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Understanding and Treating Depression

By The National Institute of Mental Health (NIMH)

Everyone occasionally feels blue or sad. But these feelings are usually short-lived and pass within a couple of days. When you have depression, it interferes with daily life and causes pain for both you and those who care about you. Depression is a common but serious illness.

Many people with a depressive illness never seek treatment. But the majority, even those with the most severe depression, can get better with treatment. Medications, psychotherapies, and other methods can effectively treat people with depression.

Different Forms of Depression

Major depressive disorder, or major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes.

Dysthymic disorder, or dysthymia, is characterized by long-term (2 years or longer) symptoms that may not be severe enough to disable a person but can prevent normal functioning or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Minor depression is characterized by having symptoms for 2 weeks or longer that do not meet full criteria for major depression. Without treatment, people with minor depression are at high risk for developing major depressive disorder.

Some forms of depression are slightly different, or they may develop under unique circumstances. However, not everyone agrees on how to characterize and define these forms of depression. They include:

Psychotic depression, which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs or a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations).

Postpartum depression, which is much more serious than the "baby blues" that many women experience after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.[1]

Seasonal affective disorder (SAD), which is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively

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Antidepressants: A Complicated Picture

By Thomas R. Insel, MD, Director The National Institute of Mental Health (NIMH)

A new report tracking antidepressant use among Americans from 2005-2008 found that more than 1 in 10 Americans ages 12 and older report taking an antidepressant medication.[i] These new data, from the Center for Disease Control and Prevention's (CDC's) National Health and Nutrition Examination Survey (NHANES), comes in the wake of a lively debate in the media about whether antidepressants are effective in treating depression, or if they are just expensive, overused placebos.

The issue is more complicated than that. Treating depression involves many moving parts, only one of which is antidepressants. And a person's response to them is dependent on many factors. It's worth taking a few moments to review the multiple issues surrounding antidepressant use and efficacy.

Who is Taking Antidepressants and Why?

As these new CDC data show, 11 percent of Americans aged 12 and older (3.7 percent of youth between 12 and 17) report taking antidepressants. Last year, antidepressants were the second most commonly prescribed medications, right after drugs to lower cholesterol. About 254 million prescriptions were written for them, resulting in nearly $10 billion in costs.[ii]

Antidepressants are approved for the treatment of certain mood and anxiety disorders. These disorders are common. Depression affected 6.4 percent of adults in the U.S. in 2008,[iii] and about 4 percent of 8-15-year-olds.[iv] Anxiety disorders (including obsessive compulsive disorder, post traumatic stress disorder, generalized anxiety disorder and phobias) affect about 18 percent of the adult population in a given year.[v] Although depression and anxiety disorders are the primary indications for prescribing antidepressants, doctors have prescribed these medications, generally "off-label," to treat chronic pain, menstrual symptoms, low energy, and other maladies, with or without accompanying depressive or anxiety symptoms. However, we do not know how many of these prescriptions are actually taken after they are prescribed.

Are Antidepressants Overused?

Depression continues to be the leading cause of medical disability in the United States and Canada, accounting for nearly 10 percent of all medical disability.[vi] Depression is also associated with increased mortality. In severe major depressive disorder, some reports have estimated a risk of suicide beyond 6 percent.[vii] Depression after heart attack confers a three-fold increase in cardiovascular mortality. The persistence of such high morbidity and mortality in the face of widespread use of antidepressants suggests either that the medications are ineffective, or they are not being used by those who need them the most. Indeed, there are data suggesting both underuse and overuse of psychiatric medications. Certainly it is clear that there are high proportions of persons with mental disorders who receive no treatment whatsoever. In the case of depression, recent findings indicate that only about half of those with major depressive disorder receive care.[viii]

Who is Prescribing Antidepressants?

Much of the growth of antidepressant use has been driven by a substantial increase in antidepressant prescriptions by non-psychiatrists.[ix] One study found that nearly 80 percent of antidepressant prescriptions are written by medical professionals other than psychiatrists.[x] Many of

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ECT For Depression: An 'Old' Treatment Gets Better

By Robert C. Young, MD
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Electroconvulsive therapy (ECT) is most often prescribed for severe depression and it dramatically helps many patients. It is one of several kinds of treatment that involve brain stimulation. Findings from recent research studies are helping doctors administer ECT in ways that minimize side effects.

Severe depression, called "major depression," is a common and debilitating illness. Episodes of symptoms can last for months; they can occur only once in a person's life, but they often happen more than once. Although talking treatment or psychotherapy can help some patients, medication treatment or pharmacotherapy is required for moderate to severe symptoms. Unfortunately, medication is not helpful for some patients and some patients have difficulty with medication side effects. Since major depressive episodes can interfere with work, can lead to life threatening physical health changes, and can lead to death from suicide, it is important to have alternatives such as ECT available.

ECT is sometimes called "shock therapy" and many people have a frightening and incorrect impression that it is a painful and harmful form of treatment. ECT has been described in a disturbing way in popular books and movies, like "One Flew over the Cuckoo's Nest." Some of these depictions are loosely based on how ECT was done when it was first used 80 years ago. A lot has changed.

In ECT, doctors cause a controlled seizure, which is a brief period of excess brain activity. This seizure is started by electrical stimulation through the scalp for a few seconds. ECT is usually prescribed three times per week. The number of treatments needed to produce the most improvement in depression symptoms is different from person to person, but the average is 8-10. The reason that these ECT seizures help depression is not known; one idea is that seizures correct overactivity in brain electrical signaling, which might be part of depression.

There are many misconceptions about ECT. For example, patients are not awake; they are asleep before and during the seizure because brief-acting sleeping medication is given before the treatment. Also, the seizure does not involve strong

Robert C. Young, MD

movements: there is actually not much to see because patients are also given a muscle relaxant prior to ECT, which prevents the movement of arms and legs during the seizure and prevents stress to the body. These medications are given by an anesthesiologist who also supports breathing with a face mask and provides extra oxygen. Patients wake up within a couple of minutes and are monitored until they are no longer drowsy and they are oriented.

Temporary memory problems related to ECT have been a significant concern for patients and doctors. It is important to note, however, that memory problems caused by depression can be expected to improve with successful treatment of depression. To avoid or reduce memory impairment related to ECT, there have been several research based changes in how ECT is done. First, exactly where the electrodes are applied on a person's scalp can affect the results of the treatment. Locating on the right side (unilateral), rather than on both sides of the brain (bilateral), as was always used historically, can significantly reduce temporary memory problems. Another way of reducing "cognitive" side effects of ECT is to use special forms of electrical current. Also, at the first treatment, doctors test for the minimum amount of electrical stimulus that is required for each patient, using a "titration" procedure that was not part of routine ECT practice originally. Taken together, these changes and improvements in ECT mean that depressed patients will be more comfortable and experience fewer side effects from the treatment.

Researchers are now looking into developing ways to further increase benefit and speed of response from ECT. For example, while ECT alone can help many depressed patients, other recent studies have shown that prescribing certain antidepressant medications at the same time can improve response to ECT.

Keeping patients well after they have responded to ECT is another important challenge. Combining antidepressants with lithium is a medication strategy that is supported by recent studies.

After it has lifted someone's depression, can adding "booster" ECT treatments as needed, rather than stopping the ECT, help avoid "relapse"? Ongoing research funded by the National Institutes of Mental Health aims to test that idea.

One individual said: "When my doctor suggested that I try ECT, I was hesitant. I preferred to stay on medication, but we could not find one that helped me. When I was depressed, I couldn't bear the thought of even getting out of bed. I finally decided to go ahead with ECT. My family is amazed by my progress. I am back at work and I feel like my old self. I am looking forward to the future again."

Clinicians, patients, and families should be aware of changes in ECT practice. When discussing the possible benefits and risks of ECT in an individual with challenging depressive illness, having an up-to-date perspective is essential to the decision-making process.

Prolonging Remission in Depressed Elderly (PRIDE) Research Study

Physicians at **New York Presbyterian Hospital, Westchester Division** and the **Weill Cornell Institute of Geriatric Psychiatry** are participating in an **NIH sponsored multi-center study** focusing on **remaining depression-free after successful Electroconvulsive Therapy (ECT)** treatment of **major depression in older adults**.

STUDY OVERVIEW:

Participants who respond to state of the art acute ECT treatment are monitored for 6 months during which time they receive free treatment and assessments, and are assigned randomly to either combined FDA-approved medication (antidepressant and mood stabilizer) or combined FDA-approved medication with outpatient ECT treatment, as needed according to an algorithm.

STUDY PURPOSE:

To determine whether combined pharmacotherapy and ECT (individualized according to patient response) will be more effective in maintaining remission in depressed older adults than pharmacotherapy alone.

WHO IS ELIGIBLE?:

- Patients 60 years or older
- Diagnosis of Major Depressive Episode, Unipolar
- Clinically indicated for ECT
- Competent to provide Informed Consent

WHO IS NOT ELIGIBLE?:

- Patients with a history of *Bipolar Disorder*, *Schizophrenia*, *Schizoaffective Disorder*, *Mental Retardation*, *Dementia*, *Active Substance Abuse/Dependence*
- Patients with an active general medical condition or central nervous system disease that may affect cognition or response to treatment
- Patients with a medical contraindication to *Venlafaxine* or *Lithium Carbonate*, or failure to respond to an adequate trial of these medications in the current episode
- Patients who have failed to respond to ECT in the current episode

For Questions and Referrals Please Contact:

Robert Young, MD, Principal Investigator

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these prescriptions are written without a specific psychiatric diagnosis. However, we do not know whether this is because of inadequate assessment, or if it is due to disincentives for using psychiatric diagnoses in billing records, or for other reasons.

How do antidepressants compare to placebos?

In general, the efficacy of a drug is defined by how it differs from placebo. More than two dozen antidepressants have been approved by the Food and Drug Administration (FDA) based on trials in which the drug is better than placebo. Sometimes the differences are small. Sometimes only positive results have been selected for submission to FDA. And sometimes the placebo effects are profound. For reasons that are not entirely clear, placebo effects have increased markedly over the past two decades in trials of psychiatric medications.

Mild depression tends to improve on placebo so that the difference between antidepressant use and placebo effect is very small, or at times, absent. In more severe forms of depression, antidepressants show greater efficacy. It is important to note that these clinical studies have primarily focused on reducing the symptoms of depression and not on a broader range of potential outcomes (such as changes in everyday functions, cognitive abilities, quality of life, etc.). In addition, because clinical trials are conducted in a controlled environment, they do not necessarily reflect the way actual clinical practice operates. And even under research conditions, clinical trials for antidepressants use rating scales that may be weak or imprecise indicators of efficacy.

What does research tell us about the long-term efficacy and effectiveness of antidepressants among real-world patients and how best to use them?

Prior to the past decade, nearly all studies of antidepressants looked at outcome

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From Psychoanalysis to CBT: One Psychiatrist's Journey

By Andrew P. Levin, MD
Medical Director, Westchester Jewish Community Services (WJCS)

By now, most professionals in the mental health field acknowledge that psychotherapy treatments grounded in cognitive behavioral principles are effective for a wide range of common conditions. Their efficacy in anxiety disorders, depression, eating disorders, posttraumatic stress disorder, and borderline personality disorder is well documented, and more recently, CBT treatments have been adapted to address Bipolar Disorder, Schizophrenia, and issues connected to aging. But this wasn't always the case! My own career has spanned the transition from psychoanalysis and psychodynamic psychotherapy to CBT techniques.

Long before I embarked on medical school and psychiatric training (I knew I wanted to be a psychiatrist as a high school student!) I was enamored of psychoanalytic thought. In college I dove into Freud and the object relations theorists. By medical school I had read the psychoanalytic bible of the 1970's, Kernberg's *Borderline Conditions and Pathological Narcissism* (it still has a prominent place on my shelf). His descriptions of his patients were beautifully drawn but the underlying theory, the so-called metapsychology, seemed murky. He conceptualized that borderline individuals suffered excessive aggressive impulses that had invaded their superegos. His techniques, an adaptation of psychoanalysis, were based on the notion that analyzing the transference would result in improved function. Treatments were arduous; patients made slow progress. The approaches utilized by therapists in the TV series *In Treatment* are based on these formulations and techniques. Although Kernberg himself was a deeply caring practitioner, other practitioners utilizing his theories often left patients feeling deprecated by their application of the model. And the therapy did not provide a clear framework to characterize their problems or a roadmap to improve their lives.

Then I spent a semester of medical school on an inpatient service in London specializing in eating disorders (the leader of the unit, Gerald Russell, coined the term "bulimia nervosa"). In that era the British were developing cognitive behavioral techniques to treat anorexia nervosa and bulimia. The approach taught the person to challenge her distorted thoughts about the shape of her body and to employ modifications in eating habits and other behaviors to regain and stabilize weight. In the same time period Isaac Marks, a British psychiatrist, and his colleagues were developing behavioral techniques to address anxiety disorders. Quite an eye opener for me.

As a resident, in addition to extensive training in the emerging biological understanding and treatment of mental disorders, I dutifully learned psychoanalytic theory and technique. But I found the advice from supervisors opaque and difficult to implement. Then, on one rotation I met a psychiatrist who had delved into CBT.

Andrew P. Levin, MD

He taught me how to use diaries and other self-monitoring techniques, important cornerstones of CBT treatment. This was another revelation, but I soon learned that this was not news in the wider world! While American psychiatrists generally clung to psychoanalytic theory and technique, in the late 1960's Aaron Beck, himself a psychiatrist trained as a psychoanalyst, boldly conceptualized that depression was triggered by negative thinking about the self, other people, and the future. An array of psychologists including such pioneers as Donald Meichenbaum, David Barlow, and Edna Foa developed and validated CBT treatments of anxiety disorders. These approaches involved challenging fearful, irrational beliefs (the "cognitions") and entering avoided situations, so-called behavioral "exposure". These pioneers established that people could successfully change how they thought about themselves and fearful situations. The techniques involved identifying immediate thoughts, so-called "automatic" thoughts, occurring at times of anxiety or low mood, and then delving into the thoughts that underpin these ideas, the "intermediary" and "core beliefs". Cognitive therapists helped people recognize recurrent patterns of distorted beliefs such as "overgeneralization" (e.g., a singular failure means I will always fail) or "catastrophizing" (e.g., a small problem will invariably snowball into a disaster). Further, the CBT pioneers demonstrated that by repeatedly entering feared situations one could overcome anxiety. More recent developments extended CBT to addressing underlying core beliefs inherent in different personality types as well as challenging distorted thinking in psychotic conditions.

The turning point came after my residence when I was charged with leading an inpatient unit treating women with eating disorders, PTSD, and dissociation. I was lucky to be surrounded by several gifted psychologists who introduced me to Marsha Linehan's landmark work, *Cognitive-Behavioral Therapy for Borderline Personality Disorder.* In this work Linehan laid out an innovative approach combining CBT with principles derived from Buddhism, what she called "Dialectical Behavior Therapy" (DBT). Her approach was startling. Here was a clear delineation of the main features of this oft-maligned condition. People struggling with this disorder were no longer to be understood as "angry," "manipulative splitters" who should be loathed and derided (sadly, a common reaction by many practitioners of the day). Instead, DBT clearly described the struggles these individuals faced in managing unstable emotions, tolerating distress, caring for themselves, and navigating relationships with others. Linehan's work provided understandable, accessible techniques to address these areas. DBT was not burdened by a metapsychology that was based on theories that could not be proven. Subsequent research has established some of the genetic and environmental roots of borderline conditions. In the wider areas of depression and anxiety, brain-imaging techniques have revealed measurable changes in brain activity following effective CBT treatment for depression and anxiety. Further, the field is moving toward uncovering the neural circuits that underlie the mechanisms of cognitive and exposure treatments.

Patients welcome the respectful approach of CBT and DBT because it provides much needed understanding of painful symptoms and equips them with effective techniques to cope and change. And both CBT and DBT treatments really work! I was a convert! Since that time I have been fortunate to receive training in CBT techniques to address depression, anxiety, and PTSD, and have been able to employ these techniques in my own work.

Even more exciting, I have participated in the dissemination of these techniques to others. In the last five years, Westchester Jewish Community Services, through its Educational Institute and participation in national workshops, has brought these techniques to our community mental health and school based clinics. WJCS therapists provide state-of-the-art CBT treatment for depression and anxiety disorders in children, adults, and the elderly. In addition, WJCS clinicians have developed a network of DBT treatment groups. These groups follow the model laid out by Linehan, providing relief to many individuals struggling with these problems. Over the last five years the WJCS Treatment Center for Trauma and Abuse has implemented "Trauma Focused Cognitive Behavioral Therapy" for treatment of children who are victims of sexual abuse and domestic violence. This highly innovative technique developed by Cohen and Deblinger has provided a road to recovery for children suffering from the effects of trauma. Most recently, WJCS clinicians have been trained in STAIR (Skill Training in Affective Regulation), a treatment developed by Marylene Cloitre that combines elements of DBT and CBT for adults who have been victims of repeated trauma. All of these approaches have brought new life and hope to individuals struggling with painful disorders. I am glad to have made this journey in my own career and proud to participate in an agency that has embraced these techniques and brought them to communities throughout Westchester.

Meeting Families As Far As They Can Go: A Values-Centered Approach To Treating Sexually Abused Children And Their Families

By Adrienne Williams Myers, LCSW, Jean Holland, LCSW, Drena Fagen, LCAT, Alexis Howard, LCSW, Sandra Scott, PhD and Thelma Dye, PhD
Northside Center for Child Development

This paper describes a sexual abuse-specific treatment program for children that combines creative art therapy groups for the abused child with concurrent supportive, psychoeducational therapy groups for non-offending parents. This program, led by Northside Center for Child Development's Project SAFE program, has been supported by a grant from the World Childhood Foundation affording the program the opportunity to explore promising practices for 'treatment reluctant' families affected by sexual abuse while providing services that are essentially barrier free. The children and their parents in this program often present with myriad additional environmental stressors and emotional issues including depression, anger, denial, anxiety, guilt and diminished self esteem.

Values Informing the Creative Arts Therapy Sexual Abuse Treatment

Despite an abundance of literature, increasing knowledge about the pervasiveness of sexual abuse and the frequency of sexual abuse referrals to community mental health clinics, there is no consensus on a single best treatment approach to effectively address complex impact of sexual abuse on children (Smith, 2008; Saywitz, Mannarino, Berliner, & Cohen, 2000). Although evidence is growing that trauma-focused cognitive behavioral therapies (TF-CBT) may be the most effective treatment intervention for treating depression, anxiety and behavior problems in these children and adolescents, not all children who have been sexually abused present with these specific symptoms nor meet DSM criteria for PTSD and trauma-specific treatment. In addition, treatment-outcome studies for sexual abuse demonstrating promising results for short-term CBT interventions "have focused primarily on less complicated diagnostic pictures and higher functioning families…[and] studies indicate that a continuum of approaches is necessary to meet the treatment needs of multiproblem cases who are not the children usually (Saywitz, et al, 2000, p. 1043)." Most importantly TF-CBT interventions are often compared in controlled studies to "nondirective supportive therapy (NST)" (Cohen, Deblinger, & Mannarino, 2004) — leaving a wide range of treatment possibilities between these two ends of the treatment continuum. There is acknowledgement in the field that child sexual abuse victims are a heterogeneous group and that an array of interventions needs to be considered and researched to best serve this diverse population. (Saywitz, et al, 2000) "To accommodate the different levels of care dictated by these different groups, a continuum of interventions is necessary, ranging from psychoeducation, to short-term abuse-focused

Adrienne Myers, LCSW

CBTs with parental involvement, to more comprehensive long-term treatment plans for multi-problem cases (p. 1047)."

