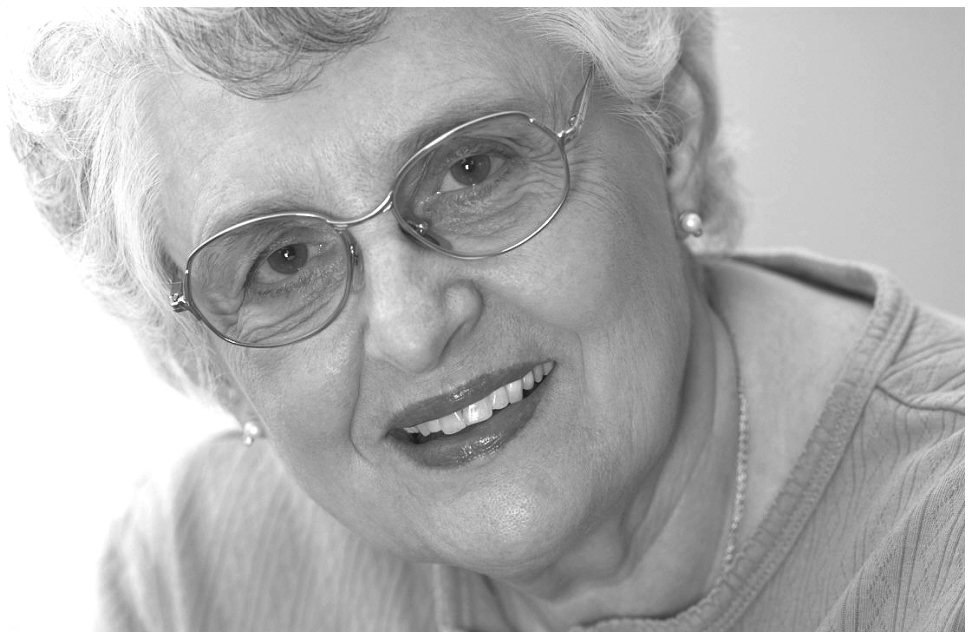
Visiting Nurse Services in Westchester: Helping Anxiety Patients in the Home Setting

By Annie Balzer, MHRN
Assistant Clinical Manager,
VNSW Mental Health Program



In most people, anxiety is a normal response to a perceived threat. As part of the fight or flight response, anxiety creates a state of heightened awareness that enables us to respond quickly to this threat in order to increase the likelihood of survival.

In patients with anxiety disorders, this normal response to a threat has become dysfunctional, causing a prolonged state of heightened awareness, often accompanied by a feeling of impending doom. This feeling is so disruptive to the individual, that it can cause panic and increased impulsive behavior. Often these people may self-medicate, attempting to numb the feeling of doom or panic through substance abuse. These people often feel that their life is spiraling out of control, and they are helpless to prevent what ever doom is coming and this may also lead to a growing feeling of despair.

As mental health nurses, we begin treatment by attempting to educate the patient on what is or is not reality based. Through reality testing we can sometimes reassure the patient that at least some of their fears are baseless. This often gives the patient at least some relief, even if only for a short period. It important to keep in mind at all times that even if they can intellectually understand that their anxiety is not based on reality, it does not take away the feeling of impending doom, heightened awareness or the growing sense of panic.

For the more cognitively impaired patient, distraction and the use of relaxation techniques is another method. By encouraging the use of relaxation techniques, such as yoga, meditation and deep breathing exercises, we can fight anxiety by stimulating the release of endorphins into the blood stream, creating an increased feeling of wellbeing.

Often engaging a patient in a hobby they enjoy can distract them long enough that it enables them to forget their anxiety. Video games, and doing puzzles with other people are also helpful. It is best to focus on activities that do not require a great deal of concentration, as a highly anxious person will not be able to concentrate effectively. For many patients this puts reading out of their reach during episodes of increased anxiety.

Medication as prescribed by a physician can also be helpful, but it is important to keep in mind that most anti-anxiety agents are also controlled substances, and may not be appropriate for patients with a history of substance abuse. It is most important to focus on what interventions the patient has control over first, as it gives him or her a feeling of empowerment over the anxiety. The use of PRN medication should ideally be reserved as a last resort.

The role of the nurse should be to support the person's self-esteem. Many people with anxiety disorders are acutely aware of how they are perceived by other people, and the effects can be devastating. Being a kind and non-judgmental care giver provides a safe haven for patients to explore their feelings, and to come to terms with them. Being accepted, even by a single person, often provides the anxiety patient with enough strength to overcome.

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Panic and Anxiety Disorder: One Person's Journey

By Elizabeth Accordino

I found myself in the middle of my own death – anyway that's what it felt like. "If I close my eyes, I will cease to exist," I thought. "They will find me slumped over the wheel dead." I looked down surprised not to see my heart beating through my waitress uniform. Surely it would burst soon and this would be over. My breath came in ragged, shallow little gasps. There just wasn't enough air. My earlobes felt hot. My throat and chest felt constricted. Fear and panic swept over me in waves. I was overwhelmed by a sense of impending doom. "You can't die while you're driving, you'll kill somebody," I told myself. I pulled the car over and opened the window, gulping air and screaming at God. "I'm not ready to die, there's too much to do!" I sat behind the wheel waiting to die for about ten minutes while hundreds of normal people drove past. Finally, feeling drained, I drove the rest of the way home.
From then on, being "in the middle of my own death" happened more and more. It happened at home, at work, on the street. During the night, it would wake me from sleep. Sometimes it would happen several times a day.

That was October 1980. I was pushing forty when panic disorder came calling for the first time. Not knowing what it was, I figured there was something seriously wrong with me and I had better keep it quiet or people would think I was crazy. I spent a lot of time wondering when it would happen again and if the next one would be the one that killed me. It was only a matter of time, I knew.

Well, at least my kids were grown. They would grieve and miss me but they would be all right. When I was alone, I cried. There was no particular reason to cry, I just did. Surprisingly, the more I cried, the better I felt. Sometimes I could cry without stopping for forty-five minutes.

Once the attacks started, they took over my life. Not that things were great before. The kids were gone, my marriage was in shambles, and I was a waitress with a high school diploma on a very short career ladder. But now I spent most of my waking hours hiding how I felt from everyone, an actress on the stage of my own life. On the outside, I smiled at customers and took their orders, bantered with coworkers, and made plans with friends. They couldn't tell my heart was racing, or that I felt detached from myself, or faint from lightheadedness. How would my weak, rubbery legs be able to hold me up? Instead of focusing on putting myself together, I concentrated on keeping everyone from knowing I was falling apart.

After about three years of attacks that came nearly every day, I figured out that whatever I had wasn't going to kill me after all. Somehow, I was still breathing, walking, and talking. I found some books that described a real condition called "panic/anxiety disorder" and was relieved to learn that I shared my symptoms with millions of other people who felt the same way.

Finding out I wasn't the only one helped me feel better. The more I learned, the less frequent the attacks were. Soon after, I found a doctor who knew about panic attacks. He prescribed medication to take "just in case." I carried it with me everywhere but didn't take it very often. I finished college and went on to earn a Masters degree. Instead of being a professional waitress, I was simply a professional. My children got married; I got unmarried. For the better part of twelve years, there were no attacks. I thought I was cured.

Someone said what doesn't kill you makes you stronger. Panic/anxiety disorder didn't kill me but it certainly didn't make me feel stronger. While I was going about the business of living my "new" life, it hid in the background, neatly disguised. Instead of turning my life upside down with dramatic "near death" experiences, it returned quietly and insidiously, planting random negative thoughts here and there. Just a few at first, then more and more. Over time, fear took over. By the mid-nineties, this condition even had a name. My acute panic attacks had morphed into something called "GAD," or generalized anxiety disorder. Now, instead of just being afraid I was about to die, I was afraid of everything - getting old, getting sick, flying, driving, being with people, being alone, going to new places, trying new things. You name it, I feared it. Every aspect of my life had a negative "what if" attached. My journal entries documented the turmoil:

see Journey on page 43

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Cognitive-Behavioral Therapy Helps Clients Cope with Anxiety Disorders

By Martha Spital, LCSW-R, ACT
Sararivka Liberman, LCSW-R
and Susan Trachtenberg Paula, PhD
Jewish Board of Family and Children's Services (JBFCS)

Anxiety disorders are the most commonly diagnosed psychiatric disorder in the United States. Approximately 40 million adults suffer from anxiety severe enough to negatively affect their lives. In addition, about 13 percent of American children and adolescents are affected by anxiety disorders each year. The impact can be debilitating, as people who suffer anxiety are often unable to have normal social interactions, leave their homes or go to stores, school or work. According to the Anxiety Disorders Association of America (www.adaa.org), anxiety disorders cost the U.S. more than 42 billion dollars a year, about a third of the country's total mental health bill.

In a 2002 article in the journal "Dialogues in Clinical Neuroscience," Thierry Steimer, Ph.D. explains that anxiety serves the very necessary function of warning us of danger or threat, and spurring us to protect or remove ourselves from that danger. According to Aaron T. Beck, MD and David A. Clark, Ph.D. in their 2010 book "Cognitive Therapy of Anxiety Disorders," though, there is considerable empirical evidence that those with excessive anxiety hold beliefs that lead them to perceive danger when there isn't any and think that they don't have the ability to tolerate anxious feelings. Beck and Clark also report that excessive attempts to stay safe and avoid situations perceived as threatening can get in the way of functioning effectively in the world. While it is natural to avoid what makes us anxious, doing so reinforces our belief that we can't handle what we are avoiding and places significant limits on our social and vocational functioning.

Anxiety takes many forms; people can suffer from separation anxiety, social phobia, obsessive compulsive disorder, generalized anxiety disorder, panic attacks, agoraphobia and post traumatic stress disorder. Along with the worried thinking associated with anxiety disorders, many sufferers also struggle with physical symptoms such as sweaty palms and rapid heartbeat, and behavioral symptoms such as avoiding going to a crowded mall or checking many times to see if the stove is turned off.

The good news is that anxiety disorders are very treatable. Yet only about a third of those who have an anxiety disorder get help. Cognitive behavioral therapy, or CBT, is considered the gold standard for the treatment of anxiety disorders, and is a well-researched, highly effective, and lasting treatment. A large number of peer-reviewed, controlled studies have demonstrated that CBT alone can greatly reduce anxiety symptoms. In some cases, however, CBT with medication produces the best treatment outcomes.

So what is CBT? According to Jesse H. Wright, MD and his co-authors in "Learning Cognitive Therapy," CBT is based on ideas about the role of cognition in controlling human behavior that have been traced to writers from ancient times to the present. CBT emphasizes that thoughts, feelings, and behaviors all influence each other. CBT is a very collaborative approach where the therapist and the client together develop therapy goals that often involve identifying and changing maladaptive thinking patterns and core beliefs, coping with feelings of anxiety more effectively, and facing situations or experiences rather than avoiding them.

In 2008, the Jewish Board of Family and Children's Services (JBFCS) launched a program to train all of its approximately 400 mental health professionals in cognitive-behavioral therapy. So far, many of the psychologists, social workers, art therapists, and case workers from JBFCS's community mental health clinics, adolescent specialty clinics, and programs for the chronically mentally ill have received intensive training in CBT. To ensure that all JBFCS clients have access to a therapist competent in CBT, staff at all levels participate in training. First, directors and supervisors receive training, individual supervision, and group supervision on CBT. Next, their staff members receive training. Learning by doing is encouraged, and all are asked to treat a client with a CBT approach and receive case-based supervision. The results are promising. Many clinicians have found that their clients respond positively and rather quickly to CBT. Below are some case examples. All names have been changed to protect privacy.

Anita

Anita, a married mother in her 40's, was diagnosed with panic attacks after repeated visits to the emergency room for what she believed were symptoms of a dangerous gastrointestinal disease or food allergies. In response to these attacks, she had been limiting herself to a few "safe" foods. Her therapist at one of JBFCS's community counseling centers in Brooklyn educated Anita about the nature of panic attacks, and informed her of research findings about effective interventions. Anita agreed to collaborate on a CBT treatment that would include psychoeducation to help her better understand her condition, relaxation training, gradual exposure to a wider range of foods, and modification of her beliefs about her fears and worries.

Anita worked hard in therapy, following up on "homework" assignments between therapy sessions, and reading David Carbonell's *The Panic Attack Workbook*, which her therapist had recommended. She learned and practiced relaxation techniques such as deep breathing, muscle relaxation, and "safe place" imagery, and discovered that with active use she could calm herself. This provided some quick relief while increasing her confidence that her problem was not medical, and that she could overcome it. In another assignment, she developed a list of foods she was afraid to eat, and rated them from the least to the most anxiety-producing. She introduced the least frightening foods, one at a time. Her instructions were to use relaxation exercises if she felt anxious, and to keep eating the same food until she could eat it without experiencing anxiety. She became more aware of the way she thought about herself and her problems, and how this affected her feelings. Her therapist helped her identify, examine, evaluate, and modify her thoughts when they were unrealistic, and develop more accurate, balanced, and useful alternatives. Anita told her therapist that she no longer fears having panic attacks because she knows how to change her experience by modifying her thinking and using coping skills.

Alicia

When six-year-old Alicia first came to one of JBFCS's community counseling centers in the Bronx, she made no eye contact, constantly clung to her mother and refused to speak. She was terrified of men, had difficulty falling asleep and sleeping alone, and became extremely distressed when her mother dropped her off at school or left her with trusted family members. Though Alicia had signs of other disorders, the main problem appeared to be separation anxiety. Alicia's excessive distress when separated from a major attachment figure, reluctance to go to school because of fear of separation, and reluctance to go to sleep without being near a major attachment figure clearly met the criteria for separation anxiety disorder.

Alicia's therapist worked with both Alicia and her mother. Cognitive-behavioral therapists often use modified play therapy techniques to help children express their thoughts and feelings and learn new behavioral skills. Using play and art work, Alicia's therapist helped Alicia learn to identify and modify her anxious thoughts about being away from her mother. The therapist provided psychoeducation for Alicia's mother about separation anxiety disorder, about how creating structure can reduce anxiety, and about how learning to sleep on her own would reinforce Alicia's self-soothing skills. The therapist also taught Alicia's mother to use behavioral charting as a tool to reward behaviors that moved Alicia toward her goals.

Alicia now looks forward to going to school everyday and no longer cries. She is able to fall asleep at bedtime and sleeps most of the night alone in her bed. When her mother leaves home, Alicia shows minimal distress. She told her therapist that she no longer worries when away from her mother.

Group Treatment

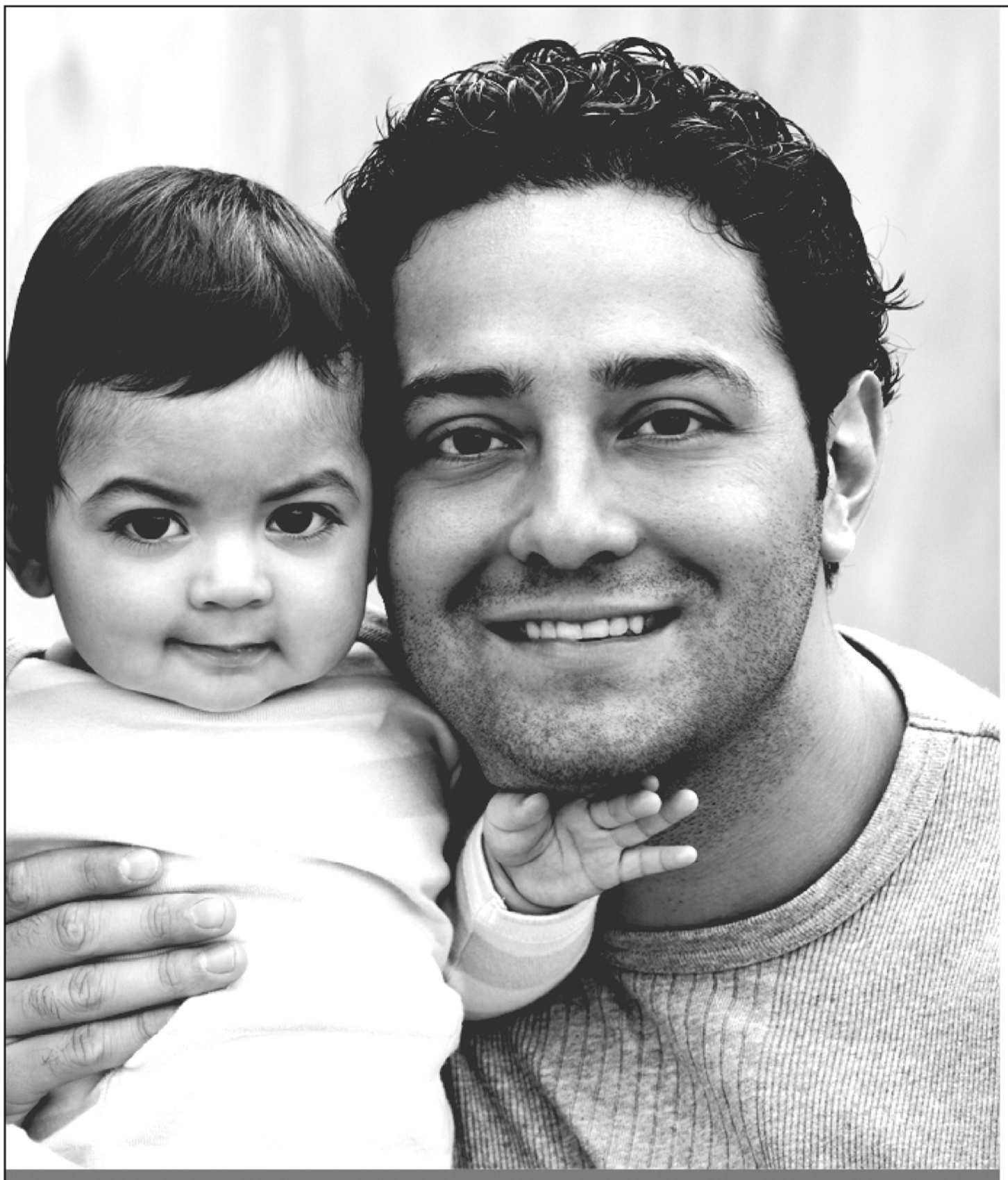
JBFCS's continuing day treatment program in Brooklyn provides day treatment services for clients diagnosed with severe and persistent mental illnesses. Some have co-morbid anxiety disorders, and most struggle with significant symptoms of anxiety that interfere with their mood, relationships, and activities. Staff members find group CBT interventions to be useful for many of their clients.

In group sessions, clients learn to use breathing exercises, progressive muscle relaxation, visualization, and aerobic exercise for reducing their anxiety and coping with stress. As members identify specific stressors, together they practice their problem-solving skills and generate possible responses. Social anxiety and interpersonal problems are targeted by having members identify, discuss, and role play social skills for meeting people, reading social cues, starting conversations, making friends, and coping with conflicts and rejection.

In a number of groups, clients identify individualized coping strategies. In group, members quickly realize how many of their struggles and solutions are shared. They also note their differences, and learn to respect their own individuality in tailoring self-help interventions to their own needs, personalities, cultures, and circumstances.

Groups also become a living social laboratory that allows members to test out some of the thoughts and perceptions connected to their anxiety, and to get feedback. One member often felt overwhelmed and anxious because of his perception that he was alone and disliked. When group members responded by spontaneously sharing how much they like and care for him, he was able to take in their support,

see CBT on page 42



JBFCS is a comprehensive network of community-based mental health and social services. We serve New Yorkers from all ethnic, racial, socio-economic and religious backgrounds.