Impetus for our Creative Art therapy model evolved from the agency's examination our use of art therapy with many types of children including those sexually abused along with individual and family therapy. We were particularly seeking a clinical model to reach children having difficulty expressing the abuse in words. Outreach when starting this program confirmed that very few agencies in the metropolitan region offered distinct programs for treating sexual abuse and none were found to offer treatment via group art therapy. In addition, our interactions with mental health workers as part of our referral process and research indicated that many clinicians reported feeling ill-prepared to effectively address the sexual abuse sequelae in individual treatment (Kolko, et al. 2009). Furthermore, those agencies that did specialize in sexual abuse treatment often had restrictions (requirements for attendance, specific symptom presentation, diagnosis, catchment area and/or insurance reimbursement) that made participation difficult or unappealing to more treatment reluctant families ---families we might identify as at highest risk for abuse re-victimization.

Our model strives to improve how our clients feel about themselves in relation to others, with the abuse experience being an event that happened to them, not one that defines them. Our approach is values-centered treatment attempting to find the middle ground between highly-specific interventions designed to reduce PTSD and depressive symptoms and client-directed psychodynamic therapies designed to validate and support. The groups integrate components of well-known evidence-based practices (i.e. TF-CBT) with the creative arts therapies, concurrent caregiver support groups, and a flexible, barrier-free program structure. Given this approach along with the lack of concrete barriers afforded us by World Childhood Foundation's grants, we have been able to serve children and families who may have previously fallen through the cracks or who presented with ambivalence to treatment through extensive, ongoing outreach throughout the group cycle, concrete support for families to facilitate attendance and an atmosphere that promotes acceptance of the child and family. Referrals have primarily come from New York Children's Services and other community programs as well as from programs within our agency.

The child art therapy groups have a 23 week group cycle serving about 25 children per year in small, gender and age based groups. Art therapy is used because the traumatic experience of abuse can be difficult to articulate using purely verbal means and children naturally communicate through play and art. The goal of our group interventions is to help the children make meaning of their experiences so that they can regain a sense of control, improve self-esteem, decrease high-risk behaviors, and know that they are not alone in their experiences. This 23 week cycle allows children to begin to develop trust for those in their group in order to feel safe enough to express in art or in words the myriad issues associated with sexual abuse victimization. Psychoeducation in the group includes learning about body safety, managing anger and impulsivity, and understanding personal boundaries.

The parallel parent group offers the unique support of knowing they are not alone, helping them accept the validity of their child's experience, and allowing them to safely expose feelings of depression, confusion, guilt, anger and stigma over this event which impacts the whole family. Research suggests that the most overriding factor in the success or failure of treatment for a sexually abused child is that the parent believes the abuse occurred.

Parents and caregivers are critically important to the healing process and not simply ancillary to the children's art group therapy. Their recognition of the child's experience and support for the child is a powerful ingredient in the child's becoming more open as they are validated by their parent leading to better prospects for recovery. In addition, and not infrequently, parents in the group reveal their own experience of abuse as a child with its damage to their emotional well being. The parent groups, led by a social worker, facilitate parental working through the range of emotions brought up by the child's abuse, (and their own, if applicable) while helping them learn positive coping skills to address the impact of the abuse on the child and family. Ongoing psychoeducation in the group includes discussions with parents around the range of sexually abusive experiences, common symptoms associated with child sexual abuse and the creation of safety plans for their family to prevent re-victimization. In addition unlike many group therapy protocols, parents in the group are encouraged

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Symptoms of Depression and the Role of Traumatic Brain Injury

By Giselle Stolper, MEd
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Mental Health Association of NYC

An elementary school student displays uncooperative behavior, emotional outbursts, social difficulties and learning challenges, and is placed in special education. A young veteran, recently home from active duty, attempts to return to pre-deployment functioning, but is hampered by feelings of despondency and hopelessness that fuel an emerging drinking problem. A recent college graduate and former star quarterback for his university's football team has been fired from his first two jobs out of college because his low mood and lack of motivation in pursuing his vocational goals have led to excessive absenteeism.

As mental health professionals, we might easily suspect clinical depression as an underlying factor of these psychosocial difficulties. But what if we also knew that the elementary school student was in a coma for three weeks following a recent, serious car accident, that the veteran survived a blast from a roadside bomb in Iraq prior to returning home to civilian life and that the college football player received multiple concussions during his athletic career? Greater sensitivity to the sequelae of traumatic brain injury could dramatically change the course of treatment.

As clinicians and social service providers, we may be familiar with the physical and/or cognitive impairments that can result from traumatic brain injury. However, we may not realize the degree to which traumatic brain injuries are also associated with a variety of behavioral health symptoms. These include increases in depressed or irritable mood, anxiety, outbursts of anger, poor judgment and decreased impulse control. If we are not aware of the mental and emotional risks traumatic brain injuries pose, these symptoms can be attributed to psychiatric illness alone, with the unfortunate consequences of inaccurate diagnosis and less than optimal treatments.

Giselle Stolper, MEd

What is traumatic brain injury? Traumatic brain injury (TBI) is an umbrella term that refers to damage to the brain due to a specific event, rather than the result of a degenerative neurological condition or other disease process. Events can include physical force, such as blows to the head, or medical emergencies such as strokes or high fevers. TBI may also result from brain damage due to consuming poisonous substances or from malnutrition. While no one has a life that is totally free of potential TBI risk, certain populations are at increased risk, including children from 0 to 4 years of age, youth aged 15-19 and older adults aged 65 or older.[1] Military personnel and athletes take on increased risk, as both face the increased possibility of receiving blows to the head from combat or competition.

Often, traumatic brain injuries are not detected by standard medical tests, such as MRIs, CT scans or other tests, as the events that cause TBI may not leave an easily detectable wound or other physiological signs of injury. Individuals who have sustained a traumatic brain injury will likely require very extensive evaluation to pinpoint difficulties in processing information, memory, distractibility and other aspects of cognitive functioning, and to receive an accurate diagnosis. Without a thorough assessment, including an evaluation by a neuropsychologist, individuals who have TBI will not obtain a comprehensive plan for recovery. Treatment for TBI typically includes cognitive rehabilitation, occupational therapy, physical therapy, speech therapy, learning how to use assistive technologies and to modify the environment in order to build on retained capabilities and skills.

Much of the available information about traumatic brain injuries stresses that only a small proportion of people who sustain these types of injuries will go on to have significant and long-lasting challenges in their physical or psychosocial functioning. In contrast, however, a study of people with mild or unidentified brain injuries indicates as many as two-thirds reported having poor emotional health.[2] Additionally, even mild traumatic brain injuries are associated with an increased risk of mental illness within 6 months of sustaining the injury. For example, another study found that traumatic brain injury increases the risk of depression over the course of a lifetime to 54%.[3] The effective diagnosis and treatment of these symptoms remain challenging for a variety of reasons, including the delayed onset, changes in brain anatomy and chemistry due to the brain injury and other complicating psychosocial factors. Yet there is no doubt that earlier identification of the behavioral signs of TBI is essential for those of us working with populations at high risk of TBI to be aware of its emotional, cognitive and behavioral manifestations in order to intervene by providing timely and appropriate referrals for neuropsychological evaluations and other necessary rehabilitative services.

We can start by asking individuals with this constellation of symptoms whether or not they have sustained a head injury or lost consciousness. Even this simple screening question could be helpful in identifying individuals who may need a more extensive assessment. At the same time, medical and other professionals working with people who have sustained TBI can also become more aware of the potential of depression and other emotional symptoms, so that if these arise, they can make the appropriate referrals to behavioral health services.

This year, the Mental Health Association of New York City has added raising awareness of the mental health impact of TBI to its policy and public education agendas. Working in partnership with other stakeholders, MHA-NYC strives to highlight the importance of protecting one of the human body's most valuable organs, the brain, while at the same time promoting the ability of individuals, families, and the myriad professionals who treat TBI, to identify and better understand the warning signs of emotional distress that may be caused by this condition. Please join us in learning more about how to effectively prevent and treat traumatic brain injury.

References

1. Faul, M., Xu, L. Wald, M.M., Coronado, V.G. (2010). Traumatic brain injury in the United States: emergency department visits, hospitalizations and deaths 2002-2006. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

2. Gordon, W., Brown, M. (2008). Mild traumatic brain injury: identification, the key to preventing social failure. Brain Injury Professional. 5(2): 8-11.

3. Aravich, P., McDonnell, A. (2005). Successful aging of individuals with brain injury. Brain Injury Professional. 2(2): 10-14.

Depression from page 1

treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.[2]

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression).

Signs and Symptoms of Depression

People with depressive illnesses do not all experience the same symptoms. The severity, frequency, and duration of symptoms vary depending on the individual and his or her particular illness. Signs and symptoms include: (1) Persistent sad, anxious, or "empty" feelings; (2) Feelings of hopelessness or pessimism; (3) Feelings of guilt, worthlessness, or helplessness; (4) Irritability, restlessness; (5) Loss of interest in activities or hobbies once pleasurable, including sex; (6) Fatigue and decreased energy; (7) Difficulty concentrating, remembering details, and making decisions; (8) Insomnia, early-morning wakefulness, or excessive sleeping; (9) Overeating, or appetite loss; (10) Thoughts of suicide, suicide attempts; (11) Aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.

Illnesses that Co-exist with Depression

Other illnesses may come on before depression, cause it, or be a consequence of it. But depression and other illnesses interact differently in different people. In any case, co-occurring illnesses need to be diagnosed and treated.

Anxiety disorders, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia, and generalized anxiety disorder, often accompany depression.[3,4] PTSD can occur after a person experiences a terrifying event or ordeal, such as a violent assault, a natural disaster, an accident, terrorism or military combat. People experiencing PTSD are especially prone to having co-existing depression.

"I started missing days from work, and a friend noticed that something wasn't right. She talked to me about the time she had been really depressed and had gotten help from her doctor."

In a National Institute of Mental Health (NIMH)-funded study, researchers found that more than 40 percent of people with PTSD also had depression 4 months after the traumatic event.[5]

Alcohol and other substance abuse or dependence may also co-exist with depression. Research shows that mood disorders and substance abuse commonly occur together.[6]

Depression also may occur with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes, and Parkinson's disease. People who have depression along with another medical illness tend to have more severe symptoms of both depression and the medical illness, more difficulty adapting to their medical condition, and more medical costs than those who do not have co-existing depression.[7] Treating the depression can also help improve the outcome of treating the co-occurring illness.[8]

What Causes Depression?

Most likely, depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Depressive illnesses are disorders of the brain. Longstanding theories about depression suggest that important

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LifeNet has a newly enhanced website:

Offering the most comprehensive, convenient and easy-to-navigate behavioral health resource featuring:

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- Get an advocate by reviewing an extensive list of organizations that assist people with mental health or substance abuse problems.
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[Addiction + Problem Gambling]

MHA-NYC
Innovations in Mental Health

LifeNet is a program of MHA-NYC (Mental Health Association of New York City), a non-profit leader in behavioral health services. LifeNet is funded through contracts with the New York City Department of Health and Mental Hygiene and the New York State Office of Alcohol and Substance Abuse Services.

— Social Security Matters —
Major Depression and Disability

By Gabriel J. Hermann, Esq.
Insler & Hermann, LLP

Many of the people who come to us to obtain Social Security or Private Disability benefits are suffering from depression. In many cases this is their primary impairment; in many more, depression is present along with other disabling conditions.

Because of the typically insidious progression of the depressive symptoms, our clients are often unaware of how significantly their depression impacts on their ability to work. While the condition might start with some sadness or preoccupation with a real or perceived loss, very often, changes in performance and their behavior at work will reveal that the underlying cause of their problems is depression.

Although many lay people associate depression with pervasive sadness, from a Disability perspective, the analysis of the ability to perform work activities is paramount. Telltale signs of severe depression in the workplace might include:

- Decreased interest in work
- Slowed thoughts
- Overly sensitive or emotional reaction to supervisor's criticism or feedback
- Slowed movement or reaction
- Difficulty remembering or learning new tasks
- Increased errors and poor work product
- Decreased or inconsistent productivity
- Tardiness, procrastination, absenteeism and missed deadlines

While an enlightened supervisor might be able to address some of the behavior identified above, it is a rare employer who will tolerate an employee who exhibits these signs of major depression. More often than not, if the depressed employee does not resign or take a leave from work, he or she will suffer from poor performance reviews, which will ultimately result in termination.

From a depressed employee's perspective, there are also a number of considerations at play which might impact on his or her ability to handle severe depression. First and often paramount is a concern about the stigma of being depressed. Unlike physical conditions such as diabetes or hypertension, depression – though an even more common disease – is something that is rarely spoken about. People are embarrassed to talk about their feelings and will often not seek treatment due to concern about the ramifications of their condition and fears of "who will know."

Often, someone suffering from depression will also be concerned about whether insurance will pay for treatment. For this reason, even those who know there is something wrong are more inclined to discuss their depression only with the family doctor instead of with mental health professionals, whether psychiatrists, psychologists, social workers or other therapists. Unfortunately, more often than not, the family doctor is not qualified to treat depression and frequently tries to medicate the problem instead of referring the patient for proper treatment.

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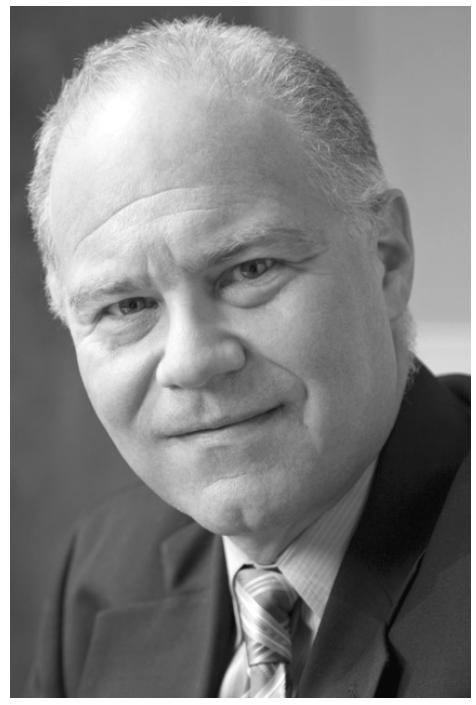

Lewis B. Insler, Esq.

Additionally, due to the often progressive build-up of symptoms, workers often are not even aware that whatever is wrong with them is a diagnosable and frequently treatable condition. Depression crawls up on them and their work performance suffers but it is so gradual that they may be unaware of how depression has impacted their job performance until their shortcomings are laid bare for them at a performance or quality review.

By the time most people come to our offices to discuss a claim for Disability benefits, they are no longer working, whether because they simply couldn't go on and left their job, or because the employer could no longer tolerate the negative changes in performance and terminated them. Our clients typically report symptoms such as fatigue, lack of interest in activities, isolation, short temper and frustration, increased or decreased appetite, inability to maintain concentration and focus, difficulties getting things done and problems with memory. Many just say "I'm depressed," and we ask them a laundry list of common symptoms to which they respond.

Clients typically report that medication makes them numb and lethargic. Although by this time many have sought mental health treatment, some report that their treatment consists solely of medication prescribed by a primary care physician.

The Social Security Administration administers two programs for the Disabled: Social Security Disability Benefits (defined in Chapter 7, Subchapter II of Title 42 of the U.S. Code, entitled "Federal Old-Age, Survivors and Disability Insurance Benefits"); and Supplemental Security Income Benefits (defined in Chapter 7, Subchapter XVI of Title 42 of the U.S. Code, entitled "Supplemental Security Income for Aged, Blind and Disabled"). These benefits are commonly called SSD and SSI or Title II and Title XVI benefits.

Social Security Disability benefits are paid to individuals who have been found "medically disabled" who have also contributed sufficient payments as payroll taxes for enough years to be eligible for Title II benefits. By contrast, Supplemental Security Income is resource and asset based, though the standard for "disability" is the same as under Title II.

The Social Security Administration has set forth the requirements that must be met to establish Disability. The first question, which is a relatively low threshold, is a query whether a claimant suffers from a "severe impairment." The United States Code states at 42 U.S.C. § 423(d): *"In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under this section, the Commissioner is required to consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. If the Commissioner does find a medically severe combination of impairments, the combined impact of the*

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Depression and Primary Care

By Lloyd I. Sederer, MD
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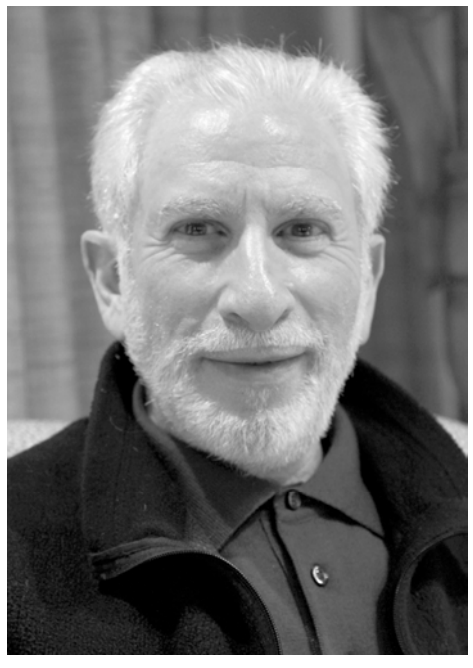
Depression is an arch enemy if you suffer from one of many chronic, physical illnesses. It appears all the time, as an unwelcome intruder, in people with diabetes, heart and lung diseases, cancer, Parkinson's disease and asthma. It impairs our ability to recover from these, and other, medical problems. Depression escalates health care spending for other medical disorders unless it is detected and treated.

Consider this: Depressed patients are at twice the risk of developing cardiac and artery disease (CAD) and stroke. They are four times more likely to die within 6 months after a myocardial infarction (MI or heart attack). They are three times more likely to be non-compliant with treatment – a reflection of how the illness diminishes our ability to or interest in taking care of ourselves as well as its harmful effects on the body's stress response, immunity and hormones. As a result, those people, for example, with diabetes and depression average four times greater health expenditures. Individuals with major depression make an average of twice as many visits to their primary care physicians as do non-depressed patients – though not for their depression but for a myriad of other symptoms which are explainable when the depression is uncovered.



Lloyd I. Sederer, MD

Goodness, these are troubling statistics. This state of affairs is not because there are bad doctors (though there are some of those just like in any profession). It is because depression has not yet gained a needed foothold in the standard operations of every primary care doctor's office. We have not yet begun to screen for depression and set as a clinical standard the proven ways of effectively detecting and treating depression in general medical care settings.

Primary care practices have become the principal sites of medical care where adults with common mental health problems in this country (and throughout the world) go for care. These individuals seldom announce they are there for a mental condition. But good medical practice will readily reveal it. Moreover, most patients prefer to have their health and mental health care delivered in one place, by the same team of clinicians. This is called integrated health and mental health care.

Depression also will hurt you at work. It reduces the productivity of our businesses through absenteeism and presenteeism (showing up but not being able to do much). Data from the "National Expenditures for Mental Health and Substance Abuse (MHSA) Treatment" indicates that the U.S. spent $104 billion on mental health and substance abuse treatment in 2001. In 2005 total spending on mental health and substance abuse services was $135 billion. While depression clearly has a significant economic impact on society, the estimated total costs of depression in the US (in 2001) were $44 billion, in 1990 dollars. However, the majority (72%) of costs incurred by society are indirect costs in the form of reduced productivity, absenteeism, and mortality – not the direct costs of care. Medical care costs (inpatient emergency and outpatient medical and/or psychiatric care) comprised only 25% and medications were only approximately 3% of overall costs. In other words, it costs more to NOT treat depression than it does to treat it.

Depression is today the leading cause of disability (by Years of Life Lost, YLLs) and the 3rd leading contributor to the global burden of disease (DALYs 2008). Projections are that by 2030 neuropsychiatric disorders will be the leading contributor to the global burden of disease (these conditions include depression, bipolar disorder, schizophrenia, epilepsy, alcohol and drug use disorders, Alzheimer's and other dementias, Parkinson's, MS, PTSD, OCD, and panic disorder).

Moreover, depression is highly associated with suicide. Estimates are that as many as 90% of completed suicides occur in people with an active mental disorder, depression in particular. An estimated 60% of people over 55 years old who took their lives were in a primary care doctor's office in the month before their death: otherwise known as a missed opportunity to detect and intervene.

What About Quality of Care For Depression in Primary Care Today?

The answer is short and troubling: The quality is poor.

see Primary Care on page 36

— Point of View —

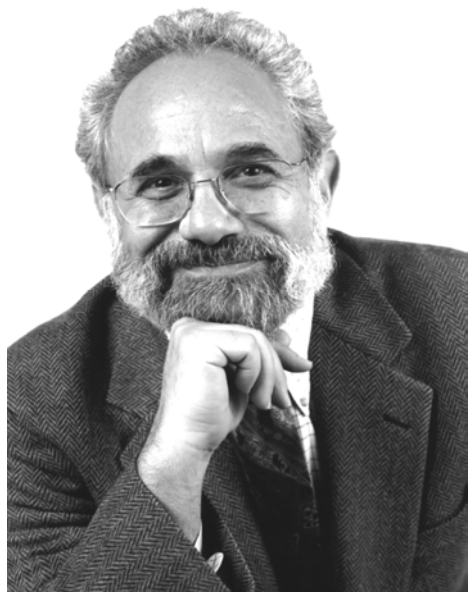
Address the Mental Health Needs of People with Dementia and Their Caregivers[1]

By Michael B. Friedman, LMSW

Ms. S. began to experience confusion when she was 84. She was a friendly woman and active in local politics. One day when she was on her way to a meeting at her political club, she forgot where she was going and got lost. It happened again and then again. She began to make excuses for not going out at all. Increasingly she kept to herself. It took a while but eventually her friends and family realized that something was wrong. The family doctor diagnosed her as in the early stages of Alzheimer's. In fact, Mrs. S. was also depressed, and the depression added to the cognitive impairment due to Alzheimer's.

Mr. V. moved into an assisted living facility after his wife died. At first he did well. He made friends and participated in activities both inside and outside the facility. Over time he suffered major memory loss and became extremely repetitive in conversations. His friends and family became increasingly uncomfortable with him and began to avoid him. He had to rely on facility staff for company and to engage him in activities. Despite their patience and kindness, he became edgy with them, sometimes angry, and occasionally verbally abusive. He was miserable—lonely, bored, and embarrassed by his dependency.

Mrs. A. was determined to keep her husband of nearly 50 years at home despite the fact that he had advanced dementia. He needed help eating, bathing, and going to the bathroom. He often paced around their apartment in the middle of the night, so that she got little sleep. Seeing him this way and not being able to talk with him as her life's partner made her very sad. The demands of caregiving and lack of sleep also took a toll on her. She began to look and feel haggard. Their family doctor, their children, and her friends all told her that she had done enough and that she should send her husband to a nursing home. Eventually, she could not bear the stress and agreed. He moved to a lovely facility, but she remained profoundly guilty that she had "abandoned" him.



Michael B. Friedman, LMSW

These are just three examples[2] of the kinds of mental health issues that arise for people with Alzheimer's or other dementias and their caregivers. Mental health problems are common—perhaps even universal—for them. Addressing such problems is key to helping them have the best possible quality of life; but, sadly, mental health issues have been largely ignored in the development of America's current long-term care system and even in efforts to bring about long-term care reform.

Passage of *The National Alzheimer's Project Act (NAPA)* in 2011 has created an opportunity to address the mental health needs of people with dementia. This act calls for the U.S. Department of Health and Human Services (HHS) to develop a long-term plan regarding dementia. Hopefully that plan will recognize the importance of mental health issues.

But it will be an uphill battle, I suspect, because of competition regarding what the nation's priorities should be. Many press for singular focus on the search for a biomedical breakthrough that will produce a cure for dementia or at least result in the development of medications that will arrest its progressive decline long enough for people with dementia to die from other causes. (It's interesting, to say the least, that almost everyone seems to believe that it is preferable to die from cancer or heart disease than from dementia.)

This point of view was recently expressed in an editorial in *Alzheimer's and Dementia by* Zaven Khachaturian of the Campaign to Prevent Alzheimer's Disease by 2020. Khachaturian—a researcher himself--argues, "Ultimately, the only deliverable that counts is a credible plan of action that calls for significant and systematic increases in the allocation of resources and funds for Alzheimer's research... particularly in the discovery and development of interventions to prevent disability."[3]

Many of us, however, are more than a little skeptical that biomedical research can bring relief in time for the 5.4 million Americans who already have dementia or for the additional five to six million people who will develop dementia over the next two decades.[4] We believe that humane care to help them have the best possible quality of life is the critical goal. We see this not as competitive with, but as complementary to, biomedical research.

Even among those of us who are focused on the need for more humane and more effective services and supports, there is some dispute about the importance of mental health services.

In part, this is the result of an outmoded view about the separation of mind and body. Dementia has physical roots with mental manifestations. Many advocates for better Alzheimer's care and treatment focus on the physical roots and do not regard dementia as a mental health condition. Others of us believe that mind and body are inextricably intertwined and that both physical and mental health perspectives and interventions are needed to help people with dementia and their families to have the best possible quality of life.

As the examples at the beginning of this article illustrate, many mental health issues arise in the lives of people with dementia and their caregivers. One way of thinking about them is very well articulated in a recent article by Constantine Lyketsos and others, who argue that "neuropsychiatric symptoms (NPS) are core features of Alzheimer's disease and related dementias." They cite "depression and apathy ... verbal and physical agitation ... [and in later phases] delusions, hallucinations and aggression" as particularly common and important to address with mental health interventions, preferably non-pharmacological interventions.[5]

Lyketsos and his colleagues recognize that many, if not most, people with dementia have co-occurring mental disorders, that they can be treated for these disorders albeit with great caution regarding the use of anti-psychotic and anti-depressant medications, and that treatment often results in a significant improvement in cognitive functioning and quality of life. It's not that treatment for psychiatric disorders reduces cognitive impairment due to dementia, but, when effective, it does reduce cognitive impairment due to depression, anxiety, or psychosis.

There is another psychological perspective that can also be brought to bear on the emotional challenges faced by people with dementia. This perspective arises from the fact that, despite widespread belief that dementia is an unmitigated horror, some people with dementia lead lives that they find satisfying. Helping people with dementia to retain a sense of self-worth and be at peace with who they are can result in substantially improved quality of life for people with Alzheimer's or other dementias. [6]

Mental health issues also touch family caregivers, who provide 80 percent of the care for their relatives with disabilities. They are at high risk for depression, anxiety and physical illnesses that contribute to burn-out. Solid research by Mary Mittelman has shown that psychological support helps family caregivers live better with the stress they face, resulting in delay in nursing home placement by upward of 18 months.[7]

Unfortunately, current policy and practice do not reflect the state-of-the-art. For example, long-term care reform is largely focused on reducing the use of nursing homes, which are over-used in significant part because of the need for better home and community-based mental health services for people with dementia and their families. Despite this, long-term care reform has ignored mental health issues for the most part.

Practice also lags behind our knowledge. There is good reason to believe, for example, that antipsychotic, anti-depressant, and anti-anxiety medications should be used with great caution for people with dementia. Yet, it appears to be routine practice in emergency rooms, acute psychiatric inpatient facilities, nursing homes, and primary care practices to rely on medications as the intervention of first resort. There is also good reason to believe that individualized psycho-social interventions can improve the quality of life of people with dementia in their homes and in residential or day programs. But it appears to be common practice to provide activities that are designed for groups of individuals without regard to personal interests and abilities. And, as noted above, there is strong evidence that family support programs that are also individualized and built on realistic understanding of the demands on the time and strengths of family caregivers can result in reduced stress and better health for the caregivers as well as delay of placement in nursing homes. But families are largely left to their own devices.

A sound national plan for Alzheimer's and other dementias would address these facts. Specifically the national plan should include:

- An explicit priority on addressing the mental health needs of people with dementia and their family caregivers
- Increased funding for research regarding non-pharmacological interventions and psycho-social supports that will help to improve quality of life for people with dementia and their family caregivers
- Funding for demonstration projects using state-of-the art practices
- Funding for translation of research findings into common practice
- A study to determine the changes that are needed in Medicaid, Medicare, and other federal funding streams and regulations to make it possible for providers to address the mental health needs of this population appropriately
- A requirement that state mental health, long-term care, aging, and Medicaid plans include provisions addressing the mental health needs of this population.

Can these steps be taken during a period of history when the federal government will be reducing discretionary spending? That depends more on political will than fiscal reality. Demonstration programs, training initiatives, restructuring, and using the federal bully pulpit to lead the nation in a progressive direction would cost a very small portion of the hundreds of billions of dollars currently spent on mental disorders and dementia care. They might even result in cost offsets due to the avoidance of high cost acute and residential care.

Cost savings, of course, are never certain. What is certain is that failure to build the National Alzheimer's Plan on an understanding of the mental health needs of people with dementia and their families

see Dementia on page 37

— The NYSPA Report —
Medicaid Redesign and the Public Mental Health System in NYS

By Barry B. Perlman, MD, Director, Department of Psychiatry, Saint Joseph's Medical Center, Yonkers, New York and Legislative Chair and Past President New York State Psychiatric Association

In my last piece for *Mental Health News* I presented an overview of the attack on Medicaid, including mental health services, taking place across the nation. I expressed my belief that given NYS's expenditures on Medicaid, which are far higher than any other state, reductions were necessary, although not welcome, in the current dismal economic climate and that we are fortunate that the changes in NYS are being implemented in a thoughtful manner meant to preserve the gains made in the delivery system in recent years and, perhaps, even to improve that system of care.

The work of fostering the wide ranging transformation of the mental health system and the Medicaid system more broadly in NYS has been developed under the aegis of the semitransparent/semi opaque MRT (Medicaid Redesign Team) process and its Behavioral MRT subcommittee working group. All of the changes in our system are playing out against the vast array of changes occurring nationally which include the implementation of ARRA, American Recovery & Reinvestment Act, and the PPACA, Patient Protection & Accountable Care Act.

How NYS's system of public health care will look in the future hangs in the balance and will be based on how well these state and national changes are implemented and work together. Needless to say, we all hope for the best, as our ability to provide care for those we serve as well as our professional practices and the care we ourselves receive depend on it. (Yes, given the dependence of NYS's hospitals on Medicaid reimbursement, the quality of care all New Yorkers receive in hospitals depends on the hospitals' Medicaid revenue.) At the same time it would not be inappropriate to remain skeptical that it will all come out right. Some steps taken give reason for hope while others do not.

The 2011 NYS budget affected wide ranging reductions to the Medicaid program. The resulting changes included but were not limited to: a 2% reimbursement cut for hospitals, including most mental health services both inpatient and outpatient; creation of thresholds for outpatient mental health and drug & alcohol visits which, when exceeded, result in automatic reimbursement reductions; reduction of reimbursement for Continuing Day Treatment Programs (CDT) to the extent that many were shuttered or changed to PROS (Personalized Recovery Oriented Services) programs; transition of the NYS Medicaid formulary to Medicaid HMO based formularies, a limited formulary for those enrollees remaining in the Medicaid Fee For Service (FFS) system and repealed the long standing statutory requirement that when a difference exist between a physician and a Medicaid formulary, the "physician prevails"; the process of moving all of those covered under the Medicaid FFS system in to a fully managed system; initiation of a process of creating Health Homes to provide varying intensities of case management to a "high user" population composed persons with SPMI and/ or chronic medical diseases.

Barry B. Perlman, MD

What questions should NYSPA and other advocates be asking and, based on answers received, what policies and programs should be advocated for or against? Concern needs to be raised about the "Tower of Babel" towards which we have moved as a result of changes made to the Medicaid formulary. Rather than leveraging NYS's immense purchasing power to realize savings, as NYSPA's advocated in its 2005 position paper on the Preferred Drug List, NYS now requires of each Medicaid HMO the task of creating its own formulary. The result is a capricious process resulting in a multitude of differing formularies for psychoactive medications. Many of the HMO formularies do not conform to the NYS OMH PSYCKES Quality Initiative, the goal of which is to minimize exposure of those requiring atypical antipsychotics to risks such as Cardiometabolic Syndrome. The state's own formulary is similarly flawed. Also, given the limitations on drugs, doses and numbers of pills dispensed, psychiatrists are forced to expend treatment time on these matters during patient visits. The new approach is especially problematic when patients are seen in the Emergency Department. NYSPA provided testimony on this matter to a Hearing held by Assemblyman Richard Gottfried, Chair of the Assembly Health Committee, who scheduled the hearings because of his own concern about these matters. The loss of "physician prevails" was ill advised, harmful for patients and deserves to be reversed.

Psychiatrists' experience with managed care has been a particularly difficult. Thus, the news that all NYS Medicaid enrollees will be moved into managed care over the next several years was not good news! However, we are pleased that the transition is a phased one, providing an opportunity to create a more collaborative, less adversarial form of care management. By designating 5 regional carve out BHOs (Behavioral Health Organizations) which will gather data and engage in collaborative management for the next year or so, the state and the providers will gain information that should inform decisions when risk bearing entities are contracted with in 2013 or thereafter. Mental health advocates often have seen their interests decimated when they are drawn into full service medical managed care and often have been savaged by commercial carve out managed care, which are notorious for "just saying no" without helping to solve clinical problems. Hopefully, nonprofit carve out managed care will provide a more collaborative route, one which NYS will hopefully embrace going forward.

Health Homes, encouraged by the PPACA, will replace Targeted Case Management (TCM) over the next couple of years. They will seek to incorporate more than 700,000 persons enrolled in NYS's Medicaid program who by virtue of their having SPMI and/ or multiple chronic medical diseases cost the system disproportionately large amounts of money. While NYS will be advantaged by the federal governments assuming 90% of the cost for the first 2 years, it remains unclear given the reimbursement scheme whether there will be adequate funding to realize the cost saving goals of the effort, especially given the limited funding for the high need SPMI cohort when contrasted with current funding of the TCM program, an approach tailored specifically for those with SPMI. Ultimately, how Health Homes and BHOs work together and align their goals or trip over each other remains an open question with serious potential consequences for patients and providers.

NYS OMH has sought to move the mental health system towards a person centered, recovery oriented approach. The agency has also expressed its belief in a data driven system and one in which consumers should experience more choices of accessible services. Recent years have seen reimbursement for CDT programs so reduced as to force the closure of many across the state in favor of pushing for the opening of PROS (Personalized Recovery Oriented Services) programs. Many clinicians remain skeptical of this programmatic realignment, believing that for an important cohort of vulnerable persons with SPMI, CDT offered an important level of care, given its focus on stability and protection, which PROS does not offer given its emphasis on focused skills training and shorter stays. Those clinicians believe that one program should not have been endorsed at the expense of the other and that both might have continued to be viable, thus providing consumers with a broader array of therapeutic options. It also would have been appropriate to collect data on the impact of the shift, especially on metrics such as success with independent living and avoidable

see Medicaid Redesign on page 33

Many New York City Residents Helped By DOHMH's Depression and Primary Care Initiatives

By Rachael A. Petitti, LCSW, MPhil, Director, Mental Health Treatment Programs and Trish Marsik, Assistant Commissioner, Bureau of Mental Health, New York City Department of Health and Mental Hygiene

The term depression has become pervasive within our culture, from the more common use of the word reflecting a person's temporary state of unhappiness, to the DSM-IV TR classification used to describe a person's medical condition involving a prolonged state of sadness, loss of interest in life, feelings of hopelessness, and decreased energy. The latter definition describes a serious and often untreated life-threatening illness, affecting millions each year, so many in fact, that depression is now believed to be a common and recurrent health problem for more than 35 million people annually. (National Comorbidity Study, NIH 2003). Subsequently, depression in the United States is now the leading cause of disability for all ages (WHO 2008).

Equally, the U.S. Department of Health and Human Services 2005-2006 Household population report revealed:

- 5.4% of Americans experienced depression, with 80% reporting some level of functional impairment.
- 27% of those people reported serious difficulties in work and home life.

Since 2006, DOHMH has been collecting information about depression from New York City residents in its annual Community Health survey (CHS). As of 2009, 13.1% of NYC residents report a history of depression, with 4% reporting their first diagnosis of depression.

Additionally, of the 20 leading causes of disability-adjusted life years (DALYs) in New York City, (NYC, 2011 Epi Data Brief), major depression was the second leading cause of DALYs.

Rachael A. Petitti, LCSW, MPhil

Depression causes suffering, decreases quality of life, and affects serious impairment in social and occupational functioning (NIMH 2008). Although depression can be reliably identified when seen by a professional, vast numbers of people go undiagnosed and untreated. This is the problem.

So if This problem is So Universal, Why Don't More People Get Treated?

We know that depression affects both the mind and the body, producing changes in the biochemistry of the brain, much like other medical disorders. When left untreated, depression can result in not only unnecessary suffering, but also more serious physical complications.

Similarly, most people go to their doctor primarily with complaints of physical ailments never linking a depressive episode as their primary aliment. At the same time primary care doctors, don't typically screen for depressive symptoms as a rule, and therefore do not identify depressive symptoms as being the underlining problem. Research shows that screening in medical facilities can increase early identification rates and lead more people to treatment (Rost 2011). If asked, people often feel more comfortable telling their primary care doctors about these symptoms, therefore, primary care doctors provide the most logical gateway for combating barriers to treatment.

Over the past several years, the NYC Department of Health and Mental Hygiene (DOHMH) has been active in depression-related activities as well as generating depression related publications for doctors, clinicians, and the general public to use.

- Our 2008, City Health Information (CHI) entitled, "Detecting and Treating Depression in Adults" provides physicians with materials for diagnosing and appropriately treating depressive patients, such as the simple PHQ-2 screen for depression.
- Our 2010 CHI, "Improving the Health of Adults With Serious Mental Illness," targeted at physicians and mental health professionals alike, explains potential courses of action in treating physical health problems among those with serious mental illness (SMI), and encourages the coordination of metal and physical health care in patients living with SMI, including depression.
- The June 2011 Health Bulletin "Depression: Feeling Better" defines depression and explains how to identify and self-manage the disease.
- Lastly the Depression Action Kit, available on the DOHMH website includes a number of publications aimed at health care professionals and the general public about identifying and treating depression, such as depression management goal sheets and depression fact sheets.

Older adults have a disproportionate incidence of depression if they are experiencing isolation. The risk of depression in the elderly increases with other illnesses as well, when ability to function becomes limited. Estimates of major depression in older people living in the community range from less than 1 percent to about 5 percent, but rises to 13.5 percent in those who require home healthcare and to 11.5 percent in elderly hospital patients. (Hybels CF and Blazer DG)

As part of our efforts to address this growing problem, through the New York City Council funded Geriatric Initiative, DOHMH has structured screening, referral and reporting of depression for the individuals served. These are delivered in a multitude of non-traditional settings such as senior centers, doctor's offices, naturally occurring retirement communities (NORCs), homeless shelters, soup kitchens, churches, synagogues, and social clubs and as outreach to homebound seniors.

In fiscal year 2011, the Geriatric Initiative screened 5,819 older adults for depression, and has provided treatment referrals and support as needed for countless others.

In truth there has never been a better time to embrace the idea that one's physical health is directly affected by one's mental well-being, and no better time to take the necessary steps toward health integration practices. With Healthcare reform upon us, and the advent of Health Homes in New York State, we now have the road map and the green light to make it finally possible.

Depression from page 10

neurotransmitters—chemicals that brain cells use to communicate—are out of balance in depression. But it has been difficult to prove this.

Brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people who have depression look different than those of people without depression. The parts of the brain involved in mood, thinking, sleep, appetite, and behavior appear different. But these images do not reveal why the depression has occurred. They also cannot be used to diagnose depression.

Some types of depression tend to run in families. However, depression can occur in people without family histories of depression too.[9] Scientists are studying certain genes that may make some people more prone to depression. Some genetics research indicates that risk for depression results from the influence of several genes acting together with environmental or other factors.[10] In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode. Other depressive episodes may occur with or without an obvious trigger.