At our community counseling centers, caring and highly trained mental health professionals offer a wide range of services, including:

- *Individual, family, couple and group counseling*
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Riverdale, NY 10463
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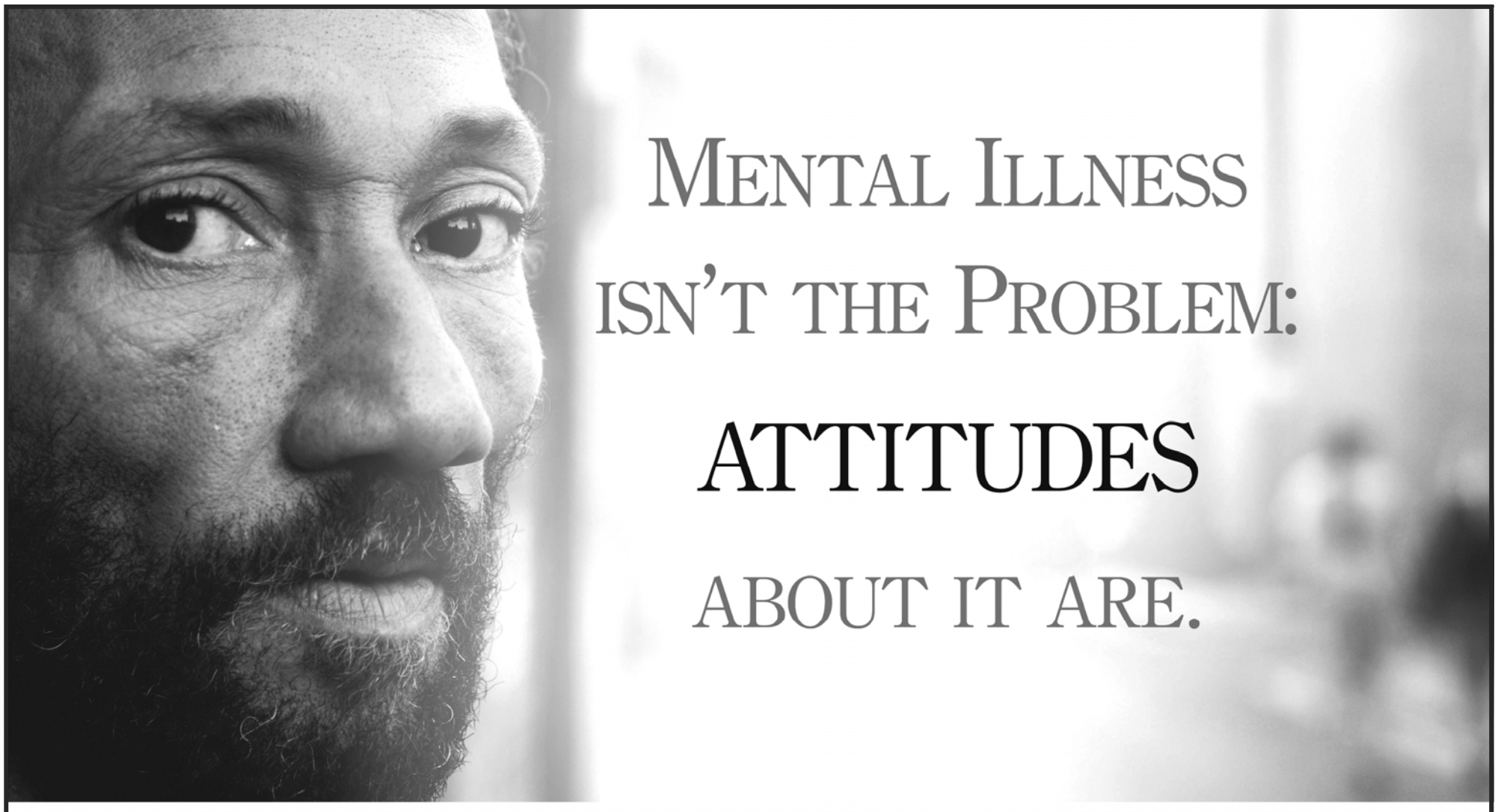

Respect. Realize. Reconsider. Ignorance is not bliss. 1 in 4 adults suffers from a diagnosable mental disorder each year.

As a mental health advocate, you know the importance of compassion and understanding. To be effective in empowering those with serious psychiatric illness, mental retardation and/or developmental disabilities, we must work together. With over 20 years in the mental health field, the Institute for Community Living is here when you need us, with:

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The National Council for Community Behavioral Healthcare
An Interview with Linda Rosenberg, MSW, President and CEO

By Ira H. Minot, LMSW
Executive Director
Mental Health News Education, Inc.

In our continuing efforts to keep our readers informed of important issues on the advocacy and political scene, Mental Health News spoke with Linda Rosenberg, MSW, President and CEO of The National Council for Community Behavioral Healthcare. In the interview that follows, Linda Rosenberg gives us a look at The National Council and some of the issues they are advocating for on behalf of the mental health community in Washington.

Q: Tell us about the National Council for Community Behavioral Healthcare.

A: The National Council began in the early 1960's during the nation's transformation to community mental health care. New community-based mental health centers that were mandated by the federal government were being created and the CEO's of these centers came together and formed the National Council as a place where they could share information, education, and learn from each other about the many challenges they faced during the early years of the community mental health care movement.

Community mental health was a new concept that envisioned mental health centers throughout the country that would serve as a resource in communities that everyone could be involved with and take advantage of – from serious mental illnesses to families whose children were having difficulties in school. In addition, prevention and treatment was to be included in the mission of these centers from the very beginning. Throughout the years that followed, these centers developed and dramatically changed to meet the needs of society and the political climate of the day.

The National Council is a nationwide membership organization that began with about 800 members and today has over 1700 members. We are the largest national membership organization of the mental health and substance abuse national associations. All of our members

Linda Rosenberg, MSW

provide mental health or substance abuse treatment services, with many of the agencies providing both services. Many treat both adults and children while some focus just on either adults or children.

The National Council also leads members in the delivery of high-quality care through practice based on the best-available evidence. We know that high quality care is that which is personalized, prevention-oriented, and based on evidence about the benefits, costs, and the desires of each person. We believe that quality care requires a focus on integrated physical and mental health; the pursuit of clinical excellence; workforce development; and investment in information technologies.

What brings everyone together is a commitment to provide effective mental health and substance abuse services. Almost all of the services are provided in the community, although we do have members that have inpatient units or may have a crisis stabilization program. We also have members who are some of the larger peer-run organizations that provide a whole range of services. A great majority of our members provide supportive housing where consumers are provided a safe living environment as well as other supportive services to assist them in being successful in their recovery and to become a part of the community around them.

Q: Do any of your member organizations provide services to the autism community?

A: Yes, many do. Some of our member organizations have specialized treatment programs, special schools, and programs for families of children on the autism spectrum.

Q: What are some of the benefits that the National Council offers to its members?

A: What attracts organizations to the National Council is that we are voice for them here in Washington. More and more initiatives affecting the mental health and substance abuse community are taking place at the federal level. So many mental health and substance use organizations are dependent on Medicaid and Medicare funding. That has become the mainstay for organizations that provide services as opposed to 20 years ago when these organizations received their funding primarily from contracts from their state and local communities. What goes on here in Washington has become increasingly important, and people want to be a part of an organization that they know is representing the interests of the consumers that they serve. I think we do that, and I think we do it very well.

Q: So the National Council is a public policy advocate for its members.

A: Yes, that is our major role. We are a voice for consumers and families and for the organizations that provide services to them. There is a big difference between having government benefits available to consumers and families, then to actually have access to services that would enable them to utilize those benefits.

Q: What are some of the leading issues in Washington that the National Council is spearheading?

A: During the Bush administration, we were leading the charge to stop cuts to Medicaid, particularly the "rehab option" and targeted case management. The National Council formed a coalition of many advocacy groups to fight against those cuts. We have a public policy staff and we also have lobbyists under contract with the National Council. We nurture friends in both The House of Representatives and in The Senate who will help us and become champions for people with mental illness and addictions. Our big victory in the above mentioned campaign was to secure a moratorium that prevented the Bush administration from really gutting the rehab option and targeted case management.

Now, with the new and more progressive Obama administration we see a different vision about healthcare. Currently there are two big pieces of work at hand for the National Council. One was to get mental health parity passed at the federal level – and it was passed. However, that was just the start. The real agenda now is what will the new Parity regulations actually look like? You see, you can have parity laws as we do in many states. However, they don't matter very much because for the most part they consist of a very narrow benefit where people can perhaps get a few days of inpatient care, a few outpatient visits, and that's about it. People often need other forms of services such as case management, assertive community treatment, children's services, and other home and community-based services. Our fight has been to make sure that the parity regulations are as broad and as strong as we can get them to be.

Q: So when we all heard that Parity legislation had passed, that was only part of the story?

A: Yes. When a piece of legislation passes, that is just a very broad outline, and then the regulations for the legislation are written by the federal government. These regulations tell the whole story about what that piece of legislation is really going to mean to the public. We have been putting a lot of pressure on the Administration to make sure the parity regulations are as robust as they can possibly be.

see National Council on page 32

Mental Health First Aid

The initial help given to a person showing symptoms of mental illness or in a mental health crisis, until appropriate professional or other help, including peer and family support, can be engaged.

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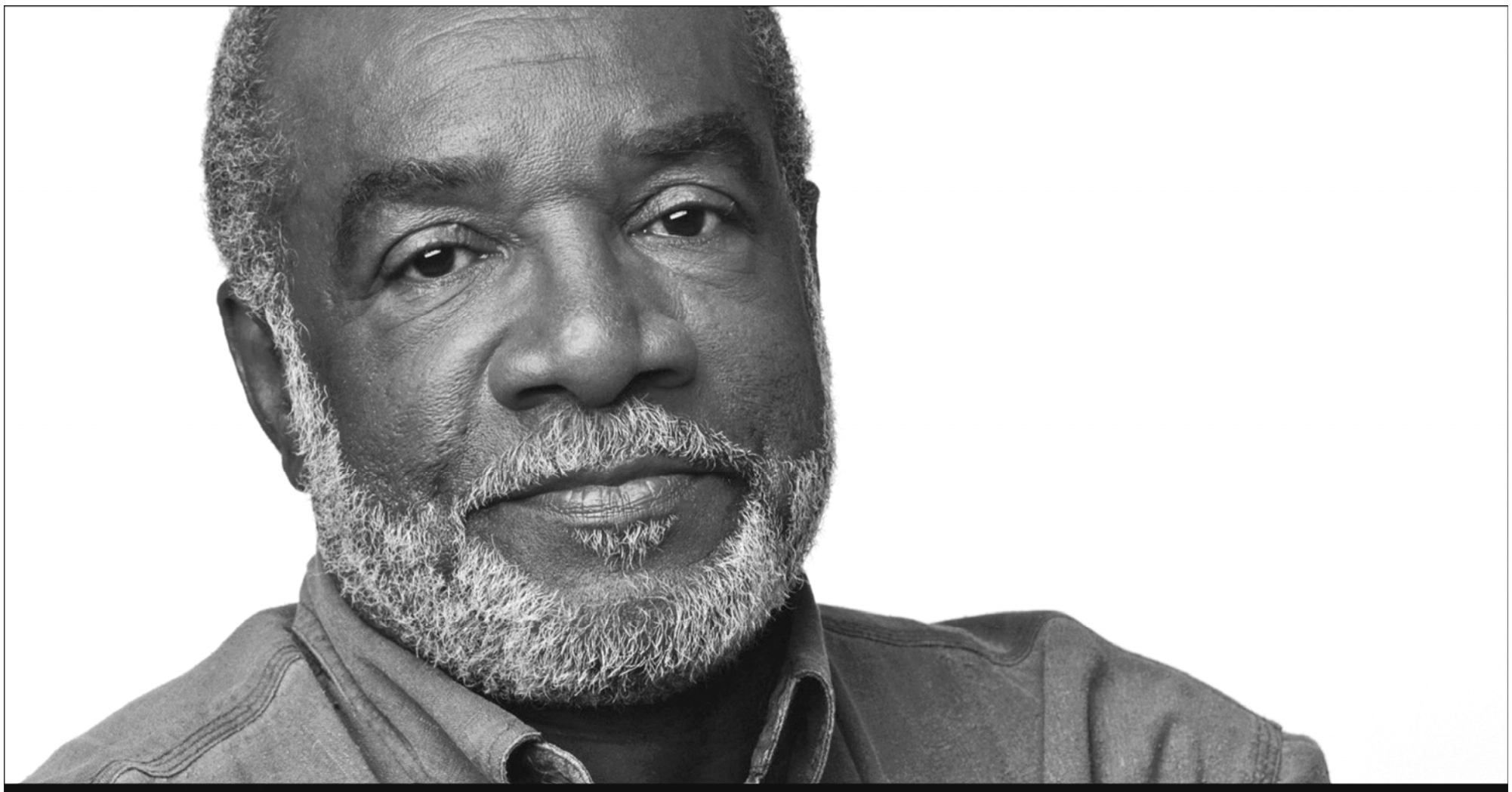
www.MentalHealthFirstAid.org



Open Access: for the patients, for the people

All too often, people who depend on public assistance are denied access to newer, safer, and more effective treatments for mental illness. This inability to obtain the treatment they need can trigger a pattern of deterioration — becoming unemployed, being hospitalized, imprisoned, and often ending up homeless. This destructive cycle is costly for taxpayers and devastating to the families of people with mental illness.

That's why Lilly continues to support open and unrestricted access to all available treatments for mental illness.

Scientific advances have resulted in medications that are effective in delaying relapse[1], provide more effective symptom control, fewer side effects, and offer longer-term treatment than in the past.

Give them access to the treatments they need, and give them hope for taking their lives back.

[1]Fenton WS, Blyler CR, Heinssen RK. Determinants of medication compliance in schizophrenia: empirical and clinical findings *Schizophr Bull.* 1997;234:637-651.

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DBT at Four Winds: The Challenges of Change

By Jonathan Bauman, MD
Chief Medical Officer

In May of 2008, a group of about fifteen staff from various disciplines embarked on a journey of learning and discovery to begin the re-tooling of our treatment paradigm at Four Winds. We felt that business-as-usual "routine" care was less and less able to address the serious behavioral problems of our patients, particularly in an acute care setting. We needed a coherent, structured treatment protocol around which staff could organize and communicate with each other and with patients. Dialectical Behavior Therapy provides such a paradigm, so a group of staff from our Adult and Adolescent services attended the first part of intensive DBT training for a week in White Plains, along with groups from other treatment settings, some as far away as Argentina. Our goal was to get "trained up" so that we could bring back enough knowledge and spirit to initiate implementation of Dialectical Behavior Therapy in the Adult and Adolescent programs at Four Winds.

When we returned, the first target of our efforts was to maintain the excitement and enthusiasm of our training experience by having weekly "DBT Consultation Group" meetings so that the energy and camaraderie of our training week did not dissipate into the day-to-day demands of our work. We supplemented our own Consultation Group meetings with consultation with DBT experts from outside, who made valuable suggestions and coached us through obstacles to organizational change. These experts also provided a series of lectures on DBT theory and practice to help train the rest of the Four Winds staff.

Another early target of the core group's intervention was getting the language and concepts of DBT into general use within the treatment teams. To that end, we began focusing on "behavioral targets" for our patients in team meetings and in discussions with our patients. These targets are the specific behaviors that got our patients into trouble and resulted in hospitalization. Since most of us were trained to think psychodynamically, conversion to thinking behaviorally has been a major and ongoing challenge.

A third target has been to abandon jargon and pejorative labeling in favor of non-judgmental, precise description of behavior, without assumptions (e.g., the patient "just wants attention"; the patient is "acting borderline"). Of course, staff must first notice that jargon may be imprecise or pejorative and teaching this to staff can be challenging (and *challenging*). It is a work in progress – old habits die hard – but the advances we have made are encouraging.

Our fourth target has been to enhance "validation" of patients by our staff as a

see DBT on page 26

Positive Behavioral Interventions and Supports for Children

By Jeanette Palmesi, RN
Program Director/Nurse Manager
Child Unit at Cliffside

Our Cliffside Child Inpatient Unit, treating children ages 5-10, has implemented a unit-wide positive behavior support plan known as Positive Behavioral Interventions and Supports (PBIS). This program has been derived from the principles of Applied Behavior Analysis (ABA). Decades of research and extensive use in education verify the effectiveness of strategies and tactics based on ABA. ABA is the branch of behavioral science that deals with the application of scientific principles to improve socially significant behavior. It includes the methods by which behaviors are observed and measured, and new behaviors are taught. Since ABA has a significant research history, especially for children with disabilities, it is the primary approach taken at many schools and psychiatric treatment centers.

Learning is defined as change in behavior due to experience. PBIS is a systems approach to evaluate the purpose of a child's behaviors, reinforce appropriate behavior and effectively manage disruptive behavior. The primary goal is to create an environment that provides positive reinforcement for improved socially appropriate behavior and prevents challenging behavior. Four Winds staff have been trained to understand what purpose each behavior serves for an individual patient and what maintains or reinforces specific behaviors.

Our treatment teams, which include therapists, nurses, mental health workers and teachers, have adopted PBIS. All of our staff are in the process of ongoing intensive training to identify disruptive behavior early so that they can redirect the child to use the coping skills that they are learning. Four Winds' approach is based on the belief that there are reasons behind difficult behavior, that children should be treated with compassion and respect, and that behavior can be predicted and managed when the principles of behavior are understood.

So how is PBIS used at Four Winds? Expectations for every activity are clearly defined. Having clear expectations sets each child up for success. Posters displaying the expectations are on the walls. Staff selectively praise children for appropriate behavior instead of focusing on undesired behavior. The development of social skills is the foundation for all activities. Each child participates in academic instruction and social skills groups on a daily basis. Both activities are co-lead by the teacher, clinical and the nursing staff and PBIS is implemented during every activity. Education is a very important part of the program. Our goal is to have school time in the hospital resemble a day of school in the community and to have the child practice appropriate behaviors.

Throughout the day our children earn stars for engaging in expected behaviors. The children choose various rewards such as time playing video games, a later bedtime and other reinforcing activities, depending on the number of stars earned. Appropriate behaviors increase as the children are consistently reinforced.

During the past year using PBIS, our behavior management incidents have decreased significantly. We remain committed to this approach and continue to enhance the training our staff receives.

We are confident that PBIS has made a major impact on the quality of the treatment.

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health Services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides Comprehensive Inpatient and Outpatient Mental Health Services for Adults, including Psychiatric and Dual Diagnosis Treatment.

FOUR WINDS HOSPITAL • SPRING 2010

APRIL 2010

GRAND ROUNDS

A Four Winds Foundation Presentation

Friday, April 16, 2010 • 9:30 – 11:00 am

The Kids are Alright: Ensuring Happiness, Hope, and Healing in the Midst of a Family Health Crisis

Jennifer Powell-Lunder, PsyD

Clinical Child Psychologist; Program Director, The Lodge Inpatient Adolescent Unit, Four Winds Hospital; Private Practice in Katonah, NY; Co-author of the upcoming book *Teenage as a Second Language: A Parent's Guide to Becoming Bilingual*

A family illness affects each member of a family in different ways. Whether the patient is the mother, father, sibling or self, each situation brings with it different stressors. Children are particularly vulnerable during such a crisis. Parents are often unsure how to act or what to say to their children in the midst of a family health crisis. The focus of this presentation is on how caregivers (who may also be the patient) can take care of the family and themselves. Special attention will be centered on helping the children and adolescents within the family cope with the issues unique to this type of crisis.

Dr. Powell-Lunder is not only a clinical child psychologist she is also a parent, a spouse and a cancer survivor. It is with the perspective of each of these roles in mind that she will offer insights regarding this topic.

At the conclusion of this presentation participants will:

- Possess an understanding of the complex issues related to a family health crisis.
- Be equipped with a set of tools to manage specific issues related to a family health crisis.
- Have an understanding of how and where support is available and what type of support may be beneficial given the individual situation.

Fee: $20 payable to the Four Winds Foundation, a not-for-profit organization
1.5 CME Credits Available
Application pending for 1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours*

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

Registration is Required for All Programs.
Please Call 1-800-546-1754 ext. 2413.
Register online at www.fourwindshospital.com

*This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0815. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.

APRIL 2010

OPEN HOUSE

Tuesday, April 27, 2010 • 4:00 – 7:00 pm

Nursing Career Day

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, and an Opportunity to Meet with Nursing Leadership

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RSVP by April 20th to 1-800-546-1754 ext. 2413

MAY 2010

A COMMUNITY SERVICE

Wednesday, May 5, 2010 • 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 illness.