How Women Experience Depression

Depression is more common among women than among men. Biological, life cycle, hormonal, and psychosocial factors that women experience may be linked to women's higher depression rate. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. For example, women are especially vulnerable to developing postpartum depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming.

Some women may also have a severe form of premenstrual syndrome (PMS) called premenstrual dysphoric disorder (PMDD). PMDD is associated with the hormonal changes that typically occur around ovulation and before menstruation begins.

During the transition into menopause, some women experience an increased risk for depression. In addition, osteoporosis—bone thinning or loss—may be associated with depression.[11] Scientists are exploring all of these potential connections and how the cyclical rise and fall of estrogen and other hormones may affect a woman's brain chemistry.[12]

Finally, many women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It is still unclear, though, why some women faced with enormous challenges develop depression, while others with similar challenges do not.

How Men Experience Depression

Men often experience depression differently than women. While women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt, men are more likely to be very tired, irritable, lose interest in once-pleasurable activities, and have difficulty sleeping.[13,14]

Men may be more likely than women to turn to alcohol or drugs when they are depressed. They also may become frustrated, discouraged, irritable, angry, and sometimes abusive. Some men throw themselves into their work to avoid talking about their depression with family or friends, or behave recklessly. And although more women attempt suicide, many more men die by suicide in the United States.[15]

How Older Adults Experience Depression

Depression is not a normal part of aging. Studies show that most seniors feel satisfied with their lives, despite having more illnesses or physical problems. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms. They may be less likely to

see Depression on page 30

Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers

By The National Institute of Mental Health (NIMH)

Depression is a serious disorder that can cause significant problems in mood, thinking, and behavior at home, in school, and with peers. It is estimated that major depressive disorder (MDD) affects about 5 percent of adolescents.

Research has shown that, as in adults, depression in children and adolescents is treatable. Certain antidepressant medications, called selective serotonin reuptake inhibitors (SSRIs), can be beneficial to children and adolescents with MDD. Certain types of psychological therapies also have been shown to be effective. However, our knowledge of antidepressant treatments in youth, though growing substantially, is limited compared to what we know about treating depression in adults.

Recently, there has been some concern that the use of antidepressant medications themselves may induce suicidal behavior in youths. Following a thorough and comprehensive review of all the available published and unpublished controlled clinical trials of antidepressants in children and adolescents, the U.S. Food and Drug Administration (FDA) issued a public warning in October 2004 about an increased risk of suicidal thoughts or behavior (suicidality) in children and adolescents treated with SSRI antidepressant medications. In 2006, an advisory committee to the FDA recommended that the agency extend the warning to include young adults up to age 25.

More recently, results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders. The study, partially funded by NIMH, was published in the April 18, 2007, issue of the Journal of the American Medical Association.[1]

What Did the FDA Review Find?

In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications. However, about 4 percent of those taking SSRI medications experienced suicidal thinking or behavior, including actual suicide attempts—twice the rate of those taking placebo, or sugar pills.

In response, the FDA adopted a "black box" label warning indicating that antidepressants may increase the risk of suicidal thinking and behavior in some children and adolescents with MDD. A black-box warning is the most serious type of warning in prescription drug labeling.

The warning also notes that children and adolescents taking SSRI medications should be closely monitored for any worsening in depression, emergence of suicidal thinking or behavior, or unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations. Close monitoring is especially important during the first four weeks of treatment. SSRI medications usually have few side effects in children and adolescents, but for unknown reasons, they may trigger agitation and abnormal behavior in certain individuals.

What Do We Know About Antidepressant Medications?

The SSRIs include: fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), fluvoxamine (Luvox), Another antidepressant medication, venlafaxine (Effexor), is not an SSRI but is closely related.

see Medications on page 35

Outcomes Research at Four Winds Hospital

By David Pogge, PhD, Director
Psychological Assessment Services
Four Winds Hospital

Long before the term "evidence based practice" was coined, Four Winds Hospital saw the need to evaluate whether the treatment provided to patients was effective. More than twenty-five years ago the Hospital decided to collect and analyze post-treatment data and the outcomes research project was born. Outcomes research seeks to determine whether the treatment provided to a patient had an effect on the abatement of symptoms, was ineffective or delayed the healing process, eliminated the patient's presenting symptoms or caused other adverse effects. In short, outcomes research tries to answer the question "is what you are doing working?" Due to its complicated nature, the collection, analysis, and understanding of outcome data has been one of the most challenging elements in behavioral healthcare.

Current Outcomes Studies

Four Winds has evolved a three-tiered approach to outcomes data collection. Therapists' ratings of symptoms are collected on all patients at admission and discharge and patient self-report data are obtained on a voluntary basis from adults and adolescents. More than 50% of such patients participate in the research. In addition, specific follow-up studies have been conducted on selected subgroups of patients in an effort to find predictors of post-discharge outcomes and to examine the effectiveness of various discharge plans and treatment strategies. The Hospital has adult and adolescent data spanning almost 20 years, which it reviews regularly to gain insights into the quality of care and the best methods for optimizing patient outcomes. In addition to evaluating the change in a patient's symptoms during treatment at Four Winds, the Hospital also evaluates patients' subjective experience of their treatment. A brief and focused measure of satisfaction was developed more then 10 years ago. This instrument, which has evolved over time, asks patients to rate their satisfaction with various aspects of their experience at Four Winds including the admissions process, their psychiatrist, their therapist, the nursing staff, the food, and their overall satisfaction with their hospital stay. They are also offered the opportunity to write comments about that experience. The cumulative data from patients' ratings are trended and reviewed on a quarterly basis while the written comments are addressed immediately. In this manner the Hospital is able to evaluate changes in the level of patient satisfaction over long periods of time within our adult, adolescent and child inpatient units and the partial hospitalization programs.

David Pogge, PhD

Additionally, The Joint Commission (TJC) began requiring that outcome data be collected and submitted to them on a regular basis for quality assurance purposes. The program, called Hospital Based Inpatient Psychiatric Services (HBIPS), focuses on documenting a limited number of very specific variables that are believed to be critical to the quality of care. These include the early assessment of substance abuse issues and trauma history, the use of high-risk interventions during the hospitalization (e.g., restraint and seclusion), the appropriate justification for treatment with multiple neuroleptic medications, the development of an appropriate discharge plan, and the timely communication of information to the providers at the next level of care. This allows the Hospital to examine the impact that these patient care variables have on clinical improvement and satisfaction. This along with our other outcomes research projects will provide us with insights that can be used to optimize outcomes and increase patient satisfaction.

Conclusions

These two forms of outcomes research represent the Hospital's commitment to understanding the effectiveness of its treatment of patients. The cumulative data from the outcomes studies are trended and

see Outcomes Research on page 22

Managing Your Fear of Side Effects

By Kevin T. Kalikow, MD
Child and Adolescent Psychiatrist

Your child is morose, somber and irritable. She refuses to go to school or see friends. She is increasingly dysfunctional. The doctor suggests medicine and suddenly relief is on the horizon.

Whether it's the pain of depression or anxiety, the dysfunction of ADHD or the conflict that results from over the top tantrums and anger, when your child is not functioning, the offer of medicine can bring the parent immediate hope. However, with that hope comes the dread of side effects. How do you evaluate side effects so that you can make the best possible decision for your child?

Side effects come in different sizes and shapes. Some side effects begin immediately after starting the medicine. You give your child an Adderall and he has no appetite for lunch that day. Other side effects don't rear their ugly heads for months or years. The antipsychotics that were more commonly used from the 1950's through the 1980's caused tardive dyskinesia, a movement disorder that was often apparent only after the patient took the medicine for years.

When you evaluate potential side effects, keep a few things in mind. First, how common is the side effect? Does it occur in 30% of people who take the medicine or only 1%? Or maybe it occurs in 0.1%. These are significantly different. If I told you that the chair you are currently sitting on had a 25% chance of collapsing, you'd probably stand up. If the chance was one in a thousand, you might well take your chances and rest your tired knees.

Next, does medicine cause the side effect more frequently than placebo (an identical pill, although not containing medicine)? When medicine is researched before being marketed, its side effect profile is compared to that of placebo. If medicine causes sedation in 15% of people and placebo causes sedation in 15% of people, one would have a tough time blaming the medicine. Some side effects are experienced commonly by those taking placebo.

Third, ask whether the alleged side effect occurs more commonly than it does in people who do not take medicine. The stimulants, like Ritalin and Adderall, currently find themselves as the target of accusations that they cause sudden death. Research is underway to attempt to answer this question. While one never wants to sound so scientific that one is out of touch with the most horrible event of the death of a child, an important background question is whether the rate of sudden death of those taking stimulants is any different than the baseline rate of sudden death in those not taking stimulants.

These are some of the factors important in evaluating side effects. Every day I help parents put their multitude of concerns into perspective by having them reduce the entire discussion to an acronym I created. Are the side effects LIV? That is, are they lethal, irreversible or

see Side Effects on page 22

FOUR WINDS HOSPITAL • SPRING 2012

APRIL 2012

GRAND ROUNDS

A Four Winds Foundation Presentation

Friday, April 20, 2012 • 9:30 – 11:00 am

The Impact of Terrorism on Children and Adolescents: Terror in the Skies, Terror on the Television

Eugene Beresin, M.D.,

Director, Child and Adolescent Psychiatry Residency Training, Massachusetts General Hospital and McLean Hospital; Co-Director, Massachusetts General Hospital Center for Mental Health and Media; Professor, Department of Psychiatry, Harvard Medical School, Boston, MA

Dr. Gene Beresin will lead this multi-faceted program, which will include a lecture on evidence-based findings in media research on Post Traumatic Stress Disorder (PTSD) secondary to children viewing media. He will then present the Emmy Award winning HBO Children's Special: (*Through a Child's Eyes: September 11, 2001.*) Dr. Beresin was a consultant for this production, and took an active role in its conception. He will conclude by leading a discussion regarding the role of educational media productions in fostering healthy growth and development of children and adolescents. At the conclusion of this program participants shall:

- Identify the symptoms of post-traumatic stress disorder.
- Understand the clinical impact of media exposure of terrorist activities on children and adolescents.
- Appreciate the range of symptoms in children and adolescents at different developmental stages.
- Understand what parents and clinicians can do to help prevent symptom formation in their children when exposed to terrorist events on television.

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

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 2012

OPEN HOUSE

Tuesday, April 24, 2012
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

Competitive Salaries/Benefits

RSVP by April 17th to 1-800-528-6624 ext. 2486

MAY 2012

A COMMUNITY SERVICE

Wednesday, May 2, 2012 • 2:00 – 4:00 pm

National Anxiety Disorder 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 2012

GRAND ROUNDS

Friday, May 18, 2012 • 9:30 – 11:00 am

Treatment of Complex Trauma in Children and Adolescents

Christine A. Courtois, Ph.D., ABPP,

Courtois & Associates, PC, Washington, DC

Complex post-traumatic conditions often develop in the aftermath of chronic cumulative trauma, particularly severe child abuse and neglect. It can also develop over the course of adulthood. This Grand Rounds presentation will provide information about the nature, diagnosis, and treatment of complex trauma, drawing upon recent clinical writings and empirical findings. Topics to be covered include: description of complex trauma and diagnostic criteria for Complex PTSD (in adults) or Developmental Trauma Disorder (in children); treatment philosophy and treatment frame; sequenced treatment, and specific strategies and approaches, especially those directed towards affect regulation, ego-enhancement, symptom stabilization, and trauma-processing. Evidence-based treatments will be emphasized.

At the conclusion of this program participants will:

- Be able to identify the aftereffects of chronic cumulative trauma (particularly during childhood) as a complex post-traumatic condition and will be able to identify criteria of this condition.
- Gain an understanding of the philosophy and sequencing of treatment for complex post-traumatic conditions in children and adolescents.
- Be able to identify a variety of treatment strategies and techniques for complex post-traumatic conditions, including the evidence base that is available.

Fee: $15, payable to Four Winds Hospital

1.5 CME Credits Pending

1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours pending*

JUNE 2012

SPECIAL TRAINING

Thursday, June 7, 2012 • 9:30 am – 12:00 pm

Child Abuse Identification & Reporting

Valerie Saltz, LCSW,

Four Winds Hospital-Westchester

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

JUNE 2012

GRAND ROUNDS

Friday, June 8, 2012
9:30 – 11:00 am

Treatment of Patients with Substance Abuse and Bipolar Disorder

Roger D. Weiss, M.D.,

Professor of Psychiatry, Harvard Medical School; Chief, Division of Alcohol and Drug Abuse, McLean Hospital

This lecture will review pharmacologic and psychosocial treatment approaches for patients dually diagnosed with substance use disorder and bipolar disorder and will focus on a new, evidence-based treatment, Integrated Group Therapy, which has demonstrated better outcomes than standard Group Drug Counseling in two different studies. The theory behind Integrated Group Therapy and key principles will be reviewed. At the conclusion of this program participants shall:

- Understand the frequency and importance of the co-occurrence of bipolar disorder and substance use disorder.
- Understand key issues related to reasons for medication non-adherence among patients with bipolar disorder and substance use disorder.
- Understand the key principles underlying Integrated Group Therapy, and the general conduct of a group session.

Fee: $15, payable to Four Winds Hospital

1.5 CME Credits Pending
1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours pending*

Outcomes Research from page 19

reviewed on a quarterly basis by Hospital leadership, while the written comments are addressed immediately. As a result of these efforts, Four Winds has more than 20 years of data from which it has been able to monitor and steadily improve its quality of care and the level of satisfaction of its patients. Over the long term, each research tool, regardless of the source of the data, has shown that patients improved significantly as a result of hospitalization, often to a degree that is life changing. Patients have shown positive changes during treatment and those changes often persist, to a remarkable degree, beyond hospitalization. These positive outcomes of hospitalization have remained consistent despite changes in the modes of treatment, the population of patients served at the Hospital, and the radical decline in the length of hospital stays. The Hospital's commitment to outcome research will continue in the future as it continues to modify its research tools, analyzes and responds to the data collection results, and strives to provide better outcomes for patients. We are pleased to have had federal grant money for some of our projects and to have reported a number of these findings in journals, meetings, and presentations.

Side Effects from page 19

very painful? If a side effect is not LIV, I am concerned, but I don't spend too much time worrying about it. If a side effect is LIV, then I carefully consider whether the potential benefit of the medicine is worth the risk of the side effect. LIV side effects are those that every doctor and patient want to avoid. Yet, sometimes the potential benefit outweighs the risk.

An example: Mrs. McGee is worried about starting her son, Mickey, on Adderall. She's heard it causes diminished appetite. Of course, Mickey needs to eat. However, while there's a fair chance that Mickey's lunchtime appetite will be diminished on the day he takes Adderall, he'll probably make up for this with an after school snack or big dinner. If not, we can always stop the Adderall and Mickey's appetite will be back to normal the next day. No harm, no foul. Mickey is none the worse for wear.

On the other hand, Mrs. McDermott is worried about starting her daughter on Risperdal. She's heard it causes diabetes. Melanie is an overweight young teen who is out of control and might have bipolar disorder. Risperdal does cause weight gain in many. And with weight gain there is the possibility of increasing cholesterol and blood sugar. These are risk factors for Melanie developing diabetes. That is by no means a certainty, but it's not clear whether such diabetes would be reversible. Mrs. McDermott has a tough decision. Using Risperdal (or one of its relatives) is not necessarily a bad idea, but the LIV side effect forces doctor, parent and perhaps patient, to more carefully weigh the potential benefit against the risk.

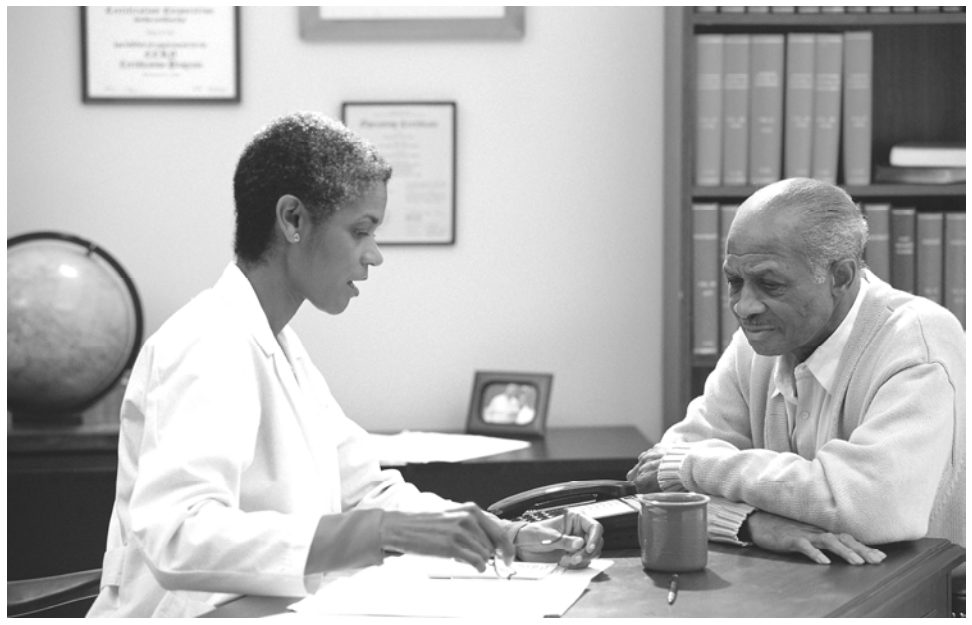
The LIV side effects are those that should give us all pause for thought. Medicines with LIV side effects are prescribed every day. However, they should only be prescribed after it is decided that the probability and extent of benefit outweighs the probability of the LIV side effect.

While there is much to be learned, doctors have a fair amount of knowledge of the side effects of the psychiatric medicines we prescribe to children. When talking to your health care professional it is important to ask about a medicine's side effects, but not to let the fear of side effects prevent a reasoned consideration of using medicine.

Dr. Kevin T. Kalikow is a Child and Adolescent Psychiatrist in Private Practice in Mt. Kisco, New York. He is Assistant Clinical Professor in Child Psychiatry at New York Medical College. He is the author of "Your Child in the Balance: An Insider's Guide for Parents to the Psychiatric Medicine Dilemma" and the newly released, "Kids on Meds: Up-to-Date Information About the Most Commonly Prescribed Psychiatric Medications."

A Comprehensive Overview of Psychotherapy

By The National Institute of Mental Health (NIMH)



Psychotherapy, or "talk therapy," is a way to treat people with a mental disorder by helping them understand their illness. It teaches people strategies and gives them tools to deal with stress and unhealthy thoughts and behaviors. Psychotherapy helps patients manage their symptoms better and function at their best in everyday life.

Sometimes psychotherapy alone may be the best treatment for a person, depending on the illness and its severity. Other times, psychotherapy is combined with medications. Therapists work with an individual or families to devise an appropriate treatment plan.

What are the Different Types of Psychotherapy?

Many kinds of psychotherapy exist. There is no "one-size-fits-all" approach. In addition, some therapies have been scientifically tested more than others. Some people may have a treatment plan that includes only one type of psychotherapy. Others receive treatment that includes elements of several different types. The kind of psychotherapy a person receives depends on his or her needs.

This section explains several of the most commonly used psychotherapies. However, it does not cover every detail about psychotherapy. Patients should talk to their doctor or a psychotherapist about planning treatment that meets their needs.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a blend of two therapies: cognitive therapy (CT) and behavioral therapy. CT was developed by psychotherapist Aaron Beck, M.D., in the 1960's. CT focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy. Behavioral therapy focuses on a person's actions and aims to change unhealthy behavior patterns.

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly. CBT can be applied and adapted to treat many specific mental disorders.