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

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

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

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

Community and Professional Education Programs

MAY 2010

SPECIAL TRAINING

Thursday, May 6, 2010 • 9:30 am – 12:00 pm

Child Abuse Identification & Reporting

Valerie Saltz, LCSW,

Four Winds Hospital

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

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

GRAND ROUNDS

Friday, May 14, 2010 • 9:30 – 11:00 am

The Diagnosis and Treatment of Co-Occurring Substance Use and Other Psychiatric Disorders

Petros Levounis, MD, MA

Director, The Addiction Institute of New York; Chief, Division of Addiction Psychiatry, St. Luke's & Roosevelt Hospitals; Associate Clinical Professor of Psychiatry, Columbia University College of Physicians & Surgeons

At the end of the session, participants will be able to:

- Discuss the bio-psycho-social basis of co-occurring Substance Use and Other Psychiatric Disorders.
- Assess for primary psychiatric conditions in the context of substance use, abuse, and dependence.
- Modify addiction and mental health treatments to meet the needs of dually diagnosed patients.

Fee: $15 payable to Four Winds Hospital
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Application pending for 1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours*

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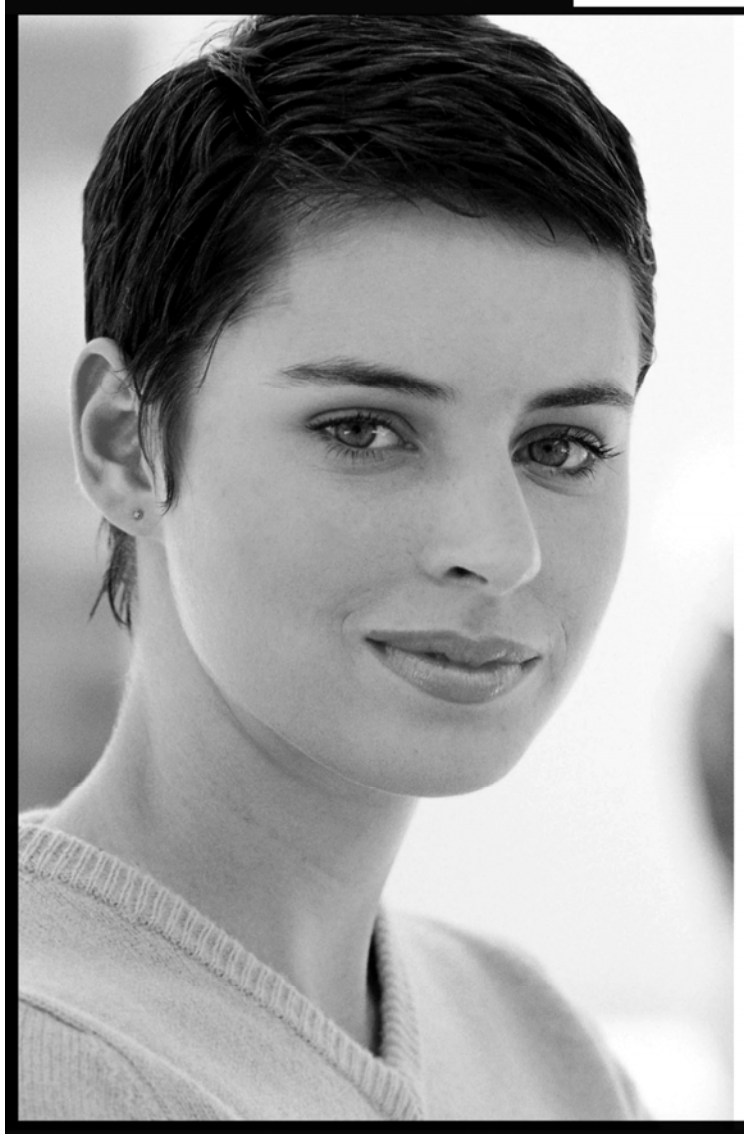

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DBT from page 23

necessary prerequisite for change. Education about the "Biosocial Theory" has helped our staff to understand that givenany individual's circumstances, it is completely understandable why they behave the way the way they do. Conveying this to our patients can provide the "foot in the door" toward motivating change. While "validation" has been a core value of the Four Winds' philosophy for many years, the application of a theory that applies validation as a prerequisite for change better informs and directs our treatment approach. Validation is a "top down" process – from administrators to clinical staff to patients – that requires mindfulness about how challenging, difficult, and scary real change can be.

Other targets of our implementation process include application of sound behavioral principles to our level and privilege systems, training of staff in conducting behavioral chain analyses with patients, development of staff competency in the delivery of DBT skills training groups (Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness), development of forms and modification of documents (e.g., Diary Cards, Crisis Plans, Chain Analysis forms, the Master Treatment Plan) to improve delivery of DBT-informed treatment, and adaptation of DBT to accommodate varied populations. Progress toward these targets is advancing at different rates and, sometimes, with fits and starts.

The initial week of training in May 2008 was followed up six months later by a second week of intensive training. The original groups re-convened to discuss the challenges with implementation of DBT in our various programs, review our "homework" assignments, further advance our skills, and learn from one another's successes and failures. The Four Winds group returned from that experience with a deeper understanding of DBT and even more enthusiasm for the task at hand.

It is approaching two years since Four Winds began this journey. We now have a self-perpetuating process of continually adopting and adapting DBT theory and practice to fit our inpatient and partial hospital programs. It is a work in progress, as we continue to learn, teach, experiment, and change. We believe our treatment programs, and our patients, are the better for it.

Evidence-Based Practices in a Community-Based Children's Summer Therapeutic Program: 33 Days to a Better Level of Functioning

By Kenneth Popler, PhD, MBA, ABPP
President and CEO
Staten Island Mental Health Society

This article will describe the synergy derived from bringing an evidence-based curriculum into a summer therapeutic day-camp for children diagnosed as severely emotionally disturbed.

What child doesn't look forward to summer vacation from school? And what child doesn't anticipate attending a camp or a program where he or she can make friends, play sports, go on trips, learn new hobbies, and just have fun?

Every child yearns for these opportunities. But a segment of our population of children - those who have severe emotional or behavioral challenges and who attend special education programs during the school year - is missing out. Their mental health disorders deny them participation in the kaleidoscope of summer programs open to their typically functioning peers.

Kenneth Popler, PhD, MBA, ABPP

Summer Therapeutic Program

The Staten Island Mental Health Society's (SIMHS) Summer Therapeutic Program (STP) was created to be the answer for many families facing this dilemma; the summer program has been supporting these special-needs children for a quarter-century. Each year, the seven-week long STP enables approximately 100 youngsters, 5 to 12 years old, to enjoy an enriching and playful experience during July and August, and to receive extra therapeutic and educational services. The program operates five days a week from 9 a.m. to 3 p.m., correlating to the full-day of supervision and services normally available during the school year, and providing supervised transportation and two nutritious meals a day. This approach also furnishes continuity of care for children who are enrolled in other mental health programs housed within their community-based schools during the rest of the year.

On the heels of Independence Day, the SIMHS's campus explodes with energy as the STP gets underway, and it doesn't cool down until the end of August. Launched in 1985, the program is not a school or a camp, but a synergistic mix of therapeutic, educational, social, and recreational activities in the structured and caring environment these children need. The program's goals are to provide stability, to help the children feel more confident about themselves and their abilities, and to prepare them for the coming school term, with friendship, spontaneity, and fun liberally in the mix.

Integrating an Evidence-Based Curriculum

On the first day of the program, each child is assigned to one of 12 groups, based on his or her age. Each group is led by two counselor-interns who are college or graduate students studying psychology, special education, social work, or a related field. With the interns as their activities counselors, the children participate in a variety of recreational and social activities including sports, art, drama, creative writing, painting, music, trips to local museums, zoos, libraries, and parks, and special projects. The children in each group stay together throughout the day. Each counselor is closely supervised by a member of the SIMHS's clinical staff.

Using an evidence-based treatment program, our clinical staff provide daily therapeutic counseling, extra support for the children who need it, and crisis services. Medication evaluation and prescriptions are provided by staff physicians as indicated.

The specific evidence-based curriculum that is the basis of the SIMHS STP was developed and refined by Dr. William Pelham and his colleagues at the Center for Children and Families at the State University of New York at Buffalo. The program is based on a social learning model. Throughout each program day's activities, attention is focused on each child's needs. Examples include individual and group problem solving and developing appropriate social interactions; improving learning skills and academic

see Summer Program on page 44

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Abnormal Micro-RNA: Hypothesis On a Possible Cause of ASD and Schizophrenia

By Edward R. Ritvo, MD
Professor Emeritus
UCLA School of Medicine

Key Concept: Abnormal micro-RNA programming disrupts early brain development causing autistic spectrum disorder, characterized by delays, plateaus and spurts of brain development. Similar abnormal micro-RNA programming disrupts brain development during adolescence causing schizophrenia, characterized by positive and negative symptoms. The degree of micro-RNA abnormality determines the time of onset, severity, and duration of symptoms in both disorders.

The theory presented in this essay is that autism spectrum disorder and schizophrenia are caused by abnormal micro-RNA, the non-coding part of the genome that directs the development of the brain. It is based upon two key clinical observations: (1) the nature of their symptoms, and (2) their clinical course.

Let's first consider what clues their symptoms can give us as to their cause. In autistic spectrum disorder, symptoms usually appear first during the earliest years of life when the brain is developing rapidly.

What we observe are delays in onset, prolonged phases, and spurts of development of language, social relatedness, and sensory-motor modulation. This tells us that the normal rate and coordination of

Edward R. Ritvo, MD

brain development is disrupted, and different parts of the brain are developing at different rates.

In schizophrenia, symptoms usually first appear during late adolescence when there is a rapid period of brain development. The classical "positive" and "negative" symptoms of schizophrenia indicate that the normal development of the coordination of thoughts, feelings, and sensations occurring at this time are disrupted (This is the observation that led Bleuler to coin the term schizophrenia: "Schizo" for splitting – and "phrenia" for psyche).

Thus, the symptoms we observe in both disorders express abnormal brain development.

Second, let's consider what their clinical courses suggest as to their cause. In both disorders it is well known that symptoms wax and wane and in some cases they can remit completely. This tells us that the underlying brain pathology is not static, but the brain development is able to pause and restart. For this to happen, there must be "on" and "off" switches in the genome which normally orchestrate brain development, but do not function properly in these two disorders.

These two key observations lead us to ask, "Where in the genome are these "on" and "off" switches located, and what causes them to malfunction?"

The answer to these questions requires some speculation. The most likely answer to the first one, concerning location, is that the "non coding micro-RNA" part of the genome contains the instructions for the development of the brain and all other parts of the body. Typically, DNA instructions code for building specific proteins. Micro-RNA instructions, on the other hand, appear to contain timing, placing, and sequencing instruction such as "put it here," "put it there," "deliver it now," and "deliver it when XYZ happens in the future." Abnormal functioning of such instructions can explain the developmental delays, plateaus, spurts, separation of brain functions, and changing clinical picture of both autism spectrum disorders and schizophrenia.

Now we come to the crucial question, what could cause micro-RNA to malfunction? Unfortunately tools to study RNA directly are just being developed, and no direct evidence is available so far. However, with regard to other possible causes, it is important to note that no specific or unique environmental factors or abnormal brain structures or nerve cells have yet been found in either disorder. This, in spite of extensive efforts on our part and at research centers throughout the world. The search continues, and hopefully will bear fruit.

On a more positive note, however, there is some evidence from family studies that is consistent with our theory that abnormal micro-RNA plays a causative role. Both disorders, to put it in the vernacular, tend to "run in families." In autistic spectrum disorder we showed many years ago that if a couple has an affected child, the chances of each following pregnancy producing an affected child is ten percent. We also observed that autistic parents had many more than expected autistic children, and that in pairs of identical

see Hypothesis on page 41

Serge and Pierre: Coping with Schizophrenia on Two Continents

By Roxanne Lanquetot, MS, MA

Pierre's father and my husband Guy were in the same class at the School of Architecture of the Beaux Arts in Paris and worked together after graduation. We were friends and had known their son Pierre since birth. An excellent student and a personable young man, he was chosen by his high school in France to spend a year with a family in the USA.

Our own son Serge was also born in France. When my husband became interested in modern, American architecture, we moved to New York when Serge was two. Guy liked working here, and the temporary move became permanent. We saw Pierre and his family each time we returned to France. His mother and I often talked about our sons' futures.

Serge was adorable, and everyone loved him. We applied to the United Nations School for kindergarten and were told that they wouldn't have room until the new building was completed, but he so charmed the French teacher that they accepted him, anyway.

In December of 1971 the director of a children's T.V. program came to the school to choose six children out of the student body for major roles in a Christmas special for UNICEF called "The World of Love." Serge was one of the children. We have photographs of him walking beside the actress Shirley MacLaine down the aisle of the General Assembly and adlibbing on stage with actor Bill Cosby. We were so proud of our son.

Things began to change during Serge's freshman year of high school. He cut classes and didn't complete his schoolwork. High on marijuana, he skateboarded all day. He was scheduled to play the march from "Aida" in a trumpet trio at the school's annual spring concert, which we attended. We were surprised to see a duet for trumpets listed on the program and learned after the concert that our son had been dropped from the trio for not practicing. We weren't fazed by this incident and didn't think that there was anything seriously wrong with Serge. Nothing could damage our vision of a wonderful son.

We drove across country and camped that summer. Bombarded by tirades against "bad" parents from Serge in the backseat of our car, I couldn't take it any longer and told him to shut up. He bit me. He refused to get out of the tent to look at the Grand Canyon nor would he ask the address of a skateboard park in a skateboard store when we visited Los Angeles. His major complaint to the psychiatrist in New York was that we would not take him to the park. The diagnosis the psychiatrist gave us was adolescent rebellion against his parents, a tragic mistake. It was schizophrenia. This incorrect first diagnosis caused us to lose precious time helping Serge, as we later learned that the earlier a mentally ill person receives treatment, the less severe it would be.

Back in France, Pierre's father died from cancer at age thirty-five. Pierre was just starting high school. He finished high school but was unable to focus on anything afterwards, either the university or a job. He began acting strangely, withdrew from his mother and younger sister, and ran away, never to be seen or heard from for many years. He too had developed schizophrenia. His mother knew he was mentally ill, that he had been hospitalized several times, but was unable to locate him.

In France policemen have the right to pick up a person who is acting strangely and put him/her in the hospital, whether or not the behavior is dangerous. During hospitalization the patient can be forced to take medication, but after discharge he/she can choose whether or not to take it. Following discharge, the patients are not given a place to live and are not provided with any follow-up care. Because of the paucity of halfway houses and psychosocial rehabilitation programs, Pierre was left to his own devices. He did not receive any housing or allowance from social security.

Back in New York, Serge dropped out of school at age fourteen. We didn't believe neighborhood shopkeepers who warned us about his "delinquent" friends. What right did they have to interfere? When we finally realized that our son was in trouble, it was too late. The first psychiatrist, who still claimed he was a rebellious adolescent, cautioned us not to interfere. "If you don't interfere he'll eventually come around. If you do, you'll provoke him to hurt himself or you or run away," he said.

Serge's best pal at that time was another high school dropout who had run away from his family and was getting into trouble in the neighborhood. Because of his close friendship with this boy, it wasn't long before Serge got into serious trouble with the law and was arrested. The Court resolved that if Serge attended a residential treatment center, he would avoid jail time and instead be placed on probation.

Serge's fall into mental illness is complicated. Several more years passed before an accurate diagnosis was made at Bellevue Hospital. Medication resistant, he remained in the hospital for seven months before an effective medication was found. Then, he was transferred to a psychosocial rehabilitation center in Brooklyn,

see Serve and Pierre on page 42

An Update on the National RAISE Schizophrenia Project
An Interview with John Kane, MD

By Ira H. Minot, LMSW
Executive Director
Mental Health News Education, Inc.

The last issue of Mental Health News was devoted to the science, research, treatment and understanding of schizophrenia. As a follow-up to this important area of study and understanding, I had the opportunity to speak with John Kane, MD, one of the principal investigators and leaders of the nationwide RAISE (Recovery After an Initial Schizophrenia Episode) project. Dr. Kane is Vice President of Behavioral Health Services at North Shore-LIJ Health System, and Chairman of Psychiatry of The Zucker Hillside Hospital in Glen Oaks, New York. I asked Dr. Kane to give us a comprehensive look at the RAISE project and why it holds such promise for the future of schizophrenia research and treatment as well as for the lives of consumers in recovery and their families.

Q: Dr. Kane, give us an overview of the RAISE project.

A: We have all come to realize that despite the progress we have made in the treatment of schizophrenia, many patients are still left with considerable residual disability or functional impairment. Some of the work that we have done here at The Zucker Hillside Hospital suggests that if we apply strict recovery criteria to a population of first episode patients with schizophrenia, we found that after five years of follow-up that only about 14% of the patients had met full recovery criteria. Our full recovery criteria means that the patient was either working part-time, going to school or functioning as a homemaker, as well as being able to do day-to-day living tasks without supervision, having social relationships with people outside the family, etc. All of these criteria had to have been sustained for two years. Unfortunately, we found a small proportion of patients who met these criteria.

The RAISE project is really a landmark effort on the part of The National Institute of Mental Health (NIMH) to see if we can bring about better outcomes in the treatment and recovery of patients with schizophrenia. By better outcomes, we mean that the outcomes are not simply the measure of the signs and symptoms that are associated with schizophrenia like delusions and hallucinations, but involve people's ability to function in the community. That's really the goal of RAISE.

We have a team of experts around the country who have been developing a state-of-the-art intervention package that includes: psychopharmacology – the cutting edge use of medications, psycho-social interventions, psycho-education, supported employment, and supported education. All of these components will be administered together by a team of specially trained people who will work with our patient population that have recently had an initial episode of schizophrenia. The team's impact on patient outcome

John Kane, MD

will be compared to a control group of individuals who are being treated in community clinics around the country in the usual way. These groups of patients will be followed and assessed and we will compare the "quality of life" in these two groups after two years of follow-up. We will be looking for good outcomes among the people receiving the enhanced interventions in relation to the group that is only receiving traditional treatment.

Q: Are there any requirements of patients to be invited to join the RAISE study?

A: The criteria are quite liberal. However we are looking for people who are still in the early phase of illness. One of the assumptions of the study is that we want to try to get people as close to the onset of the illness as possible, because we think that if we can apply very state-of-the-art comprehensive care at that phase of the illness, we have a better chance of significantly impacting the trajectory of the illness. We are looking for people between the ages of 16 and 40 who have one of the following diagnoses included in the differential, and that would be, Schizophreniform Disorder, Schizophrenia, Schizoaffective Disorder, Psychotic Disorder NOS, or Brief Psychotic Disorder. Patients will have to have one of these diagnoses included in the differential – although we are not insisting that they have a definite diagnosis of schizophrenia at the point when they enter the study since we want to catch patients very early in the process of their illness. We are also requiring that they have less than four months of treatment with antipsychotic medications in the past. That is another way of the study insuring that we have people who are in the early phase of their illness.

Q: Can you provide our lay readership with a brief general description of the various schizophrenia diagnoses that you just mentioned?

A: The critical issue is that sometimes a person is in the very early stages of a schizophrenia illness. At that time, we aren't quite sure of the specific diagnosis. One factor is determining how long the person's symptoms have been present. That is the differential between Schizophreniform Disorder and Schizophrenia for example; or between Schizophrenia and Psychotic Disorder NOS (not otherwise specified); or Brief Psychotic Disorder (implying that the disorder is too brief to be certain that it is schizophrenia). Schizoaffective Disorder indicates that there is an affective (mood) component, and sometimes we may not be sure if this is really schizophrenia or the early stages of a Manic Depressive or Bipolar illness. Sometimes, it takes a while to sort all that out and the best diagnosis may not become obvious for many months. That is why our study is taking people initially with a range of diagnoses and patients will be evaluated at various intervals by the study's panel of researchers. We can then see if the patient's diagnosis changed. Often it doesn't change, but sometimes it does.