CBT for depression: Many studies have shown that CBT is a particularly effective treatment for depression, especially minor or moderate depression. Some people with depression may be successfully treated with CBT only. Others may need both CBT and medication. CBT helps people with depression restructure negative thought patterns. Doing so helps people interpret their environment and interactions with others in a positive and realistic way. It may also help a person recognize things that may be contributing to the depression and help him or her change behaviors that may be making the depression worse.

CBT for anxiety disorders: CBT for anxiety disorders aims to help a person develop a more adaptive response to a fear. A CBT therapist may use "exposure" therapy to treat certain anxiety disorders, such as a specific phobia, posttraumatic stress disorder, or obsessive compulsive disorder. Exposure therapy has been found to be effective in treating anxiety-related disorders.[1] It works by helping a person confront a specific fear or memory while in a safe and supportive environment. The main goals of exposure therapy are to help the patient learn that anxiety can lessen over time and give him or her the tools to cope with fear or traumatic memories.

A recent study sponsored by the Centers for Disease Control and Prevention concluded that CBT is effective in treating trauma-related disorders in children and teens.

CBT for bipolar disorder: People with bipolar disorder usually need to take medication, such as a mood stabilizer. But CBT is often used as an added treatment. The medication can help stabilize a person's mood so that he or she is receptive to psychotherapy and can get the most out of it. CBT can help a person cope with bipolar symptoms and learn to recognize when a mood shift is about to occur. CBT also helps a person with bipolar disorder stick with a treatment plan to reduce the chances of relapse (e.g., when symptoms return).[2]

CBT for eating disorders: Eating disorders can be very difficult to treat. However, some small studies have found that CBT can help reduce the risk of relapse in adults with anorexia who have restored their weight.[3] CBT may also reduce some symptoms of bulimia, and it may also help some people reduce binge-eating behavior.[4]

CBT for schizophrenia: Treating schizophrenia with CBT is challenging. The disorder usually requires medication first. But research has shown that CBT, as an add-on to medication, can help a patient cope with schizophrenia.[5] CBT helps patients learn more adaptive and realistic interpretations of events. Patients are also taught various coping techniques for dealing with "voices" or other hallucinations. They learn how to identify what triggers episodes of the illness, which can prevent or reduce the chances of relapse.

CBT for schizophrenia also stresses skill-oriented therapies. Patients learn skills to cope with life's challenges. The therapist teaches social, daily functioning, and problem-solving skills. This can help patients with schizophrenia minimize the types of stress that can lead to outbursts and hospitalizations.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT), a form of CBT, was developed by Marsha Linehan, Ph.D. At first, it was developed to treat people with suicidal thoughts and actions. It is now also used to treat people with borderline personality disorder (BPD). BPD is an illness in which suicidal thinking and actions are more common.

The term "dialectical" refers to a philosophic exercise in which two opposing views are discussed until a logical blending or balance of the two extremes—the middle way—is found. In keeping with that philosophy, the therapist assures the patient that the patient's behavior and feelings are valid and understandable. At the same time, the therapist coaches the patient to understand that it is his or her personal responsibility to change unhealthy or disruptive behavior.

DBT emphasizes the value of a strong and equal relationship between patient and therapist. The therapist consistently reminds the patient when his or her behavior is unhealthy or disruptive—when boundaries are overstepped—and then teaches the skills needed to better deal with future similar situations. DBT involves both individual and group therapy. Individual sessions are used to teach new skills, while group sessions provide the opportunity to practice these skills.

Research suggests that DBT is an effective treatment for people with BPD. A recent NIMH-funded study found that DBT reduced suicide attempts by half compared to other types of treatment for patients with BPD.[6]

Interpersonal Therapy

Interpersonal therapy (IPT) is most often used on a one-on-one basis to treat depression or dysthymia (a more persistent but less severe form of depression). The current manual-based form of IPT used today was developed in the 1980's by Gerald Klerman, M.D., and Myrna Weissman, M.D.

IPT is based on the idea that improving communication patterns and the ways people relate to others will effectively treat depression. IPT helps identify how a person interacts with other people. When a behavior is causing problems, IPT guides the person to change the behavior. IPT explores major issues that may add to a person's depression, such as grief, or times of upheaval or transition. Sometimes IPT is used along with antidepressant medications.

IPT varies depending on the needs of the patient and the relationship between the therapist and patient. Basically, a therapist using IPT helps the patient identify troubling emotions and their triggers. The therapist helps the patient learn to express appropriate emotions in a healthy way. The patient may also examine relationships in his or her past that may have been affected by distorted mood and behavior. Doing so can help the patient learn to be more objective about current relationships.

Studies vary as to the effectiveness of IPT. It may depend on the patient, the disorder, the severity of the disorder, and other variables. In general, however, IPT is found to be effective in treating depression.[7]

A variation of IPT called interpersonal and social rhythm therapy (IPSRT) was developed to treat bipolar disorder. IPSRT combines the basic principles of IPT with behavioral psychoeducation designed to help patients adopt regular daily routines and sleep/wake cycles, stick with medication treatment, and improve relationships. Research has found that when IPSRT is combined with medication, it is an effective treatment for bipolar disorder. IPSRT is as effective as other types of psychotherapy combined with medication in helping to prevent a relapse of bipolar symptoms.[8]

Family-Focused Therapy

Family-focused therapy (FFT) was developed by David Miklowitz, Ph.D., and Michael Goldstein, Ph.D., for treating bipolar disorder. It was designed with the assumption that a patient's relationship with his or her family is vital to the success of managing the illness. FFT includes family members in therapy sessions to improve family relationships, which may support better treatment results.

Therapists trained in FFT work to identify difficulties and conflicts among family members that may be worsening the patient's illness. Therapy is meant to help members find more effective ways to resolve those difficulties. The therapist educates family members about their loved one's disorder, its symptoms and course, and how to help their relative manage it more effectively. When families learn about the disorder, they may be able to spot early signs of a relapse and create an action plan that involves all family members. During therapy, the therapist will help family members recognize when

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Cognitive Behavior Therapy To Treat Depression in Individuals with Asperger's Syndrome

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This article will focus on those with Asperger's Syndrome (AS) who have a co-morbid mental health diagnosis, as current research supports the effectiveness of cognitive behavioral therapy (CBT) for this sub-group on the autism continuum. This is not to say that those diagnosed with PDD-NOS or Autism could not benefit from CBT; however, the research does not support it yet. In general, two factors that will likely contribute to the effectiveness of CBT for those with ASD's include the individual's level of communication skills and intellectual functioning.

Individuals with Asperger's Syndrome have an increased risk for developing mental health problems including mood and anxiety disorders. Individuals with Asperger's appear susceptible to experiencing feelings of depression, with about one in three children and adults having a clinical depression (Ghaziuddin et al. 1998; Kim et al. 2000). For adolescents with AS, the current research suggests that approximately sixty five percent have an affective or mood disorder with the prevalence of depression being high (Konstantareas 2005). Individuals with AS may also experience dysthymia, a type of depression with less severe, but longer lasting symptoms than major depressive disorder.

There are several reasons people with Asperger's Syndrome are prone to develop mood disorders. One being that they are aware of the difficulties they have with social understanding. This awareness can lead to overwhelming feelings of isolation and a desire to be accepted and understood. Consequently, a reactive depression can occur which can lead to strong feelings of grief, self-blame and criticism, criticism of others, and feelings of frustration or anger (Attwood, 2007).

When young children with AS feel socially secluded they can develop compensatory thoughts and attitudes (Attwood, 2004). For instance, children who struggle to develop friendships and achieve social competence can wind up internalizing their thoughts and feelings by being overly apologetic and gradually more withdrawn. The more withdrawn these children become, the fewer opportunities there are for them to develop their social skills. Children with AS can usually acknowledge their social isolation on an intellectual level, but want nothing more than to have friends. However, their difficulty lies in not knowing what to do in order to attain social success, as they lack the social skills that come so naturally to their peers.

Although those with AS may show signs of depression as early as childhood, it

Natalia Appenzeller, PhD

becomes more acute during adolescence when peer differences are more noticeable. During adolescence, the importance of and identification with the peer group increases while the influence of one's parents lessens. As an adolescent with AS becomes more intellectually mature, this can lead to an increased realization of a lack of social success, greater insight into being different from other people, and a perception of oneself as being socially inept. Furthermore, because previous negative experiences can remain with people throughout their lifetime, children with AS who may have been bullied can feel lonely and misunderstood as an adolescent. For adolescents, problems with fitting in socially and achieving academic success can result in the development of a clinical depression. At the extreme, some adolescents and adults with AS who are clinically depressed may view suicide as the only way to ending their emotional suffering and the risk of self-injury also exists. While the symptoms of depression are often similar to those seen in neurotypical children and adults, clinicians specializing in AS have observed another characteristic that can be suggestive of depression. The restricted or stereotyped interests often seen in individuals with AS, which are frequently associated with pleasure, can become morbid when the person is depressed (Attwood, 2007).

The treatment of depression in individuals with AS should include, among other interventions, cognitive-behavioral therapy (CBT), a structured, problem-focused psychological treatment approach. CBT is based on a theoretical model, that maintains a person's thoughts, feelings, and behaviors directly influence each other and play a role in the development and maintenance of psychological disorders, such as depression. Dubin (2009) posits that the fundamental idea of CBT is that changing thoughts to more accurately reflect external reality will, in turn, cause behavior to change to match the new, reality-based thoughts. Thus, the goals of CBT are threefold: 1.) Increase clients' awareness of their thoughts and help them determine whether those thoughts appropriately match up with the reality of the situation 2.) Help clients' better understand their emotions and teach strategies to improve emotion regulation. 3.) Examine and change behaviors that produce and maintain problematic thoughts and emotions.

Research studies have determined that CBT is an effective treatment to alter the way a person thinks about and responds to emotions such as anxiety, sorrow and feelings of anger (Grave and Blissett 2004; Kendall 2000). For individuals with Asperger's Syndrome, CBT can help to manage emotions better and cut back on obsessive interests and repetitive routines, according to the National Institute of Neurological Disorders at the National Institutes of Health. CBT is therefore relevant for children and adults with AS who have difficulty understanding, expressing, and managing emotions constructively and a limited capacity to understand other's mental states. CBT has shown success both by itself and in combination with medication. Importantly, research has demonstrated that CBT significantly reduces mood disorders in children and adults with AS (Bauminger 2002; Sofronoff, Attwood and Hinton 2005).

It is important that the treating therapist understand how to modify traditional CBT in order to accommodate the unique cognitive profile of an individual with AS. According to Dr. Natalia Appenzeller, Clinical Director of the Fay J. Lindner Center for Autism and Developmental Disabilities, "traditional cognitive behavioral therapy can effectively be modified and adapted to meet the cognitive styles of those with an autism spectrum diagnosis".

Using a cognitive behavior model to treat co-morbid mental health issues in individuals with Asperger's Syndrome usually follows a sequence:

1. Assess the degree of the mental health concern: (e.g. level of depression or anxiety). This can be done using self-report and/or parent report rating scales and a clinical interview.

2. Create a treatment plan: Visual supports often assist in providing a rationale to the patient for the treatment plan. A visual support could be in the form of a dry erase board or flip chart to outline to the patient the presenting problem, a plan to treat the problem and a description of the cognitive behavior model. A diagram can be drawn to help patients understand their diagnosis and conceptualize the treatment plan.

3. Education: In this phase the therapist assists by teaching a skill set that has not yet been developed and increase patients' knowledge and awareness of their own emotions. According to Gaus 2007, the most common skills that need to be taught are social and coping skills. Many patients with Asperger's syndrome appreciate the concrete concepts taught as part of the cognitive behavioral model.

4. Restructuring: Work to correct the distorted self-conceptualizations help patients to manage emotions and cope more effectively. An impaired ability to attribute beliefs, intentions and desires to others, as well as difficulty with cognitive flexibility often pose challenges when attempting to restructure distorted cognitions in those with ASD. Therefore, the use of visuals is an essential component of the treatment package. Often, therapists will provide patients with a handout highlighting material covered in the session or will write down goals or targets for each week.

5. Maintenance Activities: During this phase, patient's practice a more positive self-concept as well as coping behaviors when encountered with anxiety producing scenarios. Relaxation strategies associated with the physical symptoms of anxiety are usually more beneficial than the emotional concept of what provokes anxiety. Scripts and comic strip conversations (Gray, 1998) can assist the therapist in delivering information concretely and help to ensure that the individual understands the concept being taught.

To increase the likelihood for success when using CBT for those with Asperger's Syndrome intervention components including the use of visual aids, social stories and conversation scripts, modeling and concrete examples of abstract concepts, and the incorporation of the individual's special interests into therapy are critical to the success of the intervention program.

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Considerations For Mental Health Data Collection Using Online Methods

By Oren Shtayermman, PhD, MSW
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According to the U.S. Census Bureau, in the year 2009, 68 percent of households in the USA had internet access from their home computer. Since the early 1980's there has been more than a five-fold increase in the proportion of households with computers. Among family households with income of $75,000 or more 88 percent had at least one computer and 79 percent had at least one member who used the Internet. Married-couple households were the most likely to have a computer or Internet access. The presence of a child also influenced whether a household had a computer or Internet access. Two thirds of households with a school age child (6-17 years) had a computer, and 53 percent had Internet access. These statistics opened the door to a new method for collecting data on mental health using either Web based surveys or E-mail surveys.

The initial movement for Web based surveys came from the software industry rather than from the academic research community. In the early days of the World Wide Web, pages were largely static and allowed only one-way communication, from the Web site to the user (Saxon, Garratt, Gilroy & Cairns, 2003). The arrival of the Internet and online communications expanded the potential modes of data collection, as well as the possibility of persons' completing surveys at a time of their choosing. Thach (2003) claimed that there are three advantages for e-mail survey research over mailed surveys: speed, convenience of responding, and the absence of intermediaries. Other advantages of conducting electronic survey research include lower costs, faster transmission time, and ease of editing. In addition to that, some of the other advantages include the access to previously hidden populations and better data through the reduction of error. The reduction of error is due to the elimination of data entry.

Other advantages of the web survey are a return with a keystroke, and the information is recoded automatically into a database (McMahon, Iwamoto, Massoudi, Yusuf, Stevenson, David. et al, 2003). Schuldt (1994) argued that e-mail survey advantages are the elimination of time zone, not wasting paper (environmentally conscious), fast and easy to use, delivery is certain and the cost is low to reasonable. Aside from the obvious advantages stated above when using either web based surveys or email surveys, it is essential to remember that from a research or data collection perspective, the ability to generalize findings using these methods is limited to those individuals with computers and Internet access.

One major disadvantage of the method is the lack of anonymity, as e-mail response typically comes back to the researcher with the sender's information (Daley, McDermott, McCormack and Kittleson, 2003). Especially if we are interested in hidden or hard to reach populations, this could serve as a challenging factor. The "digital divide" (Rhodes, Bowie & Hergenrather, 2003) also presents the challenge of reaching only certain populations from certain socio-economic status. By and large, being able to retrieve and obtain data on mental health on populations with limited financial resources would be difficult to impossible.

Because most if not all measures to assess mental health relies on the ability of the person to report thoughts, feelings and behaviors, individuals who are interested in obtaining such information must take into account both the literacy level of the target individuals as well as any potential issues related to learning and developmental disabilities. A disability, for example, can possibly cause more missing data as compared with interviews administered online. The missing data can occur as a consequence of an individual's particular learning disability which may impact his/her ability to process written information and to respond to it appropriately.

One of the biggest concerns of researchers and practitioners is the ability of the person who is responsible for the data collection to observe and respond to information presented by a respondent. If a respondent reports on suicidal thoughts or severe depressive symptoms that may be linked to harm to self or others, in a virtual world, the person who is collecting data has very limited resources to address such matters. Practitioners as well as researchers have an ethical responsibility towards clients or patients as well as research participants. Being conscious of vulnerable populations as well as effectively planning how to assist individuals who are reporting on mental health issues online needs to take center stage when considering contemporary methods for data collection on mental health.

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In My Own Voice: The Disability of Mental Health

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Mental illness is known to be a devastating disease that is well understood by the treatment community. In recent years however, we have heard more input from patients (commonly referred to as "consumers") about their experience with mental illnesses of all types. Clinicians have known symptoms to be unbearable for those suffering from diseases such as major depression, schizophrenia, or bipolar disorder. Now that consumers have entered into the discussion, better understandings and new insights are being posed everyday.

As a consumer who has dealt with a history of depression, I would like to discuss my experience having and living with a mental health issue. The usual ways some consumers explaining the difficulties of their illness are in terms of the many losses they have had to endure as a result of it. Things such as not being able to have a job, or a car, or money, and being estranged from loved ones, are certainly most disabling for consumers or anyone for that matter. These are obvious basic necessities for happiness that everyone should be entitled to have in their life.

What I would like to address is my experience of wanting these basic necessities but feeling unable to take the steps necessary to begin to make progress in that direction. Some might say it is a feeling of being "stuck," unable to move forward with life-changing achievements.

Jeffrey V. Perry, CPRP, MSM

At the onset of my illness I found that I was unable to do the things I was accustomed to doing. I became so overwhelmed trying to care for myself that much of the rest of my life was put on hold. I had to give up my dreams of working or finishing school. I even believed that I could not continue my relationship with my girlfriend because I felt that she would only see me at my worst.

When my mental health condition was at its worst, I doubted everything, especially things about myself. It felt like I was losing my mind. At the same time, I was aware of the inherent stigma associated with having a mental illness. The most heart-breaking experience for me was my own thinking that I would have to succumb to my every fear in order to find peace in my madness. The madness was better than trying to cling to the little sanity that I could grasp. This is what began the disability, which I am referring to; it was like sinking into a vast oblivion, an abyss of almost being on the inside of me, looking out. My illness created a void in my life that I would never be able to fill and many people told me that I would never be able to regain the life I once knew.

The process of getting better or recovery as we now call it, is finding ways to close the distance between truth and confusion — to open up the lines of communication, bridge the gap, and link one person to another. Communication with a mentally traumatized person means changing negative comprehensions to positive ones.

How does an unhealthy mind disable me? First, there is such very low self-esteem. If I shall fall into a hole of depression, then, my only preoccupation will be to come out or to reach for the top. That may help me to get out, initially. Still, I must begin to move away from that hole so as not to fall back in it. My disability is therefore this struggle to stay out of the hole and to know that I am, indeed out. Sometimes, with mental illness we have to first validate that it is possible to get out or to recover before proceeding any further. The feeling persists that although I have been out before, it is easy to fall back into a depression, for example, as when a loved one passes away. Therefore, I need supports including self-supports, in place, to help reassure me that I can stay mentally healthy under most circumstances; particularly, those circumstances, which occur as a part of living. It is at this point, being able to use a self-supportive and networking system, I can stop allowing a mental health issue from making me disabled. As a result, just maybe, then, I could work or drive or enjoy my life with family. In addition, I may even be able to look up an old girlfriend, using social media systems to see how she has fared.

My point here is that we must stop creating negative environments with negative attitudes. We must learn to focus on "positives" with impetus and input to solve problems. We must not focus on the circumstances or the persons. The mind is still a terrible thing to waste, not just for a person suffering with a mental health issue, but it is also a tragic waste for anyone trying to be a helper to that suffering person. You can sometimes use a healthy mind to comfort an unhealthy mind or someone having a problem. Disability occurs when no one, neither consumer nor helper, is able to think anything positive or to do anything helpful, using forward-thinking.