Q: Has the pharmacology in the treatment of schizophrenia become more specific and targeted in the past number of years, or do clinicians generally find the right medication for a particular patient through a process of trial and error?

A: We certainly do not have personalized medicine yet. We cannot examine a patient and immediately say that this individual will respond to drug X and not drug Y. We are not at that point yet. All of the medications we use are efficacious; however, some drugs will work better with one patient versus another. One of the things we will be doing in this study is collecting DNA from the patients (with their consent) who participate. We will be trying to advance our understanding of why one patient responds to one drug and another patient does not. By the same token, we want to understand why one patient develops a particular side-effect to a drug while another patient doesn't develop that side-effect at all. We think that genetics plays a role in our understanding of that. As of today, there is still a certain amount of trial and error that goes into our choice of medications. We try to choose medicines that we know are efficacious and that we know are well tolerated, which is important in first episode patients, who often are particularly ambivalent about taking medication at all. Some patients, do respond differently and some patients will develop side-effects. Part of what I think is critical about our effort in this study is that we will be providing the psychiatrists with a computerized decision-support system which we are developing. This will give the clinicians a lot of guidance in terms of how to think about the choice of medication, the dose of the medication, when and if to change the medication – if so, how do they monitor side-effects, and what do they do if certain side-effects occur. Using this computerized support system we are trying to emphasize "evidence-based" decision making. We want to make sure that the clinicians have the evidence they need to help them make the best informed decisions. We are also going to be training the clinicians (and particularly the doctors) to work with the patients to make "shared" decisions about things like the medications that they are taking. We want the patients to participate in that discussion. In this respect, we have to understand what the patient wants; because we shouldn't assume that our goals are their goals. This mindset also applies to the issue of medication side-effects. Some patients may be really troubled by feeling sleepy while other patients might not be bothered by that at all. People have different vulnerabilities and they react differently to things. The patient has to really be a stakeholder in the therapeutic process.

Q: Besides the psychiatric aspects of the study will you also be looking at some of the other critical factors for a successful overall recovery process, such as housing and vocational issues?

A: Yes, we are going to be looking at that and are trying to provide as much supportive services as we can to help the patient in their recovery. We want the patient to participate in determining the goals within this process. If they get a job we want to provide the supports necessary so that they can keep it. We also want to make sure they are getting the benefits such as SSD, SSI, housing, etc. that they are entitled to. We will work with the patients with regard to resiliency, wellness management, managing stress, reducing substance abuse, smoking cessation, improving social relationships, goal setting and so forth. We will have very concrete targets for each patient and we will work very closely with them. We will also provide family psycho-education in order to get family members involved with what's going on. Families need to know what this disorder means, what the treatment entails, reducing stigma, helping them communicate and solve problems within the family and with the patient and the treatment team. We also will work to help family members process their own personal experience of the patient's illness which can be very frightening for some family members.

Q: Since the study is being conducted on a nationwide basis are you going to take into account the cultural aspects of the patient and their illness.

A: That's an excellent question. We actually have an anthropologist who is on our steering committee and we are going to try to be sensitive to cultural differences that we encounter in the study. We are also going to try to get a lot of feedback from the patients about what they like and dislike about the treatment. We are going to try to take advantage of everything that we know about the things that influence patient's behavior, attitudes, and acceptance of treatment. As you know, one of the huge issues, particularly in this

see RAISE Project on page 46

Find Your Center: PTSD and Yoga

By Miki Yoshida, LMSW
Westchester Jewish Community Services
Treatment Center for Trauma and Abuse

Miki Yoshida, LMSW

More than 5,000 years ago, yoga was developed in the Northern part of India. Who would have predicted that this tradition can bring healing to war veterans and sexual abuse victims, alike, in 2010?

Yoga has been a part of the Western life style for the last 40 years, and it has become more and more popular as years go by. I began practicing yoga about 3 years ago as part of my exercise routine, but I quickly found yoga to be something more than just an exercise technique. Yoga helps develop strength, flexibility, a healthier posture, and most importantly, it increases one's self-awareness and ability to self-regulate. It gives yoga practitioners an opportunity to stay in a present moment by encouraging them to pay attention to breathing, muscle movements, and other internal sensations. As people practice yoga, they develop skills to pay closer attention to themselves without judgment, and to accept each moment as it comes. People can experience a sense of calmness and contentment with yoga. These experiences are not limited to the time spent while practicing yoga, and people often begin to use the same skills to stay in the present moment and listen to internal sensations when they are "off the [yoga] mat."

As a clinician who works with trauma survivors, I thought yoga would be a great tool to help my clients to learn about self-regulation. People with Post Traumatic Stress Disorder (PTSD) lose skills to self-regulate because the trauma that they have experienced directly affects their physiological and neurobiological levels. Their central nervous systems get intensively activated and this alters functioning. Another way to conceptualize it is that their bodies get stuck on 'emergency call' all the time, and the trauma keeps replaying in the body. Living with a traumatized body is very difficult, uncomfortable and confusing to most people. They keep themselves busy while ignoring their body sensations and this, in turn, reinforces trauma symptoms. Trauma survivors become detached from their bodies and tend to focus on "worrying" and keeping their minds busy.

Scientists and researchers have been studying the effectiveness of yoga in a variety of physical and mental illnesses. The National Center for Complementary and Alternative Medicine has supported research on the effectiveness of yoga on reducing blood pressure, chronic low back pain, depression, insomnia and other conditions. In recent years, there has been more support for the use of yoga in reducing Post Traumatic Stress Disorder symptoms.

One study found that low GABA levels, which are associated with depression and anxiety symptoms, have increased after 60 minutes of yoga asanas (postures) practice (Streeter C, et al. 2007). Another indicator for anxiety and depression is having a low level of Heart Rate Variability (HRV). The leading PTSD researcher, Bessel van der Kolk, also a fellow yogi, has been conducting research on PTSD and yoga since 2003. In one study, van der Kolk found that after 8 session of hatha yoga, there were significant changes in HRV levels (van der Kolk, 2006). In the same study, van der Kolk concluded that yoga appears to decrease PTSD symptoms such as hyperarousal and increases self-regulation skills in people with PTSD.

Armed with my personal yoga experience and this research data, I became strongly convinced that yoga is one effective way to address the symptoms of PTSD that remain strongly rooted in the body. I completed a 200-hour yoga teacher training in 2009, and also completed a 40-hour certificate program on Trauma Sensitive Yoga with van der Kolk (The Trauma Center) in 2009. At the Westchester Jewish Community Services, Treatment Center for Trauma and Abuse, I began a 12-week yoga program with trauma survivors. During the first three sessions, the group focused on educating members about PTSD symptoms so that they could learn about their condition and be reassured that their experiences are normal under the circumstances. Also during the first three sessions, I introduced a gentle yoga practice to be done while sitting on a chair. After the fourth session, the group members were asked to move onto their yoga mats, and to practice the basic postures of yoga. At this point, I have run two cycles of 12-week groups. To examine the evidence of the group's success, I asked all participants to complete a questionnaire regarding levels of psychiatric symptoms and distress before joining the group and after its 12-week conclusion. Group members have reported a decrease in symptoms at the conclusion of group, though the sample is too small to measure with reliability at this time. In addition, the feedback from group members was that the group gave them time to relax, learn about their bodily needs, and feel really good about themselves. Through the process, group members were able to rebuild both a sense of who they are, and their ability to trust their center. They were able to reconnect with their body, mind and spirit to live a more meaningful life. This experience has solidified my belief that body work, and in particular yoga, is a very promising and rewarding way to help trauma survivors recover their essential selves.

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State Medical Group Honors Silver Hill Hospital

Staff Writer
Mental Health News

Silver Hill Hospital earned an award for excellence from the Connecticut State Medical Society for recognition of its Continuing Medical Education program which has been accredited with commendation for the maximum term of six years.

The award was presented by Bob Brunell of the Connecticut State Medical Society and accepted by Dr. Barry Kerner and Anne Romano of Silver Hill at a recent ceremony held on the hospital campus.

Silver Hill Hospital is accredited by the Connecticut State Medical Society to provide continuing medical education credits to physicians who attend education presentations sponsored by the hospital. "Our Continuing Medical Education Committee works very hard to ensure our medical staff and physicians in the community receive the highest quality of medical education in order to stay at the cutting edge of the mental health profession," said Dr. Barry Kerner, Physician-in-Chief and Director of Medical Education at Silver Hill Hospital. "We are very grateful to be recognized for these efforts."

Bob Brunell, Dr. Barry Kerner, and Anne Romano, Director of Library Services

Education presentations offered at Silver Hill Hospital focus primarily on topics of mental health and addiction. For more information about education programs at Silver Hill Hospital, contact Heather Porter at 800 899-4455 ext. 2378.

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There are many components that go into the process before a piece of legislation becoming enacted into law. Even when legislation is passed by both Houses and is signed by the President, that piece of legislation requires regulations that have to be written. These regulations tell you what the legislation is really going to do and how it will be implemented on the state and community level. The real work of for the National Council over the past several months has been to keep the pressure on Congress so that when they implement this legislation we are sure that people with mental illness and addiction disorders have a full range of services that are available to them in their communities. Parity legislation's regulations have to include meaningful benefits. We expect the regulations to be released in January and expect them to go into effect sometime in July.

Now, our big piece of work is centered on Healthcare Reform. It appears that there will be a piece of legislation in early 2010 that the President will sign. That will begin years of work to enact that legislation. If you look at either the House or the Senate Bill, you'll see that certain things will be phased-in over the next several years. In spite of the fact that this will not be a quick process, we believe Healthcare Reform will have a profound effect on the nation and on people with mental health and substance use disorders. In fact, we believe it will have more of an effect on people with substance use disorders as most of these individuals do not have insurance and are not covered currently by Medicaid or commercial insurance. Now they will have coverage.

Over the next few years, almost every American will have some form of insurance coverage. That is going to change how people get care, and it is also going to mean that providers of services have to change as well. For one thing, providers will now have to get used to dealing with insurance companies.

Q: Won't that be a daunting process for service providers?

A: Yes, it is going to be a daunting process. We are likely going to see the re-emergence of HMO's and managed behavioral healthcare organizations in many states. I believe that states alone will not want to manage all of these new insurance benefits, and will bring in intermediaries. I think we will see continued erosion of state grant funding and county and local funding. The argument will be that everyone now has an insurance card, so what do we need state general fund dollars or county dollars to support individual healthcare? We know that insurance often isn't as flexible as it needs to be, so I suspect that this will require a lot of work in the coming years.

Q: Do you see this as a positive or a negative step for community healthcare?

A: I think it's a mixed bag. On a personal level, and from the perspective of the National Council and the almost quarter of a million staff that work for our member organizations, we would say that everyone should have health insurance. I think what people are less clear about and less ready for are the changes in how we are going to have to do business with everyone now having insurance.

There are things we have to be careful to watch for with this sweeping new legislation. When there is change – even though it is a change for the good of the nation – there often are unintended consequences. We can't predict how the new healthcare reform will affect people. Having a group such as the National Council and others on the state and local level monitoring the process is very important. When Massachusetts implemented its statewide healthcare insurance initiative they soon realized that they there weren't enough primary care physicians to adequately service the people of that state. I think there will be workforce problems associated with national healthcare.

For the mental health and substance abuse community we now going to be a part of general healthcare yet we are not funded the same way and we don't have many of the same tools that general healthcare already have in place. A prime example is our community's lack of experience with information technology. We have limited electronic health records, or registries for chronic illnesses, or other technologies that can help ensure better care. We will have to fight hard to make sure the mental health and substance abuse communities will receive help in getting and implementing those needed technologies.

Q: Sounds like the job description for agency CEO's will be changing significantly in the coming years.

A: I think it will. The mental health and substance abuse organization CEO of the future will primarily need to be good business people. They will now be dealing with insurance companies, technology companies, and also banks, because they will have to maintain lines of credit to balance the ebb and flow of expenditures and reimbursements from the insurance companies. I think the CEO of tomorrow will have to either be knowledgeable about the new business of mental health and substance abuse care, or will have to have a lot of talented people around them. They will need a team of people who are knowledgeable in all those business and technology areas. I think the organization of tomorrow will also have to be big enough to weather the new changes that are coming. Some believe that many small organizations will struggle under National Healthcare because they will not benefit by "economy of scale" factors.

Q: What is the National Council doing to prepare its members for the new face of healthcare in America.

A: We do a lot of work in the areas of streamlining and business efficiencies. We are starting a new "CEO University" project which will begin next year for new CEO's to learn from each other and from specialists we will be bringing into the project. We have a similar project for Medical Directors that started last year. We do a conference that is heavily focused on leadership and on what folks need to know and do to prepare for the future. We do a whole host of activities from keeping our members current on what is going on "on the Hill," to better organization management, and to improved clinical expertise for the therapeutic missions of their organization. In addition we have newsletters, webinars and many other learning opportunities that provide essential tools for organizations to stay abreast in these changing times.

In closing, I would like to *thank Mental Health News* for providing me with this opportunity to introduce the National Council to its readers, and would like to invite your readers to visit our website at www.thenationalcouncil.org to learn more about us and to find out how they can become a member.

With more than 30 years of distinguished service in mental health policy, services and system reform, Ms. Rosenberg is one of the nation's leading mental health experts. In 2004, Ms. Rosenberg was named President and CEO of the National Council for Community Behavioral Healthcare, a not-for-profit advocacy and educational association of 1,600 organizations that provide treatment services to 6 million adults and children with mental illnesses and addictions. Prior to joining the National Council in August of 2004, Ms. Rosenberg served as the Senior Deputy Commissioner for the New York State Office of Mental Health with an annual budget of nearly 4 billion dollars. Ms. Rosenberg had responsibility for New York's adult and child psychiatric hospitals as well as the states forensic hospitals and services. She tripled New York's assertive community treatment capacity; expanded children's community based services; developed an extensive array of housing options for people with mental illnesses and addictions; implemented a network of jail diversion programs including New York's first mental health court; and promoted the adoption of evidence based practices and consumer and family programs. A certified social worker, as well as a trained family therapist and psychiatric rehabilitation practitioner, Ms. Rosenberg has extensive experience in the design, implementation, and management of hospital and community psychiatric treatment and rehabilitation programs. Ms. Rosenberg has held faculty appointments at a number of Schools of Social Work, serves on numerous agency and editorial boards, and writes and presents extensively on the need for community services and the impact of organizational, financing, and service delivery strategies on continuity of care and consumer outcomes.

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may sometimes go from doctor to doctor for years and visit the emergency room repeatedly before someone correctly diagnoses their condition. This is unfortunate, because panic disorder is one of the most treatable of all the anxiety disorders, responding in most cases to certain kinds of medication or certain kinds of cognitive psychotherapy, which help change thinking patterns that lead to fear and anxiety.

Panic disorder is often accompanied by other serious problems, such as depression, drug abuse, or alcoholism. These conditions need to be treated separately. Symptoms of depression include feelings of sadness or hopelessness, changes in appetite or sleep patterns, low energy, and difficulty concentrating. Most people with depression can be effectively treated with antidepressant medications, certain types of psychotherapy, or a combination of the two.

Obsessive-Compulsive Disorder

People with obsessive-compulsive disorder (OCD) have persistent, upsetting thoughts (obsessions) and use rituals (compulsions) to control the anxiety these thoughts produce. Most of the time, the rituals end up controlling them.

For example, if people are obsessed with germs or dirt, they may develop a compulsion to wash their hands over and over again. If they develop an obsession with intruders, they may lock and relock their doors many times before going to bed. Being afraid of social embarrassment may prompt people with OCD to comb their hair compulsively in front of a mirror-sometimes they get "caught" in the mirror and can't move away from it. Performing such rituals is not pleasurable. At best, it produces temporary relief from the anxiety created by obsessive thoughts.

Other common rituals are a need to repeatedly check things, touch things (especially in a particular sequence), or count things. Some common obsessions include having frequent thoughts of violence and harming loved ones, persistently thinking about performing sexual acts the person dislikes, or having thoughts that are prohibited by religious beliefs. People with OCD may also be preoccupied with order and symmetry, have difficulty throwing things out (so they accumulate), or hoard unneeded items.

Healthy people also have rituals, such as checking to see if the stove is off several times before leaving the house. The difference is that people with OCD perform their rituals even though doing so interferes with daily life and they find the repetition distressing. Although most adults with OCD recognize that what they are doing is senseless, some adults and most children may not realize that their behavior is out of the ordinary.

OCD affects about 2.2 million American adults, and the problem can be accompanied by eating disorders, other anxiety disorders, or depression. It strikes men and women in roughly equal numbers and usually appears in childhood, adolescence, or early adulthood.[2] One-third of adults with OCD develop symptoms as children, and research indicates that OCD might run in families.

The course of the disease is quite varied. Symptoms may come and go, ease over time, or get worse. If OCD becomes severe, it can keep a person from working or carrying out normal responsibilities at home. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves.

OCD usually responds well to treatment with certain medications and/or exposure-based psychotherapy, in which people face situations that cause fear or anxiety and become less sensitive (desensitized) to them. NIMH is supporting research into new treatment approaches for people whose OCD does not respond well to the usual therapies. These approaches include combination and augmentation (add-on) treatments, as well as modern techniques such as deep brain stimulation.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, be irritable, become more aggressive, or even become violent. They avoid situations that remind them of the original incident, and anniversaries of the incident are often very difficult. PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or a kidnapping.

Most people with PTSD repeatedly relive the trauma in their thoughts during the day and in nightmares when they sleep. These are called flashbacks. Flashbacks may consist of images, sounds, smells, or feelings, and are often triggered by ordinary occurrences, such as a door slamming or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again.

Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer. In some people, the condition becomes chronic.

PTSD affects about 7.7 million American adults, but it can occur at any age, including childhood. Women are more likely to develop PTSD than men, and there is some evidence that susceptibility to the disorder may run in families. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders.

Certain kinds of medication and certain kinds of psychotherapy usually treat the symptoms of PTSD very effectively.

Social Phobia (Social Anxiety Disorder)

Social phobia, also called social anxiety disorder, is diagnosed when people become overwhelmingly anxious and excessively self-conscious in everyday social situations. People with social phobia have an intense, persistent, and chronic fear of being watched and judged by others and of doing things that will embarrass them. They can worry for days or weeks before a dreaded situation. This fear may become so severe that it interferes with work, school, and other ordinary activities, and can make it hard to make and keep friends.

While many people with social phobia realize that their fears about being with people are excessive or unreasonable, they are unable to overcome them. Even if they manage to confront their fears and be around others, they are usually very anxious beforehand, are intensely uncomfortable throughout the encounter, and worry about how they were judged for hours afterward.

Social phobia can be limited to one situation (such as talking to people, eating or drinking, or writing on a blackboard in front of others) or may be so broad (such as in generalized social phobia) that the person experiences anxiety around almost anyone other than the family.

Physical symptoms that often accompany social phobia include blushing, profuse sweating, trembling, nausea, and difficulty talking. When these symptoms occur, people with social phobia feel as though all eyes are focused on them.

Social phobia affects about 15 million American adults. Women and men are equally likely to develop the disorder, which usually begins in childhood or early adolescence. There is some evidence that genetic factors are involved. Social phobia is often accompanied by other anxiety disorders or depression, and substance abuse may develop if people try to self-medicate their anxiety.

Social phobia can be successfully treated with certain kinds of psychotherapy or medications.

Specific Phobias

A specific phobia is an intense, irrational fear of something that poses little or no actual danger. Some of the more common specific phobias are centered around closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs, and injuries involving blood. Such phobias aren't just extreme fear; they are irrational fear of a particular thing. You may be able to ski the world's tallest mountains with ease but be unable to go above the 5th floor of an office building. While adults with phobias realize that these fears are irrational, they often find that facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety.

Specific phobias affect an estimated 19.2 million adult Americans and are twice as common in women as men. They usually appear in childhood or adolescence and tend to persist into adulthood. The causes of specific phobias are not well understood, but there is some evidence that the tendency to develop them may run in families.

If the feared situation or feared object is easy to avoid, people with specific phobias may not seek help; but if avoidance interferes with their careers or their personal lives, it can become disabling and treatment is usually pursued.

Specific phobias respond very well to carefully targeted psychotherapy.

Generalized Anxiety Disorder (GAD)

People with generalized anxiety disorder (GAD) go through the day filled with exaggerated worry and tension, even though there is little or nothing to provoke it. They anticipate disaster and are overly concerned about health issues, money, family problems, or difficulties at work. Sometimes just the thought of getting through the day produces anxiety.

GAD is diagnosed when a person worries excessively about a variety of everyday problems for at least 6 months. People with GAD can't seem to get rid of their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. They can't relax, startle easily, and have difficulty concentrating. Often they have trouble falling asleep or staying asleep. Physical symptoms that often accompany the anxiety include fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, nausea, lightheadedness, having to go to the bathroom frequently, feeling out of breath, and hot flashes.

When their anxiety level is mild, people with GAD can function socially and hold down a job. Although they don't avoid certain situations as a result of their disorder, people with GAD can have difficulty carrying out the simplest daily activities if their anxiety is severe.

GAD affects about 6.8 million American adults, including twice as many women as men. The disorder develops gradually and can begin at any point in the life cycle, although the years of highest risk are between childhood and middle age. There is evidence that genes play a modest role in GAD.

Other anxiety disorders, depression, or substance abuse often accompany GAD, which rarely occurs alone. GAD is commonly treated with medication or cognitive-behavioral therapy, but co-occurring conditions must also be treated using the appropriate therapies.

Treatment of Anxiety Disorders

In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both. Treatment choices depend on the problem and the person's preference. Before treatment begins, a doctor must conduct a careful diagnostic evaluation to determine whether a person's symptoms are caused by an anxiety disorder or a physical problem. If an anxiety disorder is diagnosed, the type of disorder or the combination of disorders that are present must be identified, as well as any coexisting conditions, such as depression or substance abuse. Sometimes alcoholism, depression, or other coexisting conditions have such a strong effect on the individual that treating the anxiety disorder must wait until the coexisting conditions are brought under control.

People with anxiety disorders who have already received treatment should tell their current doctor about that treatment

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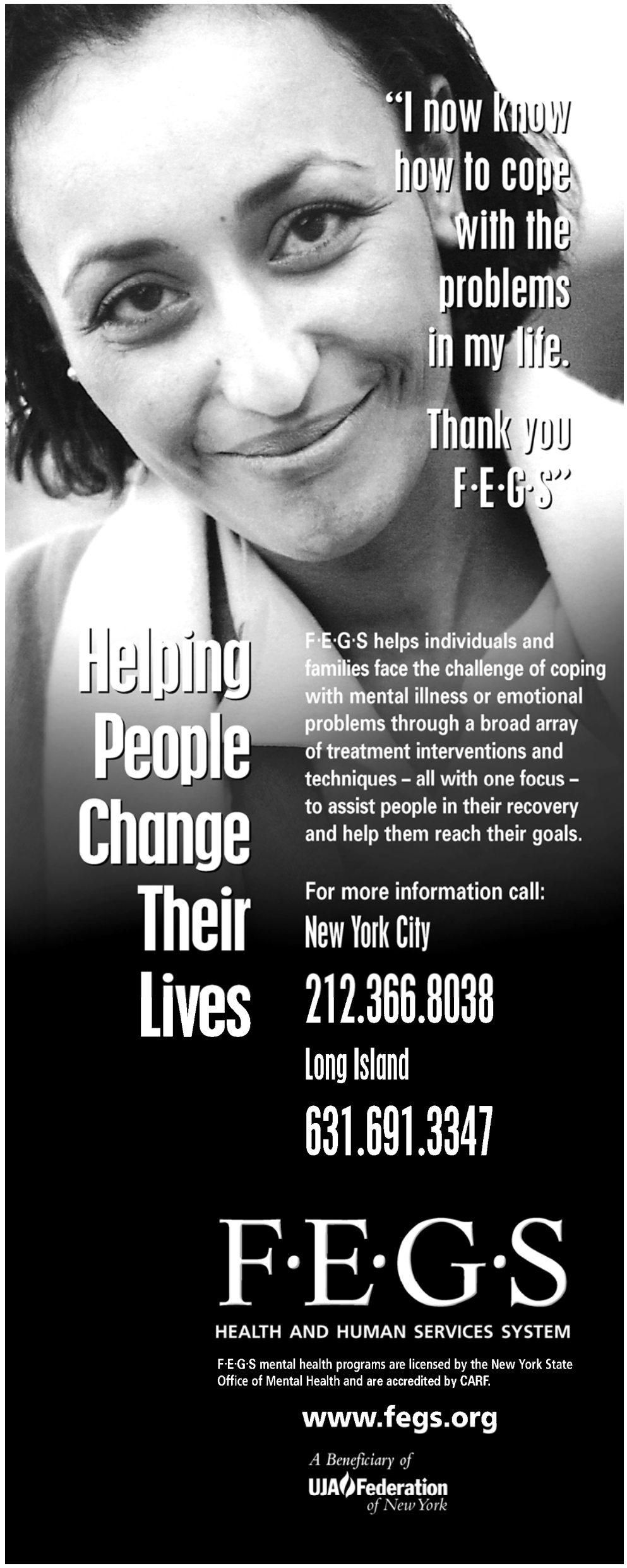

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in detail. If they received medication, they should tell their doctor what medication was used, what the dosage was at the beginning of treatment, whether the dosage was increased or decreased while they were under treatment, what side effects occurred, and whether the treatment helped them become less anxious. If they received psychotherapy, they should describe the type of therapy, how often they attended sessions, and whether the therapy was useful.

Often people believe that they have "failed" at treatment or that the treatment didn't work for them when, in fact, it was not given for an adequate length of time or was administered incorrectly. Sometimes people must try several different treatments or combinations of treatment before they find the one that works for them.

Medication

Medication will not cure anxiety disorders, but it can keep them under control while the person receives psychotherapy. Medication must be prescribed by physicians, usually psychiatrists, who can either offer psychotherapy themselves or work as a team with psychologists, social workers, or counselors who provide psychotherapy. The principal medications used for anxiety disorders are antidepressants, anti-anxiety drugs, and beta-blockers to control some of the physical symptoms. With proper treatment, many people with anxiety disorders can lead normal, fulfilling lives.

Antidepressants

Antidepressants were developed to treat depression but are also effective for anxiety disorders. Although these medications begin to alter brain chemistry after the very first dose, their full effect requires a series of changes to occur; it is usually about 4 to 6 weeks before symptoms start to fade. It is important to continue taking these medications long enough to let them work.

SSRIs

Some of the newest antidepressants are called selective serotonin reuptake inhibitors, or SSRIs. SSRIs alter the levels of the neurotransmitter serotonin in the brain, which, like other neurotransmitters, helps brain cells communicate with one another.

Fluoxetine (Prozac®), sertraline (Zoloft®), escitalopram (Lexapro®), paroxetine (Paxil®), and citalopram (Celexa®) are some of the SSRIs commonly prescribed for panic disorder, OCD, PTSD, and social phobia. SSRIs are also used to treat panic disorder when it occurs in combination with OCD, social phobia, or depression. Venlafaxine (Effexor®), a drug closely related to the SSRIs, is used to treat GAD. These medications are started at low doses and gradually increased until they have a beneficial effect.

SSRIs have fewer side effects than older antidepressants, but they sometimes produce slight nausea or jitters when people first start to take them. These symptoms fade with time. Some people also experience sexual dysfunction with SSRIs, which may be helped by adjusting the dosage or switching to another SSRI.

Tricyclics

Tricyclics are older than SSRIs and work as well as SSRIs for anxiety disorders other than OCD. They are also started at low doses that are gradually increased. They sometimes cause dizziness, drowsiness, dry mouth, and weight gain, which can usually be corrected by changing the dosage or switching to another tricyclic medication. Tricyclics include imipramine (Tofranil®), which is prescribed for panic disorder and GAD, and clomipramine (Anafranil®), which is the only tricyclic antidepressant useful for treating OCD.

MAOIs

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. The MAOIs most commonly prescribed for anxiety disorders are phenelzine (Nardil®), followed by tranylcypromine (Parnate®), and isocarboxazid (Marplan®), which are useful in treating panic disorder and social phobia. People who take MAOIs cannot eat a variety of foods and beverages (including cheese and red wine) that contain tyramine or take certain medications, including some types of birth control pills, pain relievers (such as Advil®, Motrin®, or Tylenol®), cold and allergy medications, and herbal supplements; these substances can interact with MAOIs to cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help lessen these risks. MAOIs can also react with SSRIs to produce a serious condition called "serotonin syndrome," which can cause confusion, hallucinations, increased sweating, muscle stiffness, seizures, changes in blood pressure or heart rhythm, and other potentially life-threatening conditions.

Anti-Anxiety Drugs

High-potency benzodiazepines combat anxiety and have few side effects other than drowsiness. Because people can get used to them and may need higher and higher doses to get the same effect, benzodiazepines are generally prescribed for short periods of time, especially for people who have abused drugs or alcohol and who become dependent on medication easily. One exception to this rule is people with panic disorder, who can take benzodiazepines for up to a year without harm.

Clonazepam (Klonopin®) is used for social phobia and GAD, lorazepam (Ativan®) is helpful for panic disorder, and alprazolam (Xanax®) is useful for both panic disorder and GAD. Some people experience withdrawal symptoms if they stop taking benzodiazepines abruptly instead of tapering off, and anxiety can return once the medication is stopped. These potential problems have led some physicians to shy away from using these drugs or to use them in inadequate doses.

Buspirone (Buspar®), an azapirone, is a newer anti-anxiety medication used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike benzodiazepines, buspirone must be taken consistently for at least 2 weeks to achieve an anti-anxiety effect.

Beta-Blockers

Beta-blockers, such as propranolol (Inderal®), which is used to treat heart conditions, can prevent the physical symptoms that accompany certain anxiety disorders, particularly social phobia. When a feared situation can be predicted (such as giving a speech), a doctor may prescribe a beta-blocker to keep physical symptoms of anxiety under control.

Psychotherapy

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, psychologist, social worker, or counselor, to discover what caused an anxiety disorder and how to deal with its symptoms.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is very useful in treating anxiety disorders. The cognitive part helps people change the thinking patterns that support their fears, and the behavioral part helps people change the way they react to anxiety-provoking situations.

For example, CBT can help people with panic disorder learn that their panic attacks are not really heart attacks and help people with social phobia learn how to overcome the belief that others are always watching and judging them. When people are ready to confront their fears, they are shown how to use exposure techniques to desensitize themselves to situations that trigger their anxieties.

People with OCD who fear dirt and germs are encouraged to get their hands dirty and wait increasing amounts of time before washing them. The therapist helps the person cope with the anxiety that waiting produces; after the exercise has been repeated a number of times, the anxiety diminishes. People with social phobia may be encouraged to spend time in feared social situations without giving in to the temptation to flee and to make small social blunders and observe how people respond to them. Since the response is usually far less harsh than the person fears, these anxieties are lessened. People with PTSD may be supported through recalling their traumatic event in a safe situation, which helps reduce the fear it produces. CBT therapists also teach deep breathing and other types of exercises to relieve anxiety and encourage relaxation.

Exposure-based behavioral therapy has been used for many years to treat specific phobias. The person gradually encounters the object or situation that is feared, perhaps at first only through pictures or tapes, then later face-to-face. Often the therapist will accompany the person to a feared situation to provide support and guidance.

CBT is undertaken when people decide they are ready for it and with their permission and cooperation. To be effective, the therapy must be directed at the person's specific anxieties and must be tailored to his or her needs. There are no side effects other than the discomfort of temporarily increased anxiety.

CBT or behavioral therapy often lasts about 12 weeks. It may be conducted individually or with a group of people who have similar problems. Group therapy is particularly effective for social phobia. Often "homework" is assigned for participants to complete between sessions. There is some evidence that the benefits of CBT last longer than those of medication for people with panic disorder, and the same may be true for OCD, PTSD, and social phobia. If a disorder recurs at a later date, the same therapy can be used to treat it successfully a second time.

Medication can be combined with psychotherapy for specific anxiety disorders, and this is the best treatment approach for many people.

How to Get Help for Anxiety Disorders

If you think you have an anxiety disorder, the first person you should see is your family doctor. A physician can determine whether the symptoms that alarm you are due to an anxiety disorder, another medical condition, or both.

If an anxiety disorder is diagnosed, the next step is usually seeing a mental health professional. The practitioners who are most helpful with anxiety disorders are those who have training in cognitive-behavioral therapy and/or behavioral therapy, and who are open to using medication if it is needed.

You should feel comfortable talking with the mental health professional you choose. If you do not, you should seek help elsewhere. Once you find a mental health professional with whom you are comfortable, the two of you should work as a team and make a plan to treat your anxiety disorder together.

Remember that once you start on medication, it is important not to stop taking it abruptly. Certain drugs must be tapered off under the supervision of a doctor or bad reactions can occur. Make sure you talk to the doctor who prescribed your medication before you stop taking it. If you are having trouble with side effects, it's possible that they can be eliminated by adjusting how much medication you take and when you take it.

Most insurance plans, including health maintenance organizations (HMOs), will cover treatment for anxiety disorders. Check with your insurance company and find out. If you don't have insurance, the Health and Human Services division of your county government may offer mental health care at a public mental health center that charges people according to how much they are able to pay. If you are on public assistance, you may be able to get care through your state Medicaid plan.

Ways to Make Treatment More Effective

Many people with anxiety disorders benefit from joining a self-help or support group and sharing their problems and achievements with others. Internet chat rooms can also be useful in this regard, but any advice received over the Internet should be used with caution, as Internet acquaintances have usually never seen each other and false identities are common. Talking with a trusted friend or member of the clergy can also provide support, but it is not a substitute for care from a mental health professional.

Stress management techniques and meditation can help people with anxiety disorders calm themselves and may enhance the effects of therapy. There is preliminary evidence that aerobic exercise may have a calming effect. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders,

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CUCARD from page 9

Mary be known in the classroom? Why isn't she speaking up?

Other things parents hear from teachers are, "Oh, he's so quiet, anything I ask him to do he does – he just does it automatically – I never have to worry about him." We then ask, "Why not?" What we know is, that kids suffer for two to seven years with anxiety disorders before they are even noticed. We want parents to pay attention to these subtleties that are mentioned by teachers. We don't want their kids to be jumping up and down in class being rowdy, but we want their teachers to know their voice and that they are there.

Q: What about kids that are terribly fearful of taking tests or exams?

A: The thing about school is that it is a wonderful diagnostic laboratory. Every day, kids have to go between eight in the morning until three thirty in the afternoon and through the course of their development they are bombarded with developmental challenges. They have to learn how to raise their hands, ask questions, get along with other kids, become part of the peer group, and how to negotiate multi-tasking. All of these things happen during the course of school and for the kids with anxiety, they are very clear about telling us time and time again, "I sit in school, I watch the clock, and I wait for the bell to ring." They are doing that with their stomach in knots, by trying to avoid eye-contact with the teacher, and they are making themselves as invisible as can be.

When a kid comes home and the parent asks "How was school today?" and the child just says "fine," parents really need to find out what that really means. It might mean "fine" because nobody bothered me, and that's something we don't want children to experience in that way.

Q: When many of us think about childhood disorders we think of childhood depression, anorexia and bulimia, self-mutilating disorders such as cutting, and of course substance abuse.

A: Here's the thing to know. Time and time again research in the United States, Europe and New Zealand has demonstrated that anxiety starts first. Typically, anxiety is the gateway disorder to these other conditions. The most famous and long-standing study here in the US, completed over 25 years ago by Dr. Peter M. Lewinsohn, is *The Oregon Adolescent Depression Project*. They started following kids from around 14 years of age and found that these kids had anxiety first, with depression then appearing in adolescence. Other groups have found the same pattern. The anxieties seem to start early, and as the child is unable to manage the anxiety, gates are open to other types of concerns that they might be vulnerable to that flood in. You see by 12 years of age in girls, that if they're not managing tough emotions, the risk of an eating disorders or a non-suicidal self-injury can set in. It appears that these manifestations can develop (especially for the non-suicidal self-injury) as a means to gain attention, but also as a way to regulate their emotions. In these cases there is a strong relationship to obsessive ideation and compulsion, which is anxiety based.

If a child has an anxiety disorder by the time they are fourteen or fifteen they are more likely to be developing major depression or a mood disorder – not necessarily of the bipolar type, but definitely in the realm of depression or dysthymia. Research has shown that if you have anxiety early (at around twelve to fourteen years of age), by the later years of adolescence, you see the substance abuse issue come into play. Kids learn that drinking, cigarette smoking, or marijuana use, are ways to relieve their anxiety and allow them to enter social situations that are otherwise difficult for them. Eventually that combination of anxiety, depression, and substance abuse, sets kids up for high-risk behaviors and suicide attempts. Suicide attempts usually occur in a state of high negative emotions and are a very impulsive act.

Q: Do you believe the roots of anxiety disorders in children are genetic in nature or are they learned in infancy through the parent infant interaction?

A: We do know that anxiety does tend to run in families. There are certain disorders such as panic disorder, the specific phobias, social phobia, and obsessive compulsive disorder, where you find high family aggregations. If a parent has panic disorder their child *will not* necessarily develop panic disorder. There is probably something genetic as well as environmental that both add up to put a child at higher risk for developing the disorder if the parent or the first degree relatives have the disorder.

The next thing we know is that just naturally, some kids are born with what is called an "inhibited temperament". We see this in infants where some are easy to soothe while others are difficult to soothe. The children with anxiety tend to be clingy, they don't explore their environment, and they have a tough time with new situations. What researchers have found is that children with these types of temperaments are at a higher risk for anxiety.

Kids are not growing up in test tubes; they are growing up in the world around them. One of the big things that has been demonstrated is that a certain type of parenting style will predispose a child to being more anxious than not. That is the over-protective, over-controlling parent. These parents believe that if the child struggles and doesn't get the positive results that they want, they will be damaged in some way or that they will miss out on incredible opportunities in life – and maybe it's true that they would. It is not necessarily inappropriate for the mother of a 5-year old girl who comes home saying, "The kids wouldn't play with me today" for the mother to try to facilitate the kids playtime the next day. However, if she is still doing that for her daughter when she is ten, then there are problems. There has to be a point where Mom helps the daughter figure out how to solve this problem, how to evaluate if perhaps these aren't the kids I should be playing with, and how to find new friends. Parents of anxious kids stay involved too long and typically continue to do the work for their child, and the kids never learn these sills on their own – skills like being in one group of kids and not another, that tests at school are challenging, and that teachers have different personalities that we may or may not be comfortable with.

One of the things we see quite often, especially with children who develop school refusal behaviors, is "demonizing" the teacher as being "too loud," "too strict" and such. The parents will then spend a lot of time trying to move the child from one class into another, move the child to other schools, and to the furthest extreme, ultimately home-schooling the child. We then try to tell the parents "Are you going to do this when they are adults – with their bosses?" Children have to learn to deal with all types of personalities while they are young.

Q: Do you find that many parents try to shield their children from stressful situations because they believe they are truly helping them?

A: Sure, absolutely, and this is a very important point. We don't blame parents. Anxieties begin so early in a child's life. Parents will tell you specific situations of how distraught and upset their child was in front of them because of some situation. The natural response of the parents is to soothe, reassure, and protect the child. It's not the child, but rather the anxiety that is present, that interacts with the parent's own anxiety about what's going to happen to their child. It becomes a vicious cycle of discomfort vs. overprotection, and before you know it the parent's don't know how to get out of it without a fear of harming the child if they stop intervening. By the time the child reaches adolescence some kids may become so anxious that when the parents do try to transfer control of the anxiety to them, the child will act-out in such a way that may put them in danger with a suicide attempt or something else that is terribly harmful.

Most parents are doing the best they can. At the clinic we believe that every child is different. And in families with many children - for the one or two that are experiencing anxiety - the parents may have to learn a different way of parenting that particular child, that doesn't come naturally to them. That is where the treatments that we have available for the children (depending on their age) will have more or less parent involvement. The parent involvement is geared to helping parents become coaches for the children to learn to use their anxiety coping skills. Also, and especially the older the children get, helping the child to meet developmental milestones that other kids their age are doing on their own. This is especially important for adolescents.