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experience or admit to feelings of sadness or grief.[16]

Sometimes it can be difficult to distinguish grief from major depression. Grief after loss of a loved one is a normal reaction to the loss and generally does not require professional mental health treatment. However, grief that is complicated and lasts for a very long time following a loss may require treatment. Researchers continue to study the relationship between complicated grief and major depression.[17]

Older adults also may have more medical conditions such as heart disease, stroke, or cancer, which may cause depressive symptoms. Or they may be taking medications with side effects that contribute to depression. Some older adults may experience what doctors call vascular depression, also called arteriosclerotic depression or subcortical ischemic depression. Vascular depression may result when blood vessels become less flexible and harden over time, becoming constricted. Such hardening of vessels prevents normal blood flow to the body's organs, including the brain. Those with vascular depression may have, or be at risk for, co-existing heart disease or stroke.[18]

Although many people assume that the highest rates of suicide are among young people, older white males age 85 and older actually have the highest suicide rate in the United States. Many have a depressive illness that their doctors are not aware of, even though many of these suicide victims visit their doctors within 1 month of their deaths.[19]

Most older adults with depression improve when they receive treatment with an antidepressant, psychotherapy, or a combination of both.[20] Research has shown that medication alone and combination treatment are both effective in reducing depression in older adults.[21] Psychotherapy alone also can be effective in helping older adults stay free of depression, especially among those with minor depression. Psychotherapy is particularly useful for those who are unable or unwilling to take antidepressant medication.[22,23]

How Children and Teens Experience Depression

Children who develop depression often continue to have episodes as they enter adulthood. Children who have depression also are more likely to have other more severe illnesses in adulthood.[24]

A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Older children may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. Because these signs may be viewed as normal mood swings typical of children as they move through developmental stages, it may be difficult to accurately diagnose a young person with depression.

Before puberty, boys and girls are equally likely to develop depression. By age 15, however, girls are twice as likely as boys to have had a major depressive episode.[25]

Depression during the teen years comes at a time of great personal change—when boys and girls are forming an identity apart from their parents, grappling with gender issues and emerging sexuality, and making independent decisions for the first time in their lives. Depression in adolescence frequently co-occurs with other disorders such as anxiety, eating disorders, or substance abuse. It can also lead to increased risk for suicide.[24,26]

An NIMH-funded clinical trial of 439 adolescents with major depression found that a combination of medication and psychotherapy was the most effective treatment option.[27] Other NIMH-funded researchers are developing and testing ways to prevent suicide in children and adolescents.

Diagnosing and Treating Depression

Depression, even the most severe cases, can be effectively treated. The earlier that treatment can begin, the more effective it is.

The first step to getting appropriate treatment is to visit a doctor or mental health specialist. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities by doing a physical exam, interview, and lab tests. If the doctor can find no medical condition that may be causing the depression, the next step is a psychological evaluation.

The doctor may refer you to a mental health professional, who should discuss with you any family history of depression or other mental disorder, and get a complete history of your symptoms. You should discuss when your symptoms started, how long they have lasted, how severe they are, and whether they have occurred before and if so, how they were treated. The mental health professional may also ask if you are using alcohol or drugs, and if you are thinking about death or suicide.

Once diagnosed, a person with depression can be treated in several ways. The most common treatments are medication and psychotherapy.

Medication

Antidepressants primarily work on brain chemicals called neurotransmitters, especially serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists have found that these particular chemicals are involved in regulating mood, but they are unsure of the exact ways that they work. The latest information on medications for treating depression is available on the U.S. Food and Drug Administration (FDA) website: www.fda.gov.

Popular newer antidepressants. Some of the newest and most popular antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are some of the most commonly prescribed SSRIs for depression. Most are available in generic versions. Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta).

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

One popular antidepressant that works on dopamine is bupropion (Wellbutrin). Bupropion tends to have similar side effects as SSRIs and SNRIs, but it is less likely to cause sexual side effects. However, it can increase a person's risk for seizures.

Tricyclics are older antidepressants. Tricyclics are powerful, but they are not used as much today because their potential side effects are more serious. They may affect the heart in people with heart conditions. They sometimes cause dizziness, especially in older adults. They also may cause drowsiness, dry mouth, and weight gain. These side effects can usually be corrected by changing the dosage or switching to another medication. However, tricyclics may be especially dangerous if taken in overdose. Tricyclics include imipramine and nortriptyline.

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. They can be especially effective in cases of "atypical" depression, such as when a person experiences increased appetite and the need for more sleep rather than decreased appetite and sleep. They also may help with anxious feelings or panic and other specific symptoms.

However, people who take MAOIs must avoid certain foods and beverages (including cheese and red wine) that contain a substance called tyramine. Certain medications, including some types of birth control pills, prescription pain relievers, cold and allergy medications, and herbal supplements, also should be avoided while taking an MAOI. These substances can interact with MAOIs to cause dangerous increases in blood pressure. The development of a new MAOI skin patch may help reduce these risks. If you are taking an MAOI, your doctor should give you a complete list of foods, medicines, and substances to avoid.

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. MAOIs should not be taken with SSRIs.

How To Take Medications

All antidepressants must be taken for at least 4 to 6 weeks before they have a full effect. You should continue to take the medication, even if you are feeling better, to prevent the depression from returning.

Medication should be stopped only under a doctor's supervision. Some medications need to be gradually stopped to give the body time to adjust. Although antidepressants are not habit-forming or addictive, suddenly ending an antidepressant can cause withdrawal symptoms or lead to a relapse of the depression. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely.

In addition, if one medication does not work, you should consider trying another. NIMH-funded research has shown that people who did not get well after taking a first medication increased their chances of beating the depression after they switched to a different medication or added another medication to their existing one.[28,29]

> *"It was really hard to get out of bed in the morning. I just wanted to hide under the covers and not talk to anyone. I didn't feel much like eating and I lost a lot of weight. Nothing seemed fun anymore. I was tired all the time, and I wasn't sleeping well at night. But I knew I had to keep going because I've got kids and a job. It just felt so impossible, like nothing was going to change or get better."*

Sometimes stimulants, anti-anxiety medications, or other medications are used together with an antidepressant, especially if a person has a co-existing illness. However, neither anti-anxiety medications nor stimulants are effective against depression when taken alone, and both should be taken only under a doctor's close supervision.

More information about mental health medications is available on the NIMH website: http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml.

Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.[30] The study was funded in part by NIMH.

Also, the FDA issued a warning that combining an SSRI or SNRI antidepressant with one of the commonly-used "triptan" medications for migraine headache could cause a life-threatening "serotonin syndrome," marked by agitation, hallucinations, elevated body temperature, and rapid changes in blood pressure. Although most dramatic in the case of the MAOIs, newer antidepressants may also be associated with potentially dangerous interactions with other medications.

St. John's Wort

The extract from the herb St. John's Wort (Hypericum perforatum) has been used for centuries in many folk and herbal remedies. Today in Europe, it is used extensively to treat mild to moderate depression. In the United States, it is one of the top-selling botanical products.

In an 8-week trial involving 340 patients diagnosed with major depression, St. John's Wort was compared to a common SSRI and a placebo (sugar pill). The trial found that St. John's Wort was no more effective than the placebo in treating major depression.[31] However, use of St. John's Wort for minor or moderate depression may be more effective. Its use in the treatment of depression remains under study.

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after 6 or 8 weeks, and could only address whether patients had a reduction in some symptoms. And in most clinical trials of treatment for depression, the measure of success is simply "response" to treatment, which means that the person's symptoms have decreased by at least half of what they were at the start of the trial.

Some meta-analyses (studies that combine the results from many different trials) have shown that antidepressants can certainly be efficacious for some people. For instance, meta-analyses have demonstrated that antidepressants are efficacious in depressed patients with heart disease or other chronic medical illness.[xi xii]

But what about long-term effectiveness and true remission of symptoms? In the NIMH-funded Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study, the outcome measure was remission of depressive symptoms, e.g., becoming symptom-free. This outcome was selected because people who reach this goal generally function better socially and at work, and have a better chance of staying well than do people who only achieve a response but not a remission. STAR*D reported remission rates of 31 percent after 14 weeks and 65 percent at six months. These results may seem modest (placebo response rates are often over 30 percent in antidepressant trials). But STAR*D was not a good test of efficacy or effectiveness because it did not have a placebo comparison. While STAR*D was helpful for comparing antidepressants, in the absence of placebo, one does not know how many people would have been in remission without active medication.

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Perhaps the best evidence for efficacy comes from patients who have been treated successfully with antidepressants and are switched in a blinded fashion to placebo. In a meta-analysis of 31 withdrawal studies among more than 4,000 patients, Geddes and colleagues found that 41 percent of patients who were switched to placebo relapsed, compared to 18 percent who remained on an antidepressant.[xiii] These studies provide compelling evidence that antidepressants are effective for some people.

Other research, especially among teens with depression, has found that while antidepressants can be helpful for some, it is the combination of medication and cognitive behavioral therapy that is most effective in achieving remission sooner.[xiv] Still, relapse is a concern, especially if an antidepressant is not continued. And drop-out rates during these trials are relatively high.

Combination treatment continues to show the most promise among older adults with depression as well. In a sample of older adults with depression, the combination of medication and interpersonal psychotherapy was more effective than either alone or than a placebo. When compared to placebo, Reynolds and colleagues also found that maintenance antidepressant use was more efficacious in preventing relapse during three years of follow-up.[xv xvi xvii]

The bottom line is that these medications appear to have a relatively small effect in patients broadly classified as having depression. In some patients, perhaps those with more severe clinical conditions, they appear to be essential for remission. Clearly we need to know more about who will and will not benefit. And we need better, faster, more effective medications for depression that will help more people.

What Do We Know About Treating Depression?

We know that depression is a very heterogeneous syndrome. Major depressive disorder is defined by having at least five of nine criteria described in the Diagnostic and Statistical Manual (DSM). These signs and symptoms must persist over time (at least two weeks) and cause distress or dysfunction. This means two people who share as few as one of the nine criteria could receive the same diagnosis. Depression can also vary widely in other characteristics, ranging from the length and pattern of depressive episodes, to the presence of other physical and mental disorders and medications, to family history. It is not surprising, therefore, that different people respond differently to different treatments. At a biological level, depression likely comprises scores of different disorders. A true understanding of the nature of these different forms of depression and the ability to predict who will benefit from the various treatments available depends on a better understanding of the biology of depression, either directly or indirectly through the use of "biomarkers."

NIMH is funding the Establishing Moderators/Mediators for a Biosignature of Antidepressant Response in Clinical Care (EMBARC) study, a first step in discovering biosignatures for the personalized treatment of depression. EMBARC aims to identify a standard set of biomarkers and other measures that can be used to predict which interventions will produce the best treatment outcomes for an individual. And to better sort out the heterogeneity of depression and other mental disorders, the NIMH Research Domain Criteria (RDoC) project will organize mental disorder diagnoses according to what we have learned from

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St. John's Wort can interact with other medications, including those used to control HIV infection. In 2000, the FDA issued a Public Health Advisory letter stating that the herb may interfere with certain medications used to treat heart disease, depression, seizures, certain cancers, and those used to prevent organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Consult with your doctor before taking any herbal supplement.

Psychotherapy

Several types of psychotherapy, or "talk therapy," can help people with depression.

Two main types of psychotherapies—cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT)—are effective in treating depression. CBT helps people with depression restructure negative thought patterns. Doing so helps people interpret their environment and interactions with others in a positive and realistic way. It may also help you recognize things that may be contributing to the depression and help you change behaviors that may be making the depression worse. IPT helps people understand and work through troubled relationships that may cause their depression or make it worse.

For mild to moderate depression, psychotherapy may be the best option. However, for severe depression or for certain people, psychotherapy may not be enough. For teens, a combination of medication and psychotherapy may be the most effective approach to treating major depression and reducing the chances of it coming back.[27] Another study looking at depression treatment among older adults found that people who responded to initial treatment of medication and IPT were less likely to have recurring depression if they continued their combination treatment for at least 2 years.[23]

More information on psychotherapy is available on the NIMH website: http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml

Electroconvulsive Therapy (ECT) and Other Brain Stimulation Therapies

For cases in which medication and/or psychotherapy does not help relieve a person's treatment-resistant depression, electroconvulsive therapy (ECT) may be useful. ECT, formerly known as "shock therapy," once had a bad reputation. But in recent years, it has greatly improved and can provide relief for people with severe depression who have not been able to feel better with other treatments.

Before ECT begins, a patient is put under brief anesthesia and given a muscle relaxant. He or she sleeps through the treatment and does not consciously feel the electrical impulses. Within 1 hour after the treatment session, which takes only a few minutes, the patient is awake and alert.

A person typically will undergo ECT several times a week, and often will need to take an antidepressant or other medication along with the ECT treatments. Although some people will need only a few courses of ECT, others may need maintenance ECT—usually once a week at first, then gradually decreasing to monthly treatments. Ongoing NIMH-supported ECT research is aimed at developing personalized maintenance ECT schedules.

ECT may cause some side effects, including confusion, disorientation, and memory loss. Usually these side effects are short-term, but sometimes they can linger. Newer methods of administering the treatment have reduced the memory loss and other cognitive difficulties associated with ECT. Research has found that after 1 year of ECT treatments, most patients showed no adverse cognitive effects.[32]

Nevertheless, patients always provide informed consent before receiving ECT, ensuring that they understand the potential benefits and risks of the treatment.

Other more recently introduced types of brain stimulation therapies used to treat severe depression include vagus nerve stimulation (VNS), and repetitive transcranial magnetic stimulation (rTMS). These methods are not yet commonly used, but research has suggested that they show promise.

More information on ECT, VNS, rTMS and other brain stimulation therapies is available on the NIMH website: http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml.

How to Help a Loved One Who is Depressed

If you know someone who is depressed, it affects you too. The most important thing you can do is help your friend or relative get a diagnosis and treatment. You may need to make an appointment and go with him or her to see the doctor. Encourage your loved one to stay in treatment, or to seek different treatment if no improvement occurs after 6 to 8 weeks.

To help your friend or relative: (1) Offer emotional support, understanding, patience, and encouragement; (2) Talk to him or her, and listen carefully; (3) Never dismiss feelings, but point out realities and offer hope; (4) Never ignore comments about suicide, and report them to your loved one's therapist or doctor; (5) Invite your loved one out for walks, outings and other activities. Keep trying if he or she declines, but don't push him or her to take on too much too soon; (6) Provide assistance in getting to the doctor's appointments; (7) Remind your loved one that with time and treatment, the depression will lift.

How to Help Yourself If You Are Depressed

If you have depression, you may feel exhausted, helpless, and hopeless. It may be extremely difficult to take any action to help yourself. But as you begin to recognize your depression and begin treatment, you will start to feel better.

To Help Yourself: (1) Do not wait too long to get evaluated or treated. There is research showing the longer one waits, the greater the impairment can be down the road. Try to see a professional as soon as possible; (2) Try to be active and exercise. Go to a movie, a ballgame, or another event or activity that you once enjoyed; (3) Set realistic goals for yourself;

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inpatient readmissions, which has correctly been identified as an important focus of BHOs. Unfortunately, data by which to evaluate PROS has not been sought. Furthermore, as the shift to full risk contracting for mental health services under Medicaid occurs, the future of PROS remains uncertain.

This piece can only begin to focus the readers' attention on the tectonic areas of transformation which the health and mental health systems in NYS and the nation are undergoing. As it has in the past, NYSPA will continue to advocate to prevent or minimize harm to persons we serve and to our profession during this time of radical system change.

Correction Notice - Winter 2012 Housing Issue

In the article by Insler and Hermann, LLP on page 26 of our Winter 2012 "Housing" issue we apologize for an error that occurred in the layout of the article. The corrected paragraph should read as follows:

5th Paragraph - Column #1: With regard to establishing disability, the Social Security Administration is not concerned about living arrangements under either Social Security Disability ("SSD" or "DIB") or Supplemental Security Income ("SSI"). Housing comes into play only with regard to the amount of benefits payable under SSI once the medical aspect of a disability has been established.

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(4) Break up large tasks into small ones, set some priorities and do what you can as you can; (5) Try to spend time with other people and confide in a trusted friend or relative. Try not to isolate yourself, and let others help you; (6) Expect your mood to improve gradually, not immediately. Do not expect to suddenly "snap out of" your depression. Often during treatment for depression, sleep and appetite will begin to improve before your depressed mood lifts; (7) Postpone important decisions, such as getting married or divorced or changing jobs, until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation; (8) Remember that positive thinking will replace negative thoughts as your depression responds to treatment; (9) Continue to educate yourself about depression.

Where To Go For Help

Mental Health Resources: (1) Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors; (2) Health maintenance organizations; (3) Community mental health centers; (4) Hospital psychiatry departments and outpatient clinics; (5) Mental health programs at universities or medical schools; (6) State hospital outpatient clinics; (7) Family services, social agencies, or clergy; (8) Peer support groups; (9) Private clinics and facilities; (10) Employee assistance programs.

Local medical and/or psychiatric societies: You can also check the phone book under "mental health," "health," "social services," "hotlines," or "physicians" for phone numbers and addresses. An emergency room doctor also can provide temporary help and can tell you where and how to get further help.

If someone you know is in crisis: (1) If you are thinking about harming yourself, or know someone who is, tell someone who can help immediately; (2) Do not leave your friend or relative alone, and do not isolate yourself; (3) Call your doctor; (4) Call 911 or go to a hospital emergency room to get immediate help, or ask a friend or family member to help you do these things; (5) Call the toll-free, 24-hour hotline of the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255); TTY: 1-800-799-4TTY (4889) to talk to a trained counselor.

Citations

1. Altshuler LL, Hendrich V, Cohen LS. Course of mood and anxiety disorders during pregnancy and the postpartum period. *Journal of Clinical Psychiatry*, 1998; 59:29.

2. Rohan KJ, Lindsey KT, Roecklein KA, Lacy TJ. Cognitive-behavioral therapy, light therapy and their combination in treating seasonal affective disorder. *Journal of Affective Disorders*, 2004; 80:273–283.

3. Regier DA, Rae DS, Narrow WE, Kaebler CT, Schatzberg AF. Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *British Journal of Psychiatry*, 1998; 173(Suppl. 34):24–28.

4. Devane CL, Chiao E, Franklin M, Kruep EJ. Anxiety disorders in the 21st century: status, challenges, opportunities, and comorbidity with depression. *American Journal of Managed Care*, 2005 Oct; 11(Suppl. 12):S344–353.

5. Shalev AY, Freedman S, Perry T, Brandes D, Sahar T, Orr SP, Pitman RK. Prospective study of posttraumatic stress disorder and depression following trauma. *American Journal of Psychiatry*, 1998; 155(5):630–637.

6. Conway KP, ComptonW, Stinson FS, Grant BF. Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 2006 Feb; 67(2):247–257.

7. Cassano P, Fava M. Depression and public health, an overview. *Journal of Psychosomatic Research*, 2002; 53:849–857.

8. Katon W, Ciechanowski P. Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research*, 2002; 53:859–863.

9. Tsuang MT, Faraone SV. *The genetics of mood disorders*. Baltimore, MD: Johns Hopkins University Press, 1990.

10. Tsuang MT, Bar JL, Stone WS, Faraone SV. Gene-environment interactions in mental disorders. *World Psychiatry*, 2004 June; 3(2):73–83.

11. Eskandari F, Martinez PE, Torvik S, Phillips TM, Sternberg EM, Mistry S, Ronsaville D, Wesley R, Toomey C, Sebring NG, Reynolds JC, Blackman MR, Calis KA, Gold PW, Cizza G, for the POWER Study Group. Low bone mass in premenopausal women with depression. *Archives of Internal Medicine*, 2007 Nov 26; 167(21):2329–2336.

12. Rubinow DR, Schmidt PJ, Roca CA. Estrogen-serotonin interactions: implications for affective regulation. *Biological Psychiatry*, 1998; 44(9):839–850.

13. Pollack W. Mourning, melancholia and masculinity: recognizing and treating depression in men. In: Pollack W, Levant R, eds. *New Psychotherapy for Men*. New York: Wiley, 1998; 147–166.

14. Cochran SV, Rabinowitz FE. *Men and Depression: clinical and empirical perspectives*. San Diego: Academic Press, 2000.

15. Kochanek KD, Murphy SL, Anderson RN, Scott C. Deaths: final data for 2002. *National Vital Statistics Reports*; 53(5). Hyattsville, MD: National Center for Health Statistics, 2004.