Q: Do you meet with the children individually at the clinic or only with the parents?

A: It depends on the age. Typically it is the child with the parent between the ages of three to six years of age, and then from age seven and older we do less child focused intervention and focus more on helping parents develop coaching techniques. By adolescence, we are trying encourage the teenager to be the person who is taking control of their own treatment. The parents and the teens are then brought together specifically around the issues relating to the parents role in being drawn into the teen's anxiety and maintaining it. We also bring the parents into the session when they are preventing the teen from taking on challenges such as making appointments with the college counselor, going to the doctor on their own, and other skills they need to master before going on to college.

Q: What kinds of issues do three and four year olds have to cope with?

A: We see obsessive compulsive disorders as early as three. We also see separation and social anxiety issues coming up, because so many parents who both work or are a single parent, having to leave their children in day-care at these young ages. We work to help the child to be comfortable being around other kids and being left in the care of people other than the parent in the day-care setting. Selective mutism is also a big issue which is the refusal of the child to speak outside the home. This is an important issue to resolve because kids need to be willing to verbalize their needs in the day-care setting when mom or dad isn't around.

Q: Let's talk about adult anxiety. When do you classify someone as adult – before college or during college?

A: That's a good question. There is a developmental psychologist at the University of Maryland by the name of Jeffrey Jensen Arnett, PhD, who has coined a new developmental stage called "emerging adulthood," which I fully agree with and work with on a clinical basis. The traditional classifications included children and adolescents. Then between ages 18 to 21, all of a sudden they were adults. What is the definition of an adult? It's an independent person who is working, taking care of all of their own needs, in a relationship, and so on. Well, that's not always happening between 18 to 21 years of age. In fact, more and more individuals are remaining dependent on their families into their late 20's and early 30's, and for many reasons.

When we look at the anxiety disorders and when depression is also involved, people are remaining dependent on their families as well as mental healthcare systems for support. Emerging adulthood is typically mid-adolescence around 15-16 years of age when they are supposed to be meeting certain developmental tasks, and it continues until these tasks are met, which could then take them into the mid 20's early 30's. These tasks involve managing your own emotional needs, your own financial needs, being in a job or actively working towards an occupation, being in and sustaining a meaningful relationship, and understanding and being secure in your identity.

We talk about milestones for babies – when they walk, when they talk, etc. People never really talked about the milestones for adolescents – and these are very important too. In the old way of looking at things, we thought that high school was getting you ready for college or for the workforce – one or the other – and from that point you were expected to be on your own. It doesn't really work that way. We have to pay more attention to young adults because they are not meeting these developmental tasks, and if they are it's over a longer period of time. There comes a point in time when there is an awareness that they are not keeping pace

see CUCARD on page 40

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with their peers. You often see depression and hopelessness setting in around this issue.

Q: When a young adult or someone even in their late 20's or early 30's suddenly suffers a major bout of depression – do you look at that as having its root cause in missed developmental stages from adolescence?

A: From the cognitive behavioral perspective we really want to understand the person's history. What have been the patterns that have brought them to this point of difficulty? What are the systems of support that they use, and how they use them – because maybe some of these systems have broken down? Or maybe these support systems have been less than helpful to them and they haven't realized it. What in the "here and now" is contributing to their problem?

Typically a breakdown involving a depressive episode or when panic attacks develop, isn't an all of a sudden thing. There has been a pattern that has been established. Our work is to help the individual at 28 or 30 understand that pattern and teach them how to develop a healthier way of coping. We help them recognize how they have avoided, escaped or used safety behaviors to keep them from having to deal with issues that are difficult for them.

Q: Or maybe they have been self-medicating for many years?

A: That could be. In alcohol treatment programs you find that after the person reaches sobriety their anxiety is roaring, because all those years they have been using alcohol to manage their anxiety. Something has broken down in their system of trying to manage their emotions that is not working for them anymore either because of their age, maybe a circumstance has changed, or something.

But the good news is that old dogs can learn new tricks. We work with adults who go all the way up the age spectrum. One of the most rewarding things is when we have individuals with agoraphobia who have been housebound or haven't gone outside the little radius of their neighborhood, and after working with them we receive postcards from places they are traveling to. When you release someone from that anxiety, they are able to get much more out of life.

When it comes to anxiety, we tell everybody that it is "the great liar." It has had you locked up and has actually minimized your world. By challenging your anxiety you then develop the freedom to make more choices for what you want to do as opposed to what you're afraid to do.

Q: Is this notion of challenging your anxieties something new?

A: Not at all.

Q: Is Cognitive Behavioral Treatment (CBT) the treatment of choice?

A: Absolutely. Across the board in research and clinical trials, CBT is effective for the anxiety disorders. It is the way to go, and it is built on a notion that has been around forever – you fall off the horse and you get right back on it. What CBT does differently from other forms of therapy is that it brings the horse right into the office. We take our patients out into the world as much as we can to face the things they are afraid of. We do not just do office work; we do a lot of exposure to the things people are afraid of in real time. It is through the actions of encountering what they are afraid of that they learn how they may have overblown (in their mind) how bad it would be – but mostly they learn they can manage it no matter how bad it is. This type of process is called "exposure." During this process the question the therapist asks the patient is, "how much, at what pace, and at what level of intensity are you comfortable or stressed out at?" This way there is a learning experience for them that they can manage themselves. It is not throwing somebody into the pool at the deep end to sink or swim – that is a myth. It is more like collaborating with the patient (even at the very young ages) about stressful challenges they are willing to take on, and working with them to do that.

Q: Didn't they used to call that therapeutic approach "systematic desensitization"?

A: Yes, it is built on the work of Dr. Joseph Wolpe who developed systematic desensitization – he's like one of our hero's and is the founding father of this approach.

Q: So if you are phobic of snakes (let's say) do you show the patient a picture of a snake?

A: Actually we don't do that anymore, we go right to the real snake. Certainly, if we are working with a very young child or if the anxiety level is so extreme we may first use a picture of the snake, but if possible we move as quickly as possible to get to the real thing. It has been found that for the phobias, you can treat them in about two and a half hours. A single session treatment of phobic disorders is pretty well established now for kids and adults.

Q: Can you comment on the average length of treatment for the anxiety disorders.

A: For the acute phase of anxiety disorders where we strive to get on top of the predominant symptoms such as separation, social, generalized anxiety, and OCD in about 15 sessions.

Q: Do you also prescribe medications to help people along with their anxiety disorders?

A: Our colleagues in Psychiatry do. We often see kids and adults who have been on medications or are currently on them, and we work with our psychiatrists and with the patients to maintain a stable medication regime if that is what they are on. The bottom line is that if they are coming to us, the medication hasn't done enough. We will work on reducing some of the anxieties the patients come in with and work to possibly taper the medications off, while working on how to manage their symptoms, and reducing their medication levels.

After the traditional 15 session course of treatment, patients will come to us under periods of high stress and we will do some booster sessions. In that sense it is not necessarily just a short term relationship but the acute beginning work certainly is.

Q: On the CUCARD website (www.anxietytreatmentnyc.org) you list that you treat a condition called Trichotillomania (TTM), a disorder that causes people to pull out the hair from their scalp, eyelashes, eyebrows, or other parts of the body, leading to noticeable bald patches.

A: Yes, we do see a fair amount of children with Trichotillomania (TTM) and some adults. They will pull eyebrows, the hair on their head, and sometimes the hair on their legs. We believe that this may be an "impulse control" disorder. Some kids will say "I feel good when I pull." Most people pull without being aware they are doing it. TTM is not treated directly as an anxiety disorder as such, but more as "habit reversal training" that helps an individual learn to be aware of everything from the motor movements to the emotions behind the pulling behavior. This gives them a way of substituting a competing response that is more beneficial to them than the pulling.

Q: With the soldiers returning from the battle, are you seeing a lot of PTSD in the clinic?

A: Because we are located in mid-town Manhattan we do not see that many veterans at our clinic – more I am sure at Columbia University Hospital which is located in uptown Manhattan, and at clinics closer to where returning soldiers live. However, we have worked with the NYS Office of Mental Health in developing approaches that focus more on helping the family "re-constitute" in adapting to a veteran that has returned home and is now living with their families. Veterans are mostly seen individually through the Veteran's Administration (VA) system, where as veterans, they are covered for all or most of these services.

Q: In closing, is there a message you would like to leave with our readers about anxiety disorders?

A: Yes, I would like to tell your readers that anxiety disorders are very treatable conditions, that there is a great deal that we can do to help them, and that they should never give up hope in dealing with their condition. In addition, I really want to thank *Mental Health News* for devoting an entire issue to anxiety disorders, and for helping the community better understand what anxiety disorders are all about.

Anne Marie Albano, Ph.D., is Associate Professor of Clinical Psychology in Psychiatry within the Division of Child and Adolescent Psychiatry at the New York State Psychiatric Institute/Columbia University College of Physicians and Surgeons, and Director of the Columbia University Clinic for Anxiety and Related Disorders. Dr. Albano received her Ph.D. in clinical psychology from the University of Mississippi and completed a postdoctoral fellowship at the Phobia and Anxiety Disorders Clinic of the Center for Stress and Anxiety Disorders at SUNY-Albany, under the mentorship of David H. Barlow, Ph.D. She has held past positions as the Assistant Director of the SUNY Phobia Clinic, Assistant Professor of Psychology at the University of Louisville, and the Recanati Family Assistant Professor of Psychiatry at the New York University School of Medicine.

In 2008, Dr. Albano received the Rosenberry Award in Behavioral Sciences, The Children's Hospital, University of Colorado at Denver, honoring her work with children, adolescents and families.

Among her professional activities, Dr. Albano is president-elect of the Society for Clinical Child and Adolescent Psychology of the American Psychological Association and is past president of the Association for Behavioral and Cognitive Therapies. She is an Associate Editor of the Journal of Consulting and Clinical Psychology and a past Editor-in-Chief of the journal Cognitive and Behavioral Practice. In March, 2010, Dr. Albano will co-chair with John Walkup, M.D., "Anxiety Disorders in Children: Integrating Research Into Practice", a full-day symposium sponsored by the Anxiety Disorders Association of America. She currently serves as a member of the ADAA Scientific Advirsory Board. Dr. Albano is a Founding Fellow of the Academy of Cognitive Therapy and a Beck Institute Scholar. She is board certified in Clinical Child and Adolescent Psychology.

Dr. Albano devotes her career to the study of anxiety and mood disorders in children, adolescents, and young adults. She has been a principal investigator on two of the largest clinical trials funded by the National Institutes of Mental Health, examining treatments for children and adolescents with anxiety and depression. In the Child/Adolescent Anxiety Multimodal Treatment Study (CAMS), 488 children ages 7 to 17 years with separation anxiety, social anxiety, and generalized anxiety disorders were treated with either cognitive behavioral therapy, medication, their combination, or pill placebo. Results indicated that all three active treatments were superior to pill placebo, with the combination treatment having the greatest advantage. These results tell us that anxiety in children and adolescents is highly treatable and that children do not need to suffer with these disorders (Walkup, Albano, et al., 2008, New England Journal of Medicine). Dr. Albano is also a member of the Treatments for Adolescents with Depression Study (TADS) Team, having served as a contributor to the TADS Cognitive Behavioral Therapy manual and also as a principal investigator for this monumental research study. The TADS results found that for adolescents ages 12 to 17, the combination of cognitive behavioral therapy and medication results the greatest response rate in recovery from moderate to severe depression, followed by medication alone (TADS Study Team, 2004, Journal of the American Medical Association). Cognitive behavioral therapy alone takes several weeks longer to reach an effect, suggesting that use of CBT alone in milder cases of depression is indicated as a first-line treatment. Overall, Dr. Albano's clinical and research careers have centered on developing and disseminating effective treatments for anxiety and depression in children, adolescents, and young adults.

As a teacher, Dr. Albano is actively engaged in the training of mental health professionals at the student and post-degree levels. She is a clinical supervisor at Columbia University for psychology interns and for residents and fellows in psychiatry, while also teaching within the post-degree continuing education program. Dr. Albano is a frequent invited lecturer around the United States and also abroad. In collaboration with Kimberly Hoagwood, PhD., Dr. Albano is the Director of clinician training and consultation for the Evidence Based Treatment Dissemination Center (EBTDC), a program sponsored by the NY State Office of Mental Health focused on training OMH clinicians in evidence based treatments.

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Hypothesis from page 28

twins, almost always both were affected. Similarly, with schizophrenia, there is a higher probability that affected parents will have affected children. These observations are consistent with the theory that abnormal micro-RNA could be a crucial link in the cause of autistic spectrum disorder and schizophrenia.

You might be wondering, "Can the abnormal micro-RNA account for the different clinical types of autism spectrum disorder and schizophrenia, and if so, how?" The answer to the first part is yes, and here's how. The time of onset and clinical course varies in each individual depending upon exact segments of micro-RNA that are involved and their degree of abnormality.

To explain this further, lets first look at severe, or "classical autism." Here the degree of abnormal micro-RNA is most severe, has its earliest, and its most pathological effects. These infants exhibit developmental delays from the earliest months of life. They do not gaze at their mothers, do not have smiling responses, remain mute, and are unable to modulate sensations (they appear deaf - then hypersensitive to sounds, do not react to painful stimuli - then become sensitive to the slight pressure of their clothes, etc.). They may not begin speaking until age four or five, or even later. Fortunately, in the majority of these cases, development recommences and they show later spurts of development.

In clinically defined "mild" or "high functioning" autism, speech and language may begin on time but develop slowly, and social relatedness and sensory motor modulation may be only slightly delayed. Here we postulate a milder degree of abnormality in their micro-RNA, with a greater chance of remission with age.

In the mildest form of autism, called Asperger's Disorder, speech and language and sensory-motor modulation usually develop on schedule, and are minimally affected. However, social relatedness lags and is prominent. "Social blindness" is the term we use to describe this main symptom. Here, we postulate that the abnormal micro-RNA developmental disturbance is the mildest, and impairs primarily just the parts of the brain that are involved in social relatedness.

In schizophrenia, as we pointed out before, a developmental spurt normally occurs in the frontal lobes during late adolescence. This is when abnormal micro-RNA does its damage. Instead of orchestrating normal growth and organization of the brain, the "on" and "off" switches malfunction, and the classic "positive" and "negative" symptoms of schizophrenia appear. For example, feelings may get blunted ("flattening of affect"), or misplaced ("inappropriate affect"), and sounds may be heard and body sensations felt when there are no external sources ("auditory and somatic hallucinations"). Also, internally generated optical sensations ("visual hallucinations"), and faulty reality testing ("psychosis") may occur. Attempts by such stricken individuals to explain these strange phenomena arising from within their brains would be interpreted as symptoms of madness.

As in autistic spectrum disorder, the severity of the micro-RNA abnormality determines the severity of the symptoms. If only mild disruption occurs, the clinical picture is called "schizo-affective" disorder. More serious disruption would lead to classic "paranoid", "hebephrenic", or "simple" types, and extremely abnormal micro-RNA could lead to the "catatonic" and "deteriorating" types.

Both autistic spectrum disorder and schizophrenia are known as "remittent" disorders because their natural history may show spontaneous improvements in certain cases. For example, it is well known that the majority of autistic children improve with age, and one third of schizophrenia patients are known to have only one episode and never relapse. This, we suggest, is due to the fact that developmental changes which get "switched off" can get "switched on" to re-establish normal developmental and coordination of developmental pathways.

Summary

To sum things up, we propose the following theory: The symptoms of autistic spectrum disorder and schizophrenia express abnormal development of the brain. This abnormal development is caused by abnormal micro-RNA programming. The degree of severity and clinical course of the disorders is determined by the segments of micro-RNA involved and their degree of abnormality.

Suggestions for Further Reading:

Ritvo, E. Understanding the Nature of Autism and Asperger's Disorder: Forty years of clinical practice and pioneering research. Jessica Kingsley Pub. London, 2006

John S Mattick, The hidden genetic program of complex organisms, Scientific American, Sept. 2004

Gregory Mauszek and Zohreh Talebizadeh, autism genetic database including autism susceptibility gene-cnv's integrated with known noncoding RNA's and fragile sites, BMC Medical Genetics, 2009. 10.102

Ritvo, R, Ritvo, E, Ritvo, M, Clinical Evidence that Asperger's Disorder is a Mild Form or Autism, Comprehensive Psychiatry, Volume 49, issue 1, Jan 2008 pp 1-5

If you are experiencing a difficult time in your life, always remember that you are not alone. There is a caring and helpful mental health community nearby that can help you get through this difficulty. Don't feel embarrassed or afraid to ask for help, it is not a sign of weakness. Best wishes, from Mental Health News.

Anxiety Disorders from page 36

they should be avoided. Check with your physician or pharmacist before taking any additional medications.

The family is very important in the recovery of a person with an anxiety disorder. Ideally, the family should be supportive but not help perpetuate their loved one's symptoms. Family members should not trivialize the disorder or demand improvement without treatment. If your family is doing either of these things, you may want to show them this booklet so they can become educated allies and help you succeed in therapy.

The Role of Research in Improving the Understanding and Treatment of Anxiety Disorders

NIMH supports research into the causes, diagnosis, prevention, and treatment of anxiety disorders and other mental illnesses. Scientists are looking at what role genes play in the development of these disorders and are also investigating the effects of environmental factors such as pollution, physical and psychological stress, and diet. In addition, studies are being conducted on the "natural history" (what course the illness takes without treatment) of a variety of individual anxiety disorders, combinations of anxiety disorders, and anxiety disorders that are accompanied by other mental illnesses such as depression.

Scientists currently think that, like heart disease and type 1 diabetes, mental illnesses are complex and probably result from a combination of genetic, environmental, psychological, and developmental factors. For instance, although NIMH-sponsored studies of twins and families suggest that genetics play a role in the development of some anxiety disorders, problems such as PTSD are triggered by trauma. Genetic studies may help explain why some people exposed to trauma develop PTSD and others do not.

Several parts of the brain are key actors in the production of fear and anxiety. Using brain imaging technology and neurochemical techniques, scientists have discovered that the amygdala and the hippocampus play significant roles in most anxiety disorders.

The amygdala is an almond-shaped structure deep in the brain that is believed to be a communications hub between the parts of the brain that process incoming sensory signals and the parts that interpret these signals. It can alert the rest of the brain that a threat is present and trigger a fear or anxiety response. It appears that emotional memories are stored in the central part of the amygdala and may play a role in anxiety disorders involving very distinct fears, such as fears of dogs, spiders, or flying.

The hippocampus is the part of the brain that encodes threatening events into memories. Studies have shown that the hippocampus appears to be smaller in some people who were victims of child abuse or who served in military combat. Research will determine what causes this reduction in size and what role it plays in the flashbacks, deficits in explicit memory, and fragmented memories of the traumatic event that are common in PTSD.

By learning more about how the brain creates fear and anxiety, scientists may be able to devise better treatments for anxiety disorders. For example, if specific neurotransmitters are found to play an important role in fear, drugs may be developed that will block them and decrease fear responses; if enough is learned about how the brain generates new cells throughout the lifecycle, it may be possible to stimulate the growth of new neurons in the hippocampus in people with PTSD.

Current research at NIMH on anxiety disorders includes studies that address how well medication and behavioral therapies work in the treatment of OCD, and the safety and effectiveness of medications for children and adolescents who have a combination of anxiety disorders and attention deficit hyperactivity disorder.

CBT from page 18

see himself and his relationships more accurately and positively, and notice an improvement in the way he felt.

JBFCS clinicians have found that CBT has been very effective in helping clients of all ages better manage their anxiety and function more effectively. As the case studies indicate, CBT can be used in individual and group therapy and in several different treatment settings. JBFCS plans to continue to build its capacity to provide the most effective evidence-based CBT treatments for anxiety and other disorders.

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Author Bios

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Sararivka Liberman, LCSW-R, has been a psychotherapist for over 26 years, and has run short-term CBT groups since 2002. For the past 19 years, she has provided supervision and training to mental health professionals in community settings. She currently serves as the Administrative Supervisor at the Boro Park Clinic of JBFCS, and is a Master CBT Trainer for the Martha K. Selig Educational Institute. She maintains a private practice for adults in Brooklyn.

Susan Trachtenberg Paula, Ph.D. is a psychologist and director of the cognitive-behavioral training program at JBFCS's Martha K. Selig Educational Institute. She specializes in CBT for children and evidence-based trauma treatments for children and adults.

Postpartum from page 14

have been detected at very low levels or below the threshold for detection when infant blood levels have been measured and in general infants whose mothers have taken SSRIs and other related medications have tolerated it well. Of course any decision regarding taking medication should involve a discussion with the treating clinician to address the specific considerations for that person. For women who have OCD and are planning for a pregnancy or who discover they are pregnant, careful consideration needs to go into the decision whether to continue medication through pregnancy. The data about the specific medication needs to be weighed against their history and severity of illness off medication. Although there is substantial awareness about the potential side effects of medications, there is less appreciation for the impact of maternal stress and anxiety on the developing fetus and on the pregnancy. Untreated OCD during pregnancy is also a risk factor for postpartum depression as well. Some women do well off medication during pregnancy but may experience an exacerbation post partum. Optimally the women with a diagnosis of OCD will take the opportunity to consider her options and preferences in advance of becoming pregnant while medication reduction or changes can be considered and when CBT skills and other therapy can be introduced if this had not been done before.

In Ms. J.'s case she had weaned her baby and wanted to start medication along with therapy. She had a trial of paroxetine that helped reduce her overall anxiety level and made it easier for her to implement ERP to fight back against the OCD symptoms. Even once her symptoms had subsided significantly she felt discouraged and somewhat sad about the experience she had had in the early months of motherhood. Ms. J. was an accomplished person who set high standards for herself and believed that if she worked hard, she would be successful. Prior to becoming a mother she had determined that anything short of perfection was not acceptable. As a new mother, however, she was confronted with the reality that no amount of reading or preparing guaranteed that she would always have the baby satisfied or her home under control. The intrusive thoughts she was having amplified the belief that she was failing as a mother. Addressing these beliefs helped her gain confidence and pleasure in her new role.

In recent years, celebrity memoirs and media attention have focused attention on postpartum depression. Even now, 15 years since I met Ms. J peri-natal anxiety disorders go unrecognized by many individuals. This is unfortunate because of the toll that untreated anxiety disorders takes on the woman as well as on her entire family. Hopefully with increased awareness, more women and their families will realize that there is help for these conditions as well.

Serve and Pierre from page 28

where he did not receive the best of care. However, he was safe. He had a room, meals, and financial help through social security. At the end of ten years he enrolled at The Bridge, a wonderful multi-service program on the Upper West Side of Manhattan. He changed medications and became an active member of the agency's Art Group.

Back again in France, it was impossible to locate Pierre for many years. His mother then learned Pierre had been discharged from a hospital near Paris and was going to the South of France on foot to look for a job when he was hit by a truck and killed in the village of Sens. His mother was surprised and shocked to receive the tragic news about her son's death. He never would have been identified had the receipt for a French National ID Card application not been found in his pocket.

Pierre's mother and I compared laws concerning the treatment and care of the mentally ill here in New York and in France. The differences are significant. In France the rights of the mentally ill are virtually nonexistent. Lack of follow-up after hospitalization and no government support for housing or living expenses make consumers vulnerable to following their "voices". Guy and I planned to move back to France after our retirement, but our son's mental illness made us change our plans. We are happy to live in a country where the mentally ill receive support. Had he lived in New York, Pierre may not have died so tragically.

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Inpatient Suicide from page 13

occurred within the hospital, significant environmental changes were made and the rates dropped – this was a major achievement. How to systematically lower post-discharge suicide rates is far more difficult to imagine; yet real data on frequency compels us to address this more sizeable challenge. As we attempt to meet this challenge, in an age of limited resources, it will be important to weigh the benefits of purchasing and building increasingly sophisticated environmental safety elements against the costs of enhancing the skills of staff who provide programs and aftercare.

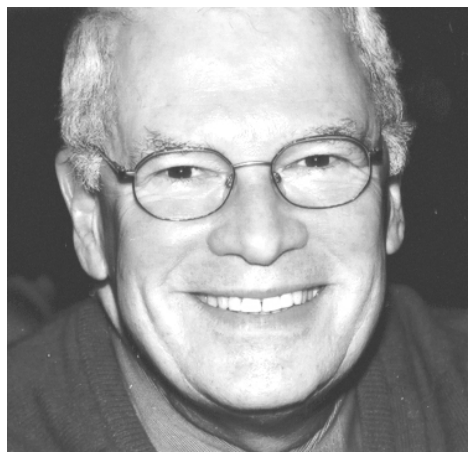
In conclusion, the OMH report makes clear that more than 2 decades of effort have made our inpatient units far safer. These gains are the result of concerted and collaborative efforts among governmental agencies, hospitals, and the professional teams providing direct care to our patients. While no system should "rest on its laurels," the mental health care system in NYS has done a remarkable job of driving down the number and probability of inpatient suicides. Persons admitted to our hospitals have every reason to believe they are in a safe place. All who worked to realize these goals should feel justifiable pride in what has been accomplished.

Barry B. Perlman, M.D. is Director, Dept. of Psychiatry, Saint Joseph's Medical Center, Yonkers, New York. Virginia L. Susman, M.D. is Associate Medical Director & Site Director, New York Presbyterian Hospital, Westchester Division.

Rust of Life from page 1

Can Corrosive "Rust" Be Stopped?

Prior to ascertaining what type of intervention is appropriate, two questions have to be considered. First, is the anxiety specific to a current stressful situation or situations? And second, is the anxiety more generalized and diffuse experienced most of the time, as in generalized anxiety disorder (GAD)? Situation specific anxiety has a better prognosis than the longer term generalized anxiety disorder. Therefore, an accurate diagnosis of the presenting problem(s) is important. Treatment is available in both cases, and in two forms, psychotherapeutic and psychopharmacological, or a combination of both. Cognitive behavior therapy is effective when the person is going through a particularly stressful time and does not have the requisite cognitive skills to cope with life stressors. Examples would be the death of a love one, divorce, loss of a job, etc. In this case the symptoms are usually of a transient nature and will slowly diminish as life circumstances begin to improve. Highly skilled cognitive-behavioral therapists have at their command many types of evidenced based treatments and interventions to aid their clients recover from the debilitating effects of



Robert M. Lichtman, PhD

traumatic events. When people are overwhelmed by their symptoms it may be difficult for them to concentrate on cognitive-behavioral interventions alone. At that point it may be indicated to refer the client to a psychiatric colleague for a prescription of an anti-anxiety medication. When there are concomitant symptoms of depression, as there are in many cases an anti-depressant may be the treatment of choice. A few of the newer anti-depressants are also effective in treating the anxiety that often accompanies depression. The treating psychiatrist and the client will usually make that decision based upon the presenting symptoms. The literature shows that in many cases a combination of psychotherapy and psychopharmacology will yield the best outcomes.

Generalized Anxiety Disorder (GAD)

Generalized anxiety disorder as a diagnosis contains the word "generalized," which presents a more complex clinical picture. The client with this diagnosis may report that their anxiety is more diffuse and general, out of proportion to the normal pressures of life. Whereas anxiety at low levels may be adaptive, these clients experience it at a level that is maladaptive, and associated with pessimism and negative self-evaluation. Treatment usually consists of relaxation training and cognitive therapy. Clients can learn to recognize the faulty logic behind their worry and rumination. Another method is to have the patient consider the worst case scenarios, which helps them to identify exaggerated worry. This is known as decatastrophisizing. Psychopharmacological interventions usually rely on SSRIs as the first line treatment for anxiety disorders, as they have similar therapeutic benefits to anti-anxiety medications and fewer side effects. SSRIs are preferred over anti-anxiety medications due to the latter's serious problems with addiction and withdrawal once the client discontinues use. There is one other medication to consider, BuSpar, which affects serotonin transmission and is used in the treatment of generalized anxiety disorder. Responses to this medication vary greatly and remain inconclusive.

The clinician must also be aware of clients' tendencies to self-medicate with readily available legal and illegal drugs. It is not uncommon for clients to present with comorbid anxiety and substance use disorders.

In conclusion, we are all faced with stressful life events, yet some of us due to particular vulnerabilities are prone to develop these disorders and fall prey to "anxiety, the rust of life."

Robert M. Lichtman, PhD, LMHC, CASAC, FAPA, is an Adjunct Associate Professor in the Department of Forensic Psychology at John Jay College of Criminal Justice. He is a Clinical Member of the American Association for Marriage & Family Counseling, and a Fellow of the American Psychotherapy Association. He specializes in Relationships, Mental Illness & Substance Abuse, Forensics, Terrorism, Violence & Aggression.

Journey from page 16

- "Mostly, I am so tired of feeling this way. I don't know what to do to make it go away. I am afraid to be afraid. It drains me of joy and makes my world dull."

- "I am so sick of this never ending battle. The saga continues . . . Fine for awhile and then fear and anxiety return . . . for absolutely no reason. There seems to be no lasting peace. Ever since the April episode, the adrenaline rushes must have sensitized my nerves because now every time I lay down to go to sleep, the slightest noise (internal or external) sets off a fear flash – the kind you feel when someone sneaks up behind you and says "boo." I have to remind myself to do deep abdominal breathing. My thoughts are rambling and negative. It's so tiring to be on guard all the time, so inner focused. When I'm distracted or physically active, I'm better – much better – when I'm alone and quiet, it's worse. Everything I read tells me to accept the symptoms and let them come and go at will. That's easier said than done. I often feel sad. What a waste of precious time this all is!"

I realized my life was out of control again. "How did I get this way?" "When did I get so scared?" and "How can I be me again?" were questions I asked myself over and over. Although I understood my illness, I couldn't make it go away.

Panic/anxiety disorder requires a great deal of energy. Left unchallenged, it's like weeds in a flower garden. Pretty soon, there are all weeds and no flowers. I had forgotten how to have fun, how to hope, how to dream. There was no time to think of such things or energy to do them. I was too busy trying to appear "normal." I was acting again, going through the motions, living on the outside of my own life.

There are all kinds of factors that contribute to panic/anxiety disorder. Chemical imbalance, wayward hormones, genetics, personality, and stress all play a part. What was rarely discussed twenty years ago seems to have become the illness of an entire generation. The condition I worked so hard at hiding has become the catch all diagnosis for stressed out people everywhere.

I am now enjoying my recovery. It took over seven months of counseling and big changes in how I think and what I think about. It was hard and it was uncomfortable. Sometimes the symptoms show up just to see what I'll do. I have learned that when you don't feed fear, it goes away. Still, I have a long way to go and don't take recovery for granted. One of my last journal entries marks the distance I have traveled:

- "After 7 ½ months of seeing Dr. A, he discharged me with the reassurance that I could call him if the anxiety ever gets out of control again. When I first went to see him I was a mess. Fear thoughts, sadness, hopelessness much of the time. I felt numb and passionless. I had no goals. It was all I could do to get through the day with my normal face on and get home. Maybe struggling to put up a normal façade was a good thing – it kept me from wallowing in my negativity at least part of the time. But it was a joyless and fearful existence. Things are better now."

It took well over twenty years to find myself in the middle of my own life. It's a pleasure to be here.

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Fall 2010 Issue:
"Mental Health Services for Children and Adolescents"
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Summer Program from page 27

achievement; following through on instruction and completing tasks; and developing individual competence and self esteem.

The SIMHS STP model Point System is based on a systematic reward/response cost program and includes: verbal positive reinforcement, daily report cards taken home, and time-out techniques such as loss of privileges or participation in ongoing activities. Each child's individually tailored program is based on his or her strengths and treatment goals.

From the child's perspective, every day is filled with a variety of fun-filled activities including sports, group trips, and arts and crafts, each integrated with academic, remedial, and therapeutic goals. Each individual or group activity, behavior, or interaction - designed to be fun for the child - is the material to be reinforced or discouraged by the SIMHS STP staff, according to social learning principles as delineated in the evidence-based curriculum.

By summer's end, the children have made good friends and good memories, have a head start on the coming fall school routine, and are meeting their emotional challenges with more confidence.

How We Measure Dysfunction and Improvement

The unique aspect of our work measuring the effectiveness of our services conceptualizes each child's level of functioning, not as a single condition, to be successfully treated or not. Rather, using the Conners' Rating Scales (1989), the major types of behavioral problems exhibited by each child are able to be differentiated through factor analyses.

At the Staten Island Mental Health Society, the Conners' Scales are routinely administered to all children receiving outpatient or day treatment services. The scale scores help us formulate treatment plans and measure improvement for each child, on an ongoing basis.

What We Measured

The seven scores that the child received, as a result of his or her group counselors completing the Conners' Teacher Questionnaire at the beginning of the summer, were compared with the seven scores similarly obtained at the end of the summer. The same counselor rated each child at the beginning and end of the summer program.

The Conners' Teacher Rating Scales allow each child's score to be converted into AT-scores,@ with a mean of 50 and a standard deviation of 10. There were 155 individual children who attended the STP during the summers of 2008 and 2009, when the evidence-based curriculum was utilized. There were 114 children who attend the STP in 2000, several years before the evidence-based curriculum was introduced.

Our Findings

Using the Evidence-Based Curriculum: Pairs of Conners' Teachers Scales were available for 155 children who attended the SIMHS STP during the summers of 2008 and 2009. For six of the seven factors, there was a significant decrease between the scores obtained at the beginning of the summer as compared to the scores obtained at the end of the 33-day summer program. (See Table One Below)

Non-Evidence-Based Curriculum: The 114 children who attended the SIMHS STP during the summer of 2000 attended a program, which while considered "therapeutic" did not use an evidence-based curriculum. Pairs of Conners' Teachers Scales derived from scores obtained at the beginning and end of the summer for 114 children who attended the SIMHS STP during the summer of 2000 showed not one significant change in the scores of any of the seven factors. (See Table Two Below)

What Do the Results Mean?

The Staten Island Mental Health Society has been providing a Summer Therapeutic Program for 25 years for children diagnosed as seriously emotionally disturbed. During the summers of 2008 and 2009, an evidence-based curriculum was integrated into the program.

The effectiveness of using the evidence-based program was measured by using the Conners' Teacher Rating Scales at the beginning and end of the summers. Similar measures were obtained for children attending the Summer Therapeutic Program in a year prior to when the evidence-based program was utilized.

Using the Conners' Teacher Scale as a measure of the children's functioning, the evidence-based curriculum was associated with significant improvement in the children's functioning on six of the seven Conners' measures. There was no improvement shown on any of the Conners' measures during the summer prior to when the evidence-based curriculum was used.

Families seeking services for their children with severe behavioral dysfunction rely on community-based providers of children's mental health services. While from the children's perspectives, they are attending a fun-filled program with sports and crafts, using an evidence-based curriculum, the program has evolved into a highly effective community resource.

Kenneth Popler, PhD, MBA, ABPP, a clinical psychologist, is the President and Chief Executive Officer of the Staten Island Mental Health Society, an organization that provides mental health and related services to Staten Island children and their families.

Table One

Changes in Conners Teachers Scores (N'155) for Children Participating in a Summer Therapeutic Program Using an Evidence-Based Curriculum
(* Student's t-Test, paired, Two-tailed distribution)

	First Conners	Last Conners	
Variable	**Mean**	**Mean**	**p(2 tail)***
Hyperactivity	59.23	56.42	0.00035
Conduct Problem	60.72	59.32	0.19657
Emotional-Overindulgent	64.14	61.44	0.01119
Anxious-Passive	54.88	51.48	0.00009
Asocial	58.17	54.38	0.00004
Daydream-Att Problem	59.05	55.38	0.00007
Hyperactivity Index	60.39	58.19	0.01835

Table Two

Changes in Conners Teachers Scores (N'114) for Children Participating in a Summer Therapeutic Program Not Using an Evidence-Based Curriculum
(* Student's t-Test, paired, Two-tailed distribution)

	First Conners	Last Conners	
Variable	**Mean**	**Mean**	**p(2 tail)***
Hyperactivity	59.05	59.89	0.31733
Conduct Problem	63.03	65.05	0.08503
Emotional-Overindulgent	63.01	64.42	0.18424
Anxious-Passive	51.36	50.39	0.31359
Asocial	55.23	55.79	0.61846
Daydream-Att Problem	54.19	55.15	0.33114
Hyperactivity Index	59.83	61.18	0.16076

Marcy from page 7

in understanding their illnesses and how to overcome the problems that often led them into conflicts."

An additional, 60-bed RMHU is tentatively scheduled to open at Five Points Correctional Facility in Seneca County in the 2011-12 State fiscal year.

DOCS and OMH will phase inmates in at the RMHU at Marcy, beginning with seven who arrived today. Each inmate-patient requires an orientation from both DOCS and OMH staff. Every employee who works in the RMHU received seven days of specialized training from OMH and DOCS prior to the unit's opening.

All correction officers working at DOCS receive training on mental illness and suicide prevention. In addition, all facility superintendents, deputy superintendents, and others who serve as disciplinary hearing officers receive training on a variety of topics involving people with mental illness.

The RMHU aims to transition its participants back into the general prison population or another prison-based mental health program where the inmate can function effectively.

The RMHU builds on 15 years of enhanced services for inmates with mental illness. During that time, DOCS and OMH significantly increased the number of employees and mental health units for inmates with mental illness. Both agencies have collaborated to create additional specialized services for inmates with disciplinary confinement sanctions, and the agencies provide a host of other treatment modalities that offer the level of mental health services each inmate requires based on his or her needs.

The commitment by DOCS and OMH to provide appropriate treatment and services to the mentally ill is embodied in more than 2,000 specialty beds for inmates with mental illness. In addition, beginning in December 2007, OMH began screening every inmate entering prison for mental health needs and providing immediate care as warranted.

The new RMHU building at Marcy, whose design and construction was managed by the Office of General Services under DOCS' direction, was awarded "Silver" level status by the U.S. Green Building Council. It is the first building in an American correctional facility setting to reach LEED-NC 2.2 status, which signifies the highest level of energy efficiency, conservation and environmental preservation of a correctional building in the nation to date. The new building was credited for a projected 26 percent energy use reduction compared to a baseline energy code-compliant building, including a projected 24 percent water use reduction and the utilization of refrigerants containing no ozone-depleting chemicals, recycled materials for 33 percent of all building content, and low volatile organic compound-emitting carpeting, adhesives, sealants and paint.

The RMHU represents the commitment by DOCS and OMH to provide appropriate and meaningful care and treatment to inmates with serious mental illness while maintaining the safety and security critical to the operation of New York's State correctional facilities.

NYSPI from page 8

You will have them not wash their hands afterwards and ask them to touch themselves and things in their home and to imagine that they will get horribly ill and die. The point is for them to discover that their fear of dying is an irrational fear but you do this by having them imagine the worst. So even though in both cases this therapy is called CBT, well-tailored treatment actually takes the differences between these disorders into account.

The ultimate question in understanding anxiety disorders is, "Are they different at the brain level?" There are some suggestions that there are both similarities and differences among the disorders, and that's the way I think about them. My brain allows me to speak to you today. If I had obsessions and compulsions, my brain would be causing that. Therefore, my brain is doing something abnormal. If I don't have obsessions and compulsions, then my brain isn't doing that abnormal activity. I believe that the differences in the phenomenology between the disorders may actually be due to certain differences in the brain mechanisms underlying these disorders, but they may be small or large differences, and the bottom line is that we do not know yet.

Q: When somebody comes in for treatment, are they aware of what the problem is? For example, do patients comes in for their first appointment and immediately say, "I am terrified of leaving my house," or, "I can't stop washing my hands"? Do they usually come in with these exact complaints or do they present in some other way?