16. Shear K, Frank E, Houck PR, Reynolds CF. Treatment of complicated grief: a randomized controlled trial. *Journal of the American Medical Association.* 2005; 293:2601–2608.

17. Gallo JJ, Rabins PV. Depression without sadness: alternative presentations of depression in late life. *American Family Physician*, 1999; 60(3):820–826.

18. Krishnan KRR, Taylor WD, et al. Clinical characteristics of magnetic resonance imaging-defined subcortical ischemic depression. *Biological Psychiatry*, 2004; 55:390–397.

19. Luoma JB, Pearson JL, Martin CE. Contact with mental health and primary care prior to suicide: a review of the evidence. *American Journal of Psychiatry*, 2002; 159:909–16.

20. Little JT, Reynolds CF III, Dew MA, Frank E, Begley AE, Miller MD, Cornes C, Mazumdar S, Perel JM, Kupfer DJ. How common is resistance to treatment in recurrent, nonpsychotic geriatric depression? *American Journal of Psychiatry*, 1998; 155(8):1035–1038.

21. Reynolds CF III, Frank E, Perel JM, Imber SD, Cornes C, Miller MD, Mazumdar S, Houck PR, Dew MA, Stack JA, Pollock BG, Kupfer DJ. Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. *Journal of the American Medical Association*, 1999; 281(1):39–45.

22. Lebowitz BD, Pearson JL, Schneider LS, Reynolds CF, Alexopoulos GS, Bruce MI, Conwell Y, Katz IR, Meyers BS, Morrison MF, Mossey J, Niederehe G, Parmelee P. Diagnosis and treatment of depression in late life: consensus statement update. *Journal of the American Medical Association*, 1997; 278 (14):1186–1190.

23. Reynolds CF III, Dew MA, Pollock BG, Mulsant BH, Frank E, Miller MD, Houck PR, Mazumdar S, Butters MA, Stack JA, Schlernitzauer MA, Whyte EM, Gildengers A, Karp J, Lenze E, Szanto K, Bensasi S, Kupfer DJ. Maintenance treatment of major depression in old age. *New England Journal of Medicine*, 2006 Mar 16; 354(11):1130–1138.

24. Weissman MM, Wolk S, Goldstein RB, Moreau D, Adams P, Greenwald S, Klier CM, Ryan ND, Dahl RE, Wichramaratne P. Depressed adolescents grown up. *Journal of the American Medical Association*, 1999; 281 (18):1701–1713.

25. Cyranowski JM, Frank E, Young E, Shear MK. Adolescent onset of the gender difference in lifetime rates of major depression. *Archives of General Psychiatry*, 2000; 57:21–27.

26. Shaffer D, Gould MS, Fisher P, Trautman P, Moreau D, Kleinman M, Flory M. Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, 1996; 53(4):339–348.

27. March J, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, Burns B, Domino M, McNulty S, Vitiello B, Severe J. Treatment for Adolescents with Depression Study (TADS) team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, 2004; 292 (7):807–820.

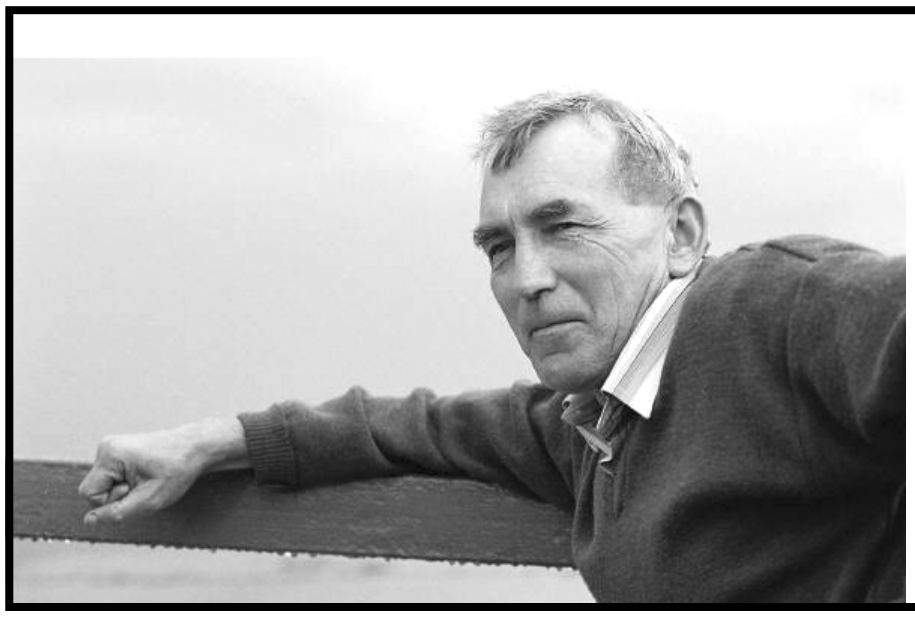
28. Rush JA, Trivedi MH, Wisniewski SR, Stewart JW, Nierenberg AA, Thase ME, Ritz L, Biggs MM, Warden D, Luther JF, Shores-Wilson K, Niederehe G, Fava M. Bupropion-SR, Sertraline, or Venlafaxine-XR after failure of SSRIs for depression. *New England Journal of Medicine*, 2006 Mar 23; 354 (12):1231–1242.

29. Trivedi MH, Fava M, Wisniewski SR, Thase ME, Quitkin F, Warden D, Ritz L, Nierenberg AA, Lebowitz BD, Biggs MM, Luther JF, Shores-Wilson K, Rush JA. Medication augmentation after the failure of SSRIs for depression. *New England Journal of Medicine*, 2006 Mar 23; 354 (12):1243–1252.

30. Bridge JA, Iyengar S, Salary CB, Barbe RP, Birmaher B, Pincus HA, Ren L, Brent DA. Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment, a meta-analysis of randomized controlled trials. *Journal of the American Medical Association*, 2007; 297(15):1683–1696.

31. Hypericum Depression Trial Study Group. Effect of Hypericum perforatum (St. John's wort) in major depressive disorder: a randomized controlled trial. *Journal of the American Medical Association*, 2002; 287 (14):1807–1814.

32. Lisanby SH. Electroconvulsive therapy for depression. *New England Journal of Medicine*. 2007; 357:1939–1945.



Major Depression from page 12

impairments shall be considered throughout the disability determination process."

A "severe Impairment" is defined in the Social Security Regulations at *20 C.F.R. §§ 404.1520, 416.920 as "*any impairment or combination of impairments that significantly limit [a claimant's] physical or mental ability to do basic work activities." In an effort to clarify the definition of "severe impairment," Social Security Ruling 96-3p states that "an impairment(s) that is 'not severe' must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the ability to do basic work activities."

If Social Security decision makers determine that someone suffers from a "severe impairment," the next step in the query is whether that impairment is severe enough to establish Disability as defined by the Social Security rules and regulations. The Social Security Administration has set forth rules to guide the assessment of whether various conditions, including mental conditions, impact on the ability to work to the extent that a claimant should be found disabled.

The Listing of Impairments in Appendix 1 to Subpart P of Part 404 of the Social Security Regulations sets forth guidelines for decision-makers on how to assess the most severe mental disorders when considering a person's mental impairments. In an analysis of depression, Subsection 12.04, which considers Affective Disorders, describes "disabling" depression as:

Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involved depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activities; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; . . . AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration; OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Listing 12.04 identifies a set of requirements that, in our experience, are difficult to satisfy. While many clients suffering from major depression do suffer from most of the symptoms identified in section (A)(1), except in extreme cases, where the claimant is frequently hospitalized or in intensive out-patient treatment, it is extremely difficult establish the degree of decompensation required to satisfy subsection (B) because, as we know, many people who suffer from major depression are still functional and have never decompensated to the degree required in that subsection.

If a claimant is not found disabled based on the Listings, the next step is for a decision-maker to assess whether a claimant's depression would prevent him or her from performing the duties and responsibilities of his or her job or of any other job as performed in the national economy. It is usually at this level of inquiry that a claim for disability due to major depression is established.

As I noted above, people suffering from major depression frequently have symptoms which, when translated to a work setting, make them unreliable employees. Managers and supervisors need their staff to be able to maintain their attention to tasks, devoting all of their focus to assignments and retaining the ability to learn both simple and complex tasks as needed. It is also expected that tasks assigned will be completed in a timely manner, without the risk that an employee will call in sick or leave his or her workstation more often and for longer than industry acceptable breaks.

Whether in a high stress managerial position or a repetitive factory job, someone who cannot maintain the production pace expected will not be tolerated by management, or customers and business will suffer. If a Disability claimant is legitimately suffering from major depression, mental health clinicians, whether psychologist, psychologist or therapist, will recognize the symptoms and, ideally, will make note both of the symptoms reported by the patient and also of their own observations.

Although contemporaneous medical records are frequently supplied to the Social Security decision makers, it is often the extra bit of information that can make or break a disability claim. Either a narrative statement that summarizes a claimant's symptoms and limitations, or a functional capacity assessment can be crucial to a disability claim, provided they have been properly prepared by a physician. A narrative or an assessment not only should present a patient's diagnosis and symptoms, but should also translate how those symptoms impact on all aspect of the patient's life and functional capacities as well as his or her ability to sustain competitive employment. When such a report or assessment is consistent with the contemporaneous records, more often than not, the Social Security decision-maker, usually an Administrative Law Judge, will draw the only logical conclusion: that a finding of Disability is warranted.

As a matter of practice, when someone comes to us for assistance in a claim for Disability benefits due to depression, we develop the case with the expectation that unless our client has had multiple psychiatric hospitalizations or extremely steady treatment from a knowledgeable and cooperative clinician, it will be necessary to present the claim to an Administrative Law Judge at a hearing. Having planned for that from the start, we are able to present a comprehensive case at the Hearing, laying out the treatment records, the clinician's opinions about the claimant's functioning, and our client's own testimony about his or her limitations. Using this approach, we have been very successful in representing our clients suffering from major depression, whether as a primary disability or as a secondary yet still overwhelming condition.

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SSRI medications are considered an improvement over older antidepressant medications because they have fewer side effects and are less likely to be harmful if taken in an overdose, which is an issue for patients with depression already at risk for suicide. They have been shown to be safe and effective for adults.

However, use of SSRI medications among children and adolescents ages 10 to 19 has risen dramatically in the past several years. Fluoxetine (Prozac) is the only medication approved by the FDA for use in treating depression in children ages 8 and older. The other SSRI medications and the SSRI-related antidepressant venlafaxine have not been approved for treatment of depression in children or adolescents, but doctors still sometimes prescribe them to children on an "off-label" basis. In June 2003, however, the FDA recommended that paroxetine not be used in children and adolescents for treating MDD.

Fluoxetine can be helpful in treating childhood depression, and can lead to significant improvement of depression overall. However, it may increase the risk for suicidal behaviors *in a small subset of adolescents*. As with all medical decisions, doctors and families should weigh the risks and benefits of treatment for each individual patient.

What Should You Do For a Child With Depression?

A child or adolescent with MDD should be carefully and thoroughly evaluated by a doctor to determine if medication is appropriate. Psychotherapy often is tried as an initial treatment for mild depression. Psychotherapy may help to determine the severity and persistence of the depression and whether antidepressant medications may be warranted. Types of psychotherapies include "cognitive behavioral therapy," which helps people learn new ways of thinking and behaving, and "interpersonal therapy," which helps people understand and work through troubled personal relationships.

Those who are prescribed an SSRI medication should receive ongoing medical monitoring. Children already taking an SSRI medication should remain on the medication if it has been helpful, but should be carefully monitored by a doctor for side effects. Parents should promptly seek medical advice and evaluation if their child or adolescent experiences suicidal thinking or behavior, nervousness, agitation, irritability, mood instability, or sleeplessness that either emerges or worsens during treatment with SSRI medications.

Once started, treatment with these medications should not be abruptly stopped. Although they are not habit-forming or addictive, abruptly ending an antidepressant can cause withdrawal symptoms or lead to a relapse. Families should not discontinue treatment without consulting their doctor.

All treatments can be associated with side effects. Families and doctors should carefully weigh the risks and benefits, and maintain appropriate follow-up and monitoring to help control for the risks.

What Does Research Tell Us?

An individual's response to a medication cannot be predicted with certainty. It is extremely difficult to determine whether SSRI medications increase the risk for completed suicide, especially because depression itself increases the risk for suicide and because completed suicides, especially among children and adolescents, are rare. Most controlled trials are too small to detect for rare events such as suicide (thousands of participants are needed). In addition, controlled trials typically exclude patients considered at high risk for suicide.

One major clinical trial, the NIMH-funded Treatment for Adolescents with Depression Study (TADS)[2], has indicated that a combination of medication and psychotherapy is the most effective treatment for adolescents with depression. The clinical trial of 439 adolescents ages 12 to 17 with MDD compared four treatment groups—one that received a combination of fluoxetine and CBT, one that received fluoxetine only, one that received CBT only, and one that received a placebo only. After the first 12 weeks, 71 percent responded to the combination treatment of fluoxetine and CBT,

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Primary Care from page 13

- Less than half the people with depression are properly diagnosed
- Less than half of those get any treatment.
- In total, one in eight (1/8) people with depression receive "minimally adequate care" (defined by minimal therapy visits and/or appropriate medications).

Yet treatment is effective: As many as 75% of individuals with depression will improve with appropriate diagnosis, treatment, and ongoing monitoring.

What Can Be Done?

A lot. In fact, a very specific approach to treating depression in primary care can achieve remarkably beneficial effects. This approach is well represented by the "Collaborative Care" model developed by the University of Washington. The success of Collaborative Care has been studied and now replicated in 40 (!) studies, including in rural areas as well as in ethnically diverse and impoverished populations.

The core elements of Collaborative Care are:

- Screening for depression (and in some instances other mental and alcohol and drug disorders): this involves the use of a screening tool that provides a depression score that improves when the condition improves. The PHQ-9 is an example of a depression measurement tool.
- Measurement-based, stepped care: The abnormal score, once the diagnosis is established (the doctor, not the test, makes the diagnosis), is followed over time. Evidence-based depression care paths direct the treatment. If a defined care path is not followed or does not result in improvement then changes in treatment are made.
- An 'activated' patient: Patient education and engagement in their own wellbeing is an essential component.
- A care manager: The discipline of this person is far less important than their unrelenting attention to helping a patient engage and remain in treatment and self-care.
- Psychiatric consultation to the primary care physician: This means an active, weekly review of cases that do not improve, not waiting for the PCP to call.
- Training of clinical and administrative staff.
- Ongoing performance measurement and quality improvement of the delivery of integrated care.

In December, 2010, a game changing article was published in the New England Journal of Medicine by Dr. Wayne Katon and colleagues. This article showed that the collaborative care approach not only improved depression, it significantly improved blood pressure, diabetes control and lipid levels. For patients and doctors, this is the Holy Grail: an approach that benefits health and mental health!

Doctors are good learners. If they need to do something they will learn to do it. If you measure their performance they learn how to do it even better. We see that with rates of immunization, mammography, reducing surgical complications, and evidence-based treatment of a host of common and serious diseases like diabetes, asthma, and heart disease. But general medical physicians have yet to tackle depression (even though it is ubiquitous in their practice) because it has not been systematically measured and monitored.

Collaborative Care can be done. It will take clear standards of care, training, and ongoing quality improvement. Not doing it carries a price we cannot afford: human suffering, morbidity and mortality, as well as great family and economic burden. At first, leadership medical groups will need to show it can be done. Then others will find the determination and the ways to follow-suit.

Work Underway in New York State

A collaboration between the NYS Department of Health and the NYS Office of Mental Health is underway to progressively implement Collaborative Care in primary care settings. 'Early adopters' will identify how to succeed and demonstrate that patients and providers can take pride in their achievements. These state agencies will seek the aid of the University of Washington and the Institute for Healthcare Improvement to provide training in Collaborative Care and to scale it up across NYS.

Stand by for more information that will emerge in the months ahead on this initiative to integrate health and mental (behavioral) health.

Conclusion

There was a time when you or a loved one would have gone to a family doctor and you would not have had your blood pressure measured. A time when we did not measure blood sugar (much less the ongoing measure of glucose control, the hemoglobin A1c), or cholesterol. A time when care paths were places to walk in shaded glens, not treatment protocols. Not so today.

Some day we will look back and wonder how we did not measure and treat depression, and other behavioral health disorders, in primary care? We are starting on the transformation road now. It will be uphill and bumpy. So is all change.

A legendary, if notorious, character said: "*There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them.*" He was Niccolo Machiavelli; he lived in the 1500s. Times may have changed, but not what it takes to get something done.

But it was Mahatma Gandhi who said in a more recent century, *"…first they ignore you, then they laugh at you. then they fight you, then you win."*

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References

Wang PS, Demler O, Olfson M, Pincus HA, Wells KB, Kessler RC. Changing Profiles of Service Sectors Used for Mental Health Care in the United States. American Journal of Psychiatry. July 1, 2006 2006;163(7):1187-1198.

Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, Ustun B. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. Lancet. Sep 8 2007;370 (9590):851-858.

Charles Roehrig, George Miller, Craig Lake, and Jenny Bryant, Health Affairs 28, no. 2 (2009): w358–w367 (published online 24 February 2009; 10.1377/hlthaff.28.2.358)

Sederer LI, Petit, JR, Paone, D, Ramos, S, Rubin, J, Christman, M. Changing the Landscape: Depression Screening and Management in Primary Care, Health Policy Institute, Washington DC, 2007

Louoma, J. et al. "Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Literature" in American Journal of Psychiatry, June 2002. http://ajp.psychiatryonline.org/article.aspx?Volume=159&page=909&journalID=13

Unutzer J, Schoenbaum M, Druss BG, Katon WJ. Transforming Mental Health Care at the Interface With General Medicine: Report for the Presidents Commission. Psychiatr Serv. January 1, 2006

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine. Sep 2001;16(9):606-613.

Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, Peterson D, Rutter CM, McGregor M, McCulloch D. Collaborative care for patients with depression and chronic illnesses. NEJM 2010; 363(27): 2611-20.

Sederer, LI. Let's Not Get Too Depressed About Depression, The Huffington Post, February 8, 2010, www.huffingtonpost.com/lloyd-i-sederer-md/lets-not-get-too-depresse_b_452599.html

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61 percent responded to the fluoxetine only treatment, 43 percent responded to the CBT only treatment, and 35 percent responded to the placebo treatment.

At the beginning of the study, 29 percent of the TADS participants were having clinically significant suicidal thoughts. Although the rate of suicidal thinking decreased among all the treatment groups, those in the fluoxetine/CBT combination treatment group showed the greatest reduction in suicidal thinking.

Researchers are working to better understand the relationship between antidepressant medications and suicide. So far, results are mixed. One study, using national Medicaid files, found that among adults, the use of antidepressants does not seem to be related to suicide attempts or deaths. However, the analysis found that the use of antidepressant medications may be related to suicide attempts and deaths among children and adolescents.[3]

Another study analyzed health plan records for 65,103 patients treated for depression.[4] It found no significant increase among adults and young people in the risk for suicide after starting treatment with newer antidepressant medications.

A third study analyzed suicide data from the National Vital Statistics and commercial prescription data. It found that among children ages five to 14, suicide rates from 1996 to 1998 were actually lower in areas of the country with higher rates of SSRI antidepressant prescriptions. The relationship between the suicide rates and the SSRI use rates, however, is unclear.[5]

New NIMH-funded research will help clarify the complex interplay between suicide and antidepressant medications. In addition, the NIMH-funded Treatment of Resistant Depression in Adolescents (TORDIA) study, will investigate how best to treat adolescents whose depression is resistant to the first SSRI medication they have tried. Finally, NIMH also is supporting the Treatment of Adolescent Suicide Attempters (TASA) study, which is investigating the treatment of adolescents who have attempted suicide. Treatments include antidepressant medications, CBT or both.

Footnotes

1. Bridge JA, Iyengar S, Salary CB, Barbe RP, Birmaher B, Pincus HA, Ren L, Brent DA, MD. Clinical Response and Risk for Reported Suicidal Ideation and Suicide Attempts in Pediatric Antidepressant Treatment: A Meta-analysis of Randomized Controlled Trials. JAMA. 2007;297:1683-1696.

2. Treatment for Adolescents with Depression Study (TADS) Team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. Journal of the American Medical Association, 2004 Aug 18; 292(7):807-20.

3. Olfson M, Marcus SC, Shaffer D. Antidepressant Drug Therapy and Suicide in Severely Depressed Children and Adults. Archives of General Psychiatry. 2006 Aug. 63:865-72

4. Simon GE, Savarino J, Operskalski B, Wang P. Suicide Risk During Antidepressant Treatment. American Journal of Psychiatry. 2006. 163 (1): 41-47.

5. Gibbons RD, Hur K, Bhaumik DK, Mann JJ. The relationships between antidepressant prescription rates and rate of early adolescent suicide. American Journal of Psychiatry 2006. 163 (11): 1898-1904

Children from page 8

to continue their support network outside the group so they will have an ongoing network of support after the group ends.

Each child/parent group cycle has at least one session in which the children and parents come together for a multi-family art therapy group to enhance their relationship going forward. To further facilitate the healing process, a recreational event for all the families is the final session helping families celebrate achievements, creating a sense of community among members, and increasing each family's circle of support.

Our Values-Centered Approach

Value 1: We respect a client's readiness for treatment. Meeting clients as far as they can go means just that. It is our value that the group process will deal with a range of experiences including but not limited to depression, denial and anger and offer a healing supportive process of acceptance of abuse as the child becomes able to express their experience in art or even in words.

Value 2: We engage from a nurturing position within a flexible holding environment. The clinical team members display nurturance with one another and with family members in a non physical yet emotional way.

Value 3: The experience of community support enhances self awareness and interpersonal communication. The social identity within the group and community concept becomes a cyclic rather than linear experience. The sense of community as they are neighbors and community members is stressed as well as that they are a community of survivors.

Value 4: Cultural and value acceptance means accepting clients values around gender, power, and identity. The parents' group membership consists primarily of mothers coming from marginalized groups in the larger society. They are encouraged to discuss their values and social identity as these socio-cultural factors are key components in their experiences. In the children's group, these issues are explored to match the developmental needs of the child. Acculturation issues, in particular children not subscribing to parents' more traditional conceptualizations of race and ethnicity, are invited into the discussion. The art therapist takes a firm, clear position regarding child-adult roles and responsibilities while remaining culturally sensitive.

Program Evaluation

Parents/caregivers have reported encouraging changes in the behavior of their children—indicating that the children have enjoyed improved relationships with others. We have also noted significant changes in the parent child relationship with many parents reporting feeling more positively about their children. The children themselves have indicated feelings of relief in knowing that they are not alone in their abuse experience and have frequently identified group members as their closest friends.

In order to seek a more objective evaluation, after several years of using behavioral check-lists and PTSD scales the team decided that we needed an evaluation tool that aligned more closely to our intended outcomes. The Tennessee Self-Concept Scale, designed to "examine the self-view a person brings to specific areas of experience," including physical, moral, personal, family, social, and academic arenas, was selected. Of particular interest to our team were the validity scores which are sensitive to an individual's efforts to "fake" being good, a common behavioral trait in sexually abused children who try to manage and control the responses and/or affection they receive from others to avoid being hurt again.

The children (average 11 years old) completing this scale to date are 88% female, 36% African American, 48% Hispanic/Latino, 8% multi-racial and 8% other. They range from 1st to 10th graders. Given the recent implementation of this tool and the small number of clients tested to date, the results below should be viewed as a very preliminary finding. On average, clients had higher Social Self-Concept scores at posttest: 61% had higher scores with the average posttest score being 51T (vs. 48T pretest), $p < .05$. The values improved so that the average score is about the same as for the U.S. norm group (50T average score) on this scale. (Individuals with scores of 60T and above are usually viewed by both themselves and others as being friendly, easy to be with, and extroverted. A score of 70T or above may reflect grandiosity or an inflated self-opinion. Scores of 40T and below are related to a perceived lack of social skill.) These results are promising but preliminary. We continue to provide what we believe is effective treatment for sexually abused children while also seeking objective methods to assess our treatment model.

Adrienne Williams Myers, LCSW, is Chief of Preventive Services; Jean Holland, LCSW, is Clinic Director; Drena Fagen, LCAT, is Art Therapist; Alexis Howard, LCSW, is Social Work Consultant; Sandra Scott, PhD, is Director of Research and Evaluation; and Thelma Dye, PhD, is Executive Director and CEO of Northside Center for Child Development.

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neuroscience and genomics in addition to clinical features, complementing the traditional "DSM" approach to psychiatric diagnosis.

In the meantime, there is promising research into fast-acting antidepressant agents that dramatically cut the response-to-treatment time. The drug ketamine has been found to lift depression in hours, rather than weeks. Although the use of ketamine— administered intravenously—is only experimental, it does provide us with a "proof of concept" that rapidly acting antidepressants can be developed. An NIMH initiative, Rapidly Acting Treatments for Treatment-resistant Depression (RAPID), will be following up on this lead to create newer, faster acting interventions.

As we engage ourselves in efforts to gain a deeper understanding of the biology of depression, it is important to remember that optimal treatment for depression does not begin or end with medication. Treating depression is an art that requires many tools. We will not save lives by dismissing any of the tools we currently have available, even as we endeavor to develop better ones. A quality treatment plan for depression includes a thorough assessment, a comprehensive treatment plan that includes choices tailored to and guided by the individual—whether that be medication, psychotherapy or both—and careful, frequent follow-up.

Thomas R. Insel, M.D., is Director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health charged with generating the knowledge needed to understand, treat, and prevent mental disorders. His tenure at NIMH has been distinguished by groundbreaking findings in the areas of practical clinical trials, autism research, and the role of genetics in mental illnesses. Prior to his appointment as NIMH Director in the Fall 2002, Dr. Insel was Professor of Psychiatry at Emory University. There, he was founding director of the Center for Behavioral Neuroscience, one of the largest science and technology centers funded by the National Science Foundation and, concurrently, director of an NIH-funded Center for Autism Research. From 1994 to 1999, he was Director of the Yerkes Regional Primate Research Center in Atlanta. While at Emory, Dr. Insel continued the line of research he had initiated at NIMH studying the neurobiology of complex social behaviors. He has published over 250 scientific articles and four books, including the Neurobiology of Parental Care (with Michael Numan) in 2003. Dr. Insel has served on numerous academic, scientific, and professional committees and boards. He is a member of the Institute of Medicine, a fellow of the American College of Neuropsychopharmacology, and is a recipient of several awards including the Outstanding Service Award from the U.S. Public Health Service. Dr. Insel graduated from the combined B.A.-M.D. program at Boston University in 1974. He did his internship at Berkshire Medical Center, Pittsfield, Massachusetts, and his residency at the Langley Porter Neuropsychiatric Institute at the University of California, San Francisco.

References

i Pratt L, Brody DJ, Gu Q. Antidepressant Use in Persons Aged 12 and Over: United States, 2005-2008. NCHS Data Brief. No 76. October 2011.

ii IMS Health National Prescription Audit PLUS.

iii SAMHSA, National Survey on Drug Use and Health

iv Merikangas KR et al. Pediatrics 2010;25:75-81.

v Kessler RC, et al.. Archives of General Psychiatry, 2005 Jun;62(6):617-27.

vi The World Health Organization. The global burden of disease: 2004 update, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004. Geneva, Switzerland: WHO, 2008. http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_AnnexA.pdf

vii Nordentoft M et al. Arch Gen Psychiatry 2011;68(10):1058-1064.

viii González H.M., et al. Archs Gen Psychiatry 2010;67(1):37-46.

ix Mojtabai R and Olfson M. Health Affairs, 2010. 30(8):1434-1442.

x Mark T et al., Psychiatric Svcs, 2009 Sept. 60:1167

xi Levkovitz Y et al., J Clin Psychiatry, 2011 Apr. 72(4):509-514.

xii Pizzi C et al.,Am J Cardiology, 2011 Apr. 107(7):972-979.

xiii Geddes et al. Relapse prevention with antidepressant drug treatment in depressive disorders: a systematic review. Lancet. 2003;361:653-61

xiv The TADS Team. Arch Gen Psychiatry. Oct 2007; VOL 64(10).

xv Reynolds, et al, JAMA, Jan. 6, 1999. 281(1): 39-45

xvi Reynolds, et al, Arch Gen Psychiatry.2011 Jan. 68 (1): 51-60

xvii Reynolds, et al., NEJM 354(1): 1130- 11381

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will rob them of the opportunity to have a decent quality of life. People who already have dementia and those who will develop it before a biomedical solution is in place don't have to wait for a cure to benefit from care.

Michael Friedman teaches at Columbia University. He is the co-founder and Honorary Chair of the Geriatric Mental Health Alliance of New York. He can be reached at mf395@columbia.edu.

Footnotes

1. This article is an elaboration of an essay called "Meet The Mental Health Needs of People with Dementia" published in *The Huffington Post* on January 10, 2012.

2. These examples are composites of characteristics of people with dementia and caregivers with mental health problems.

3. Khachaturian, Z. "Prospects for designating Alzheimer's disease research a national priority" in *Alzheimer's and Dementia*, November 2011. http://aspe.hhs.gov/daltcp/napa/cmtach21.pdf

4. Alzheimer's Association. "Facts and Figures About Alzheimer's". http://www.alz.org/alzheimers_disease_facts_and_figures.asp

5. Lyketsos, C. et al. "Neuropsychiatric symptoms in Alzheimer's disease" in *Alzheimer's and Dementia*, September 2011.http://www.alzheimersanddementia.com/article/S1552-5260%2811%2902575-1/abstract

6. Zeisel, J. *I'm Still Here.* Avery Press, 2009. http://us.penguingroup.com/nf/Book/BookDisplay/0,,0_9781583333761,00.html

7. Mittelman, M. et al. "Improving Caregiver Well-Being Delays Nursing Home Placement of Patients with Alzheimer's Disease" in *Neurology*, November 14, 2006. http://www.neurology.org/content/67/9/1592

Psychotherapy from page 23

they express unhelpful criticism or hostility toward their relative with bipolar disorder. The therapist will teach family members how to communicate negative emotions in a better way. Several studies have found FFT to be effective in helping a patient become stabilized and preventing relapses. [9,10,11]

FFT also focuses on the stress family members feel when they care for a relative with bipolar disorder. The therapy aims to prevent family members from "burning out" or disengaging from the effort. The therapist helps the family accept how bipolar disorder can limit their relative. At the same time, the therapist holds the patient responsible for his or her own well-being and actions to a level that is appropriate for the person's age.

Generally, the family and patient attend sessions together. The needs of each patient and family are different, and those needs determine the exact course of treatment. However, the main components of a structured FFT usually include: (1) Family education on bipolar disorder; (2) Building communication skills to better deal with stress, and (3) Solving problems together as a family.

It is important to acknowledge and address the needs of family members. Research has shown that primary caregivers of people with bipolar disorder are at increased risk for illness themselves. For example, a 2007 study based on results from the NIMH-funded *Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)* trial found that primary caregivers of participants were at high risk for developing sleep problems and chronic conditions, such as high blood pressure. However, the caregivers were less likely to see a doctor for their own health issues.[12] In addition, a 2005 study found that 33 percent of caregivers of bipolar patients had clinically significant levels of depression.[13]

Are Psychotherapies Different for Children and Adolescents?

Psychotherapies can be adapted to the needs of children and adolescents, depending on the mental disorder. For example, the NIMH-funded *Treatment of Adolescents with Depression Study (TADS)* found that CBT, when combined with antidepressant medication, was the most effective treatment over the short term for teens with major depression.[14] CBT by itself was also an effective treatment, especially over the long term. Studies have found that individual and group-based CBT are effective treatments for child and adolescent anxiety disorders.[15] Other studies have found that IPT is an effective treatment for child and adolescent depression.[16,17]

Psychosocial treatments that involve a child's parents and family also have been shown to be effective, especially for disruptive disorders such as conduct disorder or oppositional defiant disorder. Some effective treatments are designed to reduce the child's problem behaviors and improve parent-child interactions. Focusing on behavioral parent management training, parents are taught the skills they need to encourage and reward positive behaviors in their children.[18] Similar training helps parents manage their child's attention deficit/hyperactivity disorder (ADHD). This approach, which has been shown to be effective, can be combined with approaches directed at children to help them learn problem-solving, anger management and social interaction skills. [19]

Family-based therapy may also be used to treat adolescents with eating disorders. One type is called the Maudsley approach, named after the Maudsley Hospital in London, where the approach was developed. This type of outpatient family therapy is used to treat anorexia nervosa in adolescents. It considers the active participation of parents to be essential in the recovery of their teen. The Maudsley approach proceeds through three phases:

- *Weight restoration.* Parents become fully responsible for ensuring that their teen eats. A therapist helps parents better understand their teen's disease. Parents learn how to avoid criticizing their teen, but they also learn to make sure that their teen eats.

- *Returning control over eating to the teen.* Once the teen accepts the control parents have over his or her eating habits, parents may begin giving up that control. Parents are encouraged to help their teen take more control over eating again.

- *Establishing healthy adolescent identity.* When the teen has reached and maintained a healthy weight, the therapist helps him or her begin developing a healthy sense of identity and autonomy.

Several studies have found the Maudsley approach to be successful in treating teens with anorexia.[20,21] Currently a large-scale, NIMH-funded study on the approach is under way.

What Other Types of Therapies are Used?

In addition to the therapies listed above, many more approaches exist. Some types have been scientifically tested more than others. Also, some of these therapies are constantly evolving. They are often combined with more established psychotherapies. A few examples of other therapies are described here.

Psychodynamic therapy. Historically, psychodynamic therapy was tied to the principles of psychoanalytic theory, which asserts that a person's behavior is affected by his or her unconscious mind and past experiences. Now therapists who use psychodynamic therapy rarely include psychoanalytic methods. Rather, psychodynamic therapy helps people gain greater self-awareness and understanding about their own actions. It helps patients identify and explore how their nonconscious emotions and motivations can influence their behavior. Sometimes ideas from psychodynamic therapy are interwoven with other types of therapy, like CBT or IPT, to treat various types of mental disorders. Research on psychodynamic therapy is mixed. However, a review of 23 clinical trials involving psychodynamic therapy found it to be as effective as other established psychotherapies.[22]

Light therapy. Light therapy is used to treat seasonal affective disorder (SAD), a form of depression that usually occurs during the autumn and winter months, when the amount of natural sunlight decreases. Scientists think SAD occurs in some people when their bodies' daily rhythms are upset by short days and long nights. Research has found that the hormone melatonin is affected by this seasonal change. Melatonin normally works to regulate the body's rhythms and responses to light and dark. During light therapy, a person sits in front of a "light box" for periods of time, usually in the morning. The box emits a full spectrum light, and sitting in front of it appears to help reset the body's daily rhythms. Also, some research indicates that a low dose of melatonin, taken at specific times of the day, can also help treat SAD.[23]

Other types of therapies sometimes used in conjunction with the more established therapies include:

Expressive or creative arts therapy. Expressive or creative arts therapy is based on the idea that people can help heal themselves through art, music, dance, writing, or other expressive acts. One study has found that expressive writing can reduce depression symptoms among women who were victims of domestic violence.[24] It also helps college students at risk for depression.[25]

Animal-assisted therapy. Working with animals, such as horses, dogs, or cats, may help some people cope with trauma, develop empathy, and encourage better communication. Companion animals are sometimes introduced in hospitals, psychiatric wards, nursing homes, and other places where they may bring comfort and have a mild therapeutic effect. Animal-assisted therapy has also been used as an added therapy for children with mental disorders. Research on the approach is limited, but a recent study found it to be moderately effective in easing behavioral problems and promoting emotional well-being.[26]

Play therapy. This therapy is used with children. It involves the use of toys and games to help a child identify and talk about his or her feelings, as well as establish communication with a therapist. A therapist can sometimes better understand a child's problems by watching how he or she plays. Research in play therapy is minimal.

What Research is Underway to Improve Psychotherapies?

Researchers are continually studying ways to better treat mental disorders with psychotherapy, and many NIMH-funded studies are underway. For more information about NIMH-funded clinical trials involving psychotherapies, see the NIMH Clinical Trials page at www.nimh.nih.gov/trials/index.shtml.

How Do I Find a Psychotherapist?

Your family doctor can help you find a psychotherapist. Other resources for locating services are available at http://www.nimh.nih.gov/health/topics/getting-help-locate-services/index.shtml.

Citations

1 Hofmann SG, Smits JA. Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. Journal of Clinical Psychiatry. 2008 Apr; 69(4): 621-632.

2 Hausmann A, Hortnagl C, Muller M, Waack J, Walpath M, Conca A. Psychotherapeutic interventions in bipolar disorder: a review. Neuropsychiatry. 2007; 21(2): 102-109.

3 Pike KM, Walsh BT, Vitousek K, et al. Cognitive behavioral therapy in the posthospitalization treatment of anorexia nervosa. American Journal of Psychiatry. 2003;160 (11):2046-2049.

4 Chen E, Touyz SW, Beumont PJ, et al. Comparison of group and individual cognitive behavioral therapy for patients with bulimia nervosa. International Journal of Eating Disorders. 2003;33(3):241-254.

5 Rathod S, Kingdon D, Weiden P, Turkington D. Cognitive-behavioral therapy for medication-resistant schizophrenia: a review. Journal of Psychiatric Practice. 2008 Jan; 14(1):22-33.

6 Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, Korslund KE, Tutek DA, Reynolds SK, Lindenboim N. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. Archives of General Psychiatry. 2006 Jul;63 (7):757-766.

7 De Mello MF, de Jesus MJ, Bacaltchuk J, Verdeli H, Neugebauer R. A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. European Archives of Psychiatry and Clinical Neuroscience. 2005 Apr; 255(2):75-82.

8 Frank E, Kupfer DJ, Thase ME, Mallinger AG, Swartz HA, Fagiolini AM, Grochocinski V, Houck P, Scott J, Thompson W, Monk T. Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Archives of General Psychiatry. 2005 Sep; 62:996-1004.

9 Miklowitz DJ, Richards JA, George EL, Frank E, Suddath RL, Powell KB, Sacher JA. Integrated family and individual therapy for bipolar disorder: results of a treatment development study. Journal of Clinical Psychiatry. 2003 Feb;64(2): 182-191.

10 Rea MM, Tompson MC, Miklowitz DJ, Goldstein MJ, Hwang S, Mintz J. Family-focused treatment versus individual treatment for bipolar disorder: results of a randomized clinical trial. Journal of Consulting and Clinical Psychology. 2003 Jun;71(3):482-492.

11 Miklowitz DJ, Otto MW, Frank E, Reilly-Harrington NA, Wisniewski SR, Kogan JN, Nierenberg AA, Calabrese JR, Marangell LB, Gyulai L, Araga M, Gonzalez JM, Shirley ER, Thase ME, Sach GS. Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program. Archives of General Psychiatry. Apr 2007; 164 (4):419-426.

12 Perlick DA, Rosenheck RA, Miklowitz DJ, Chessick C, Wolff N, Kaczynski R, Ostacher M, Patel J, Desai R, STEP-BD Family Experience Collaborative Study Group. Prevalence and correlates of burden among caregivers of patients with bipolar disorder enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder. Bipolar Disorders. 2007 May; 9(3): 262-273.

13 Perlick DA, Hohenstein JM, Clarkin JF, Kaczynski R, Rosenheck RA. Use of mental health and primary care services by caregivers of patients with bipolar disorder: a preliminary study. Bipolar Disorders. 2005 Apr; 7(2): 126-135.

14 The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; 64(10):1132-1143.

15 Silverman WK, Pina AA, Viswesvaran C. Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. Journal of Clinical Child