A: We see everything. We see people with OCD who don't know what they have. Many are terribly ashamed of their symptoms because they don't realize what it is. People with OCD have obsessions and compulsions, but the content of their obsession and compulsion can really vary. In one version of OCD people have intrusive fears that they may do something bad or might even have intrusive images of doing something bad - really bad things like killing their mother - which these people don't want to have at all. In the past, people really thought these were their real desires and were afraid to tell anyone about them because they were so awful. Back in 1996 our clinic was often diagnosing OCD in patients who knew they were depressed and knew they felt anxious, but didn't really know what was going on with them. They were often terribly relieved to learn that there was a name for these awful thoughts (i.e., OCD), that other people had thoughts like this, and that there was treatment.

Today, there has been an enormous shift which I credit to publications like *Mental Health News*, public education campaigns, and the internet, that have been very helpful in providing useful information about anxiety disorders. More people come to us today who have actually done a lot of research on their own to try to understand what's going on for them. They will come in to our clinic and say that they think they have OCD or PTSD and so on. The self-diagnosis is not always correct, but there is a lot of information that helps people overcome their fear and anxiety about seeking help.

It's really important for clinicians in the field to understand that anxiety disorders may lie below the surface of some of the more overt conditions they see in their patients – such as depression for example. If they are seeing anyone with depression, they should ask their patients about anxiety in a very detailed and clear way, because they often go hand-in-hand. The notion that the depression is more important than the anxiety "so let's only treat the depression" is a mistake. Anxiety can be horribly severe and incredibly debilitating, and it can be present with depression, schizophrenia, bipolar disorder and so on. OCD can also be found alongside Autism Spectrum Disorders. We tell the residents at Columbia University Hospital to be aware of anxiety disorders when they are seeing anyone with mental health problems.

The National Comorbidity Study (NCS) done in the U.S. by Ron Kessler up at Harvard, as well as many collaborators, gave us some of the best data we have on the prevalence of psychiatric disorders. If you add up all the anxiety disorders, the lifetime prevalence is 29%. That means that almost a third of all adults in the US have an anxiety disorder. Now 12% of these adults have specific phobias. Often, people make light of this diagnosis. Certainly, if you have a fear of snakes and you live in NYC, it isn't usually a big deal. However, I have colleagues who are afraid to fly and can't get on a plane to attend conferences in other cities or who would be unable to fly to see a sister as she is dying. They have to take a train to get across the country or get on ocean liners to go to Europe.

I saw a woman in the hospital who had a pill phobia. I met her on the cardiac transplant unit where she was being treated for end-stage congestive heart failure. She was on the waiting list for a heart transplant when an observant nurse on the unit noticed that she wasn't swallowing the pills they were giving her. That led to them calling in a psychiatric consultation which determined that the woman had a pill phobia her entire life and had never actually taken any of the pills that had been given to her all along. No one had ever detected it or intervened, and now she was in end-stage heart failure because she had not taken any of the heart medicines that were prescribed for her years earlier. So the lesson here is that specific phobias (which many people dismiss) can actually be quite disabling.

The NCS pointed out that Social Anxiety Disorder is one of the next most common anxiety disorders. These are people who usually do not make trouble for the world because of their tremendous social inhibitions. However, they are people who can't advance in their life because of their terrible social anxiety. OCD, on the other hand, is the least prevalent anxiety disorder at maybe one to two percent. However, 50% of OCD cases are severe and 35% of the cases are moderate, and they have a typically chronic waxing and waning course with half the cases of OCD starting by the age of 19. So if you add all that up: chronicity, prevalence, and severity, you can see that OCD is one of our most disabling mental illnesses that get people off track early in life. Once off track, it is very difficult to get them back on. The point is that anxiety disorders can range in their severity. What keeps me motivated is my belief that these are disorders we should be able to treat, and when you can treat people with these disorders, they can go on to live full and satisfying lives. When it works, treatment can transform a life.

Q: Are anxiety disorders a hallmark of all the other mental illnesses, and do they have their roots in childhood?

A: Yes, many of our anxiety disorders start in childhood and adolescence, such as specific phobias, separation anxiety, OCD, social anxiety disorders, and generalized anxiety disorder (which used to be called the over-anxious disorder of childhood). PTSD is the one disorder that requires a specific environmental event or trauma to trigger it, so it can unfortunately happen to anybody at any time. The data show that when any of these appear early in life, our normal development can become derailed.

We all go through different stages in our life. All of us go through a cycle of life that includes important things we learn in childhood and in adolescence. In young adulthood we usually master our autonomy from our family of origin, figure out our new partner, and our career path. Imagine how having any of these anxiety disorders in childhood or adolescence might disrupt one's normal developmental milestones. For example, someone with a social anxiety disorder who never dates in high school and has very few friends arrives into their 20s without important social skills that most of us have learned by that point. It's a terrible problem with OCD when people hide their OCD from others in the world around them. Maybe that person can make it to college, but they don't make it through college – or maybe they don't make it from moving out of their parent's house.

I met a 39 year old woman who had never dated in her life. Now, she's seeing all of her friends married with children. Today, she understands her OCD and her symptoms, has been treated, and is doing much better overall in her life. However, she looks at her life and realizes that she is in a job that she doesn't like because she didn't dare take promotions because of her OCD. She has never dated, and the likelihood of her ever becoming married and having children is now very low. These losses are very difficult to give back to people. The more I work with adults, the more I have a sense of the importance of treating anxiety disorders early, when they appear in childhood and adolescence.

The ultimate question is whether we can actually prevent these disorders if identified and treated early. Through early detection and intervention, can we prevent people from having an anxiety disorder later on in life? And, as you asked in your question, can we prevent people from getting other disorders later on?

There is some data that indicates if anxiety disorders are treated in childhood, depression may be prevented later.. There is some very interesting work with *prodromal* (in its earliest stage before it even fits a conventional diagnosis) *schizophrenia* where up to 25% of people with schizophrenia or schizoaffective disorder will also have either OCD itself, or OCD symptoms. A completely unanswered question is if those symptoms arise early, what happens if they are treated then? Can early treatment change the course of any of these disorders – we just don't know. The new research looking at prodromal schizophrenia finds that there are tell-tale signs in people who are likely to go in the next 2-5 years to be become floridly psychotic. If we could figure out which people have a high likelihood to have that problem, could we do something before they have that problem to prevent it? If we borrow this idea from schizophrenia research, can we identify kids at risk for developing an anxiety disorder and if we can, can we intervene and prevent it from developing?

I would be very interested to follow kids at risk over time to see where the earliest glimmer of a future anxiety disorder appeared. Many kids go through a period of when they are scared of the dark, have intrusive thoughts about intruders, or are overly checking the sidewalk, and so on – but children usually go in and out of these phases. Let's say you found someone who is going to get OCD at age 19 in a very dramatic way. What did they look like at age six, eight, or at 12 years of age? If you could work with them in childhood – if their trajectory was towards getting that illness – could you intervene to prevent it or at least make it much milder than it otherwise would be? It's a different way of thinking about illness. One way is to see a person who is absolutely fine and then suddenly an illness hits. The goal here is to find a treatment for the illness once it develops. Another way is to see a person who is at risk for an illness; the goal here is to find out what sets them up for an illness in the first place; and to understand why that illness finally appears years down the road and to intervene early. That's the notion of "prodromal."

I am not advocating the idea that if we could detect the early glimmer of later disorders that we would throw medications at children. Rather, could we give children cognitive behavioral interventions? Let's say you have a child that looks very anxious throughout elementary school, but they don't have a disorder so they don't need an entire treatment regime. Since you already see that the child is anxious why not begin helping them develop flexibility around their anxiety so they don't have to start avoiding situations and get stuck in that anxiety? You could also then work with their parents to develop a family environment that might help protect the child from going down an anxious pathway.

Q: Is it difficult for parents to spot early warning signs of an anxiety disorder in their children?

A: Some parents are very aware. Some parents who have suffered with anxiety disorders themselves are very attentive to these issues in their children and are very proactive in alerting us. Unfortunately, some parents who have suffered themselves feel guilty and think "Have I passed this on to my child – have I given them bad genes – are they destined to get my illness?" To me that's very sad, because the parent is suffering twice – for themselves and with worry for their child. The positive side of this is that they know what some of the early warning signs are and if they have been helped by the mental

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health profession in the past themselves, they are less worried about bringing their child in to early intervention for help, and they are usually less concerned about stigma. Other parents that have no experience with anxiety disorders or have it themselves and have never had it treated, can actually be very frightened of seeing this in their child, and don't often come into the clinic as often as they might, for a whole host of reasons. It might be that to have an anxiety disorder diagnosed in their child may mean it then becomes diagnosed in them. And then there are those parents who don't believe treatment can help or that if they bring their child in, someone will insist that their child be placed on medications. In fact, the first line of treatment for anxiety disorders in kids is Cognitive Behavioral Therapy (CBT) which can be highly effective in many children. I would argue that if CBT isn't enough for your child and your child does need a trial of medication – if it helps keep your child in school with friends and going through normal developmental stages so they don't go off track – you need to balance that against the concerns you have about medications – some of which can be very safe.

Q: Is Attention Deficit Hyperactivity Disorder (ADHD) in the spectrum of anxiety disorders?

A: That's a very interesting question. I teach an anxiety disorders class and the school came to me and said "We have no place to put our ADHD class… could we add it to yours?" At first I thought that seemed a bit silly. Then I realized it was brilliant. In children that can't *attend* (listen or watch carefully), one of the reasons is ADHD, another is depression and the third one is anxiety. Most of us when we are anxious tend to tune-out when someone is trying to explain something to us during that anxious moment. A little anxiety encourages us to study for the exam the next day; too much anxiety prevents us from actually attending or focusing. There is often that differential in children. In particular there is a specific relationship with OCD. In OCD the typical age of onset is sometime in adolescence, but there is a tendency for boys to have an earlier age of onset in general and girls to have it sometime later. In boys there is often a triad that is tic-disorder, attention deficit disorder, and OCD. Sometimes they are all present together. Whether ADHD is a particular subtype of OCD with a slightly different neurobiology and a slightly different genetic basis is an area that some people are studying very aggressively. In OCD there is a particular relationship with ADHD. We find that it becomes a problem when you want to do CBT because the main treatment for OCD is a prolonged exposure, and if you have trouble sticking with something or attending, it can be very hard to do that type of treatment which requires a sustained focus.

Q: Can you tell us about some of the research studies you are now conducting at the Clinic?

A: We study all the anxiety disorders at the Clinic. The Clinic is a complete research facility. We do not charge patients for anything and all of our work is funded by foundations or the NIMH – and now the Department of Defense, which is very interested in studying PTSD because so many of our returning veterans have PTSD.

Right now we have very active programs in the area of OCD and PTSD. For the last 5-10 years we have been doing a lot of studies that compare medications to psychotherapies; developing novel psychotherapies; figuring how to augment medications to make them work better, and comparing medications or psychotherapy as augmentations. In addition there is a group of us who have become very interested in finding out how to get important treatment breakthroughs (both the medications and the therapies) into community mental health clinics across the country and out to real clinicians in the field. That type of research is called "services research." There are a number of studies going on at our clinic by my colleagues Drs. Roberto Lewis Fernandez and Carlos Blanco, specifically finding ways to get these treatments out to minority populations which have historically been under-represented in research trials.

Another group of us, including me, are looking at understanding "brain mechanisms" of certain anxiety disorders. For the patients of today, we are using clinical trials methodology to figure out what are the best ways to use our current treatments and what are the best ways to combine and improve them. For the patients of tomorrow the goal is to develop even better treatments than we have now that are based on a better understanding of the brain mechanisms. With OCD, for example, we are investigating the brain mechanisms underlying obsessions and compulsions by conducting brain imaging studies and comparing neurocognitive function in those with and without OCD. The hope is that if we really understand what generates these abnormal symptoms at the brain level, we may be eventually able to devise novel or better treatment strategies for patients in general. The "Holy Grail" here is to tailor treatments to individual patients because we know that not all patients are the same.

We are now actively recruiting patients for a study we are doing in collaboration with the University of Pennsylvania funded by the NIMH. It is for people with OCD who are on a serotonin reuptake inhibitor at the maximum dose they can tolerate but who still have significant symptoms. Patients in the study receive either another medication or CBT and are carefully followed for up to eight months – a duration of treatment that can be hard to find or to afford in private practice. If they do not respond to one treatment they are offered the other, with the hope that one of the two will help them. We invite people who are on a serotonin reuptake inhibitor and still have symptoms and are considering additional medication or CBT to come to our clinic in NYC or to our collaborating clinic in Philadelphia, and we'd be happy to see if we can help them get better. For more information about this study, people can go to our website (www.ocdproject.org) or call Rena Staub at 212-543-5380.

Q: What message would you like to leave with our readers today?

A: I think there is a lot of hope for people that suffer with anxiety disorders. There has been a period during the last 5-7 years where a lot of effort has gone into more basic research. I am really hopeful that over the next 5-10 years that this research is going to really pay off. I believe we are about to learn a lot more about the role of genes and the impact of the environment on anxiety disorders, and we are developing new treatment options for disorders like OCD and PTSD and social anxiety disorder.

Helen Blair Simpson, MD, PhD, is Associate Professor of Clinical Psychiatry at the College of Physician and Surgeons of Columbia University and the Director of the Anxiety Disorders Clinic at the New York State Psychiatric Institute. The clinic can be reached at 212-543-5367. Information about Dr. Simpson's research on OCD can be accessed through the OCD Research Clinic website: www.columbia-ocd.org.

Dr. Simpson's research program focuses on how to improve treatments for people with obsessive-compulsive disorder (OCD) so that they can live productive and meaningful lives. Her research is interdisciplinary. It ranges from treatment development studies to clinical trials examining the effects of medication and cognitive-behavioral therapy to brain imaging studies exploring the brain mechanisms of OCD. Her work has been funded by the National Institutes of Mental Health and private foundations like the Obsessive Compulsive Foundation and the National Alliance for Research on Schizophrenia and Depression. She was a member of the workgroup that developed the first Practice Guidelines for the Treatment of Patients with OCD for the American Psychiatric Association. She was invited to present her interdisciplinary research to the National Advisory Mental Health Council of the National Institutes of Mental Health.

Dr. Simpson graduated from Yale College with a BS in biology. She then entered the MD-PhD program at The Rockefeller University/Cornell University Medical College. For her PhD, she studied the brain pathways underlying learned versus unlearned vocalizations in songbirds. She then completed her internship and residency in psychiatry at the Columbia-Presbyterian Medical Center/New York State Psychiatric Institute. Dr. Simpson has been associated with the Anxiety Disorders Clinic since 1996, first as a National Institutes of Mental Health Research Fellow under the mentorship of Dr. Michael Liebowitz, and then as an independent researcher and Director of the Obsessive-Compulsive Research Program.

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early stage of illness are when patients think about, "Am I going to stay in treatment?" or "I am feeling better now – I only had one psychotic episode – it's not going to happen again – and I am not going to take this medicine anymore." We have to work very hard to try to minimize that to the extent possible, to help our patients accept the need for treatment, for them to feel that the treatment is being helpful to them, etc. All of the cultural sensitivity issues comes into play there.

Q: Are the studies being conducted in an outpatient setting or while they are in the hospital?

A: We are going to try to identify people in either setting, but the bulk of their treatment will take place in a community clinic. We are partnering with 25-30 real-world clinics across the United States, not special academic settings or special programs for first episode patients, but average community clinics in different geographic regions across the country. The clinicians who work in these clinics will be trained to deliver the interventions of the study. Clinicians will receive special training sessions, training manuals, and they will receive ongoing supervision as the study progresses. They will become a cohesive team and will follow the study patients in their community.

Q: How will the clinicians report their findings to the study's leaders?

A: The local clinicians will do some of the assessments, but the bulk of the major outcome assessments will be conducted using live two-way video conferencing, by a group of trained professional researchers who will be centrally located. We have subcontracted with a company that facilitates this process, which lends several advantages to the study. One is that most of the community clinics across the country do not have people who are trained to do the study's careful research assessments. In addition, the local treatment team will know what treatment the patient is getting – whereas our centralized researchers can be kept "blind" to the location of the patient, what treatment they are getting, etc. The major outcome assessments will be done using live two-way video by the study researchers in a different location. This centralized panel of researchers will actually interview the patients. The patient will be brought into a room at the clinic near where they live and using teleconferencing they will see and speak to the researcher who will be located in another city and state. They will carry on a conversation, and the researcher will assess how the patient is doing on a whole host of variables.

Q: What is the expected time-line of the study?

A: We have been working very hard to finalize the study manuals for the participating clinicians, and we are still in the process of recruiting a good geographic distribution of study sites including, suburban, urban, semi-rural, and so forth. We expect to enroll the first patients sometime in the late spring of this year. The study will go on for at least another four and a half to five years.

Q: From everything you have spoken about this study seems to be putting together all the best components of psychiatric assessment, treatment and long-term care. If anyone will be helped, it certainly would be by following the model that you

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describe. Are you looking to have the study's results and experiences serve as a blueprint for psychiatric care in general throughout the country?

A: Yes, if we can demonstrate that the model we are using in the RAISE study is helpful we are hopeful that our results can have an impact on the practice of psychiatric treatment in the future. One of the things we have designed into the study is that almost everything we are doing is going to be done under real-world reimbursement constraints. The only area where we are kicking in a little extra money is where the treatment site has limited resources in the availability of supportive employment or supportive education. We will give those sites some financial support to make sure they can address those services if they do not have them available in-house or in that community. Our hope is that if the study proves to be much more successful in bringing about recovery, then we can have a serious discussion with the states, the federal government and other payers. We can say to them that this is a model that works and a model that does not cost significantly more, and that we want to make sure that our model gets implemented across the country.

Q: As you know, supportive housing can be a very critical aspect of a patient's survival throughout the treatment process, and that in some communities there are limited supportive housing beds available. In some communities there is a waiting list for a bed that can take several years. How are you going to address this problem within the study?

A: That is something we can't address in the context of this study. All we can do is to make sure that we help patients gain access to whatever services are available to them in the community that they live in. Certainly, if we find that the patients who happen to live in communities that have good supportive housing end up doing better than the patients who live in communities that don't, we'll be able to say something about that in the final results of the study, and say that this is an issue of vital importance to patient's recovery. The same constraints would apply to us not being able to control the unemployment rate in a particular community and to the extent that that affects our patient's ability to go out and find a job. We are going to do the best we can under those limited circumstances.

We are very thankful that the NIMH has funded this exciting project, we have assembled a terrific team of clinicians around the country, and I look forward to giving the readers of Mental Health News future updates about our progress with the study. (Another RAISE project, with a somewhat different approach is being led simultaneously by Jeffrey Lieberman and colleagues at Columbia).

In addition to having oversight for system-wide behavioral health services as well as academic, research and clinical programs in psychiatry at NorthShore-LIJ's psychiatric hospital, Dr. Kane directs the NIMH-funded Research Center for the Study of Schizophrenia at The Zucker Hillside.

Dr. Kane has been a member of the Board of Scientific Counselors for NIMH. He has served on the council of the American College of Neuropsychopharmacology, and chaired the American Psychiatric Association Committee on Research on Psychiatric Treatments. He is president of the American Society of Clinical Psychopharmacology and the Schizophrenia International Research Society.

Dr. Kane has chaired the NIMH Psychopathology and Psychobiology Review Committee as well as the Psychopharmacologic Drugs Advisory Committee of the Food and Drug Administration. He has served as a consultant to the Veterans Administration and the U.S. Department of Justice.

Dr. Kane is professor of psychiatry, neurology, and neuroscience, and holds the Dr. E. Richard Feinberg Chair in Schizophrenia Research at the Albert Einstein College of Medicine. He has published over 300 papers in scientific journals and is one of the most highly cited researchers in psychiatry.

He is a recipient of the Arthur P. Noyes Award in Schizophrenia, the NAPPH Presidential Award for Research, the American Psychiatric Association Foundations' Fund Prize for Research, the Kempf Fund Award for Research Development in Psychobiological Psychiatry, the Lieber Prize for Outstanding Research in Schizophrenia, the Heinz E. Lehmann Research Award from New York State, and the Dean Award from the American College of Psychiatrists.

Dr. Kane received his medical degree from New York University School of Medicine.

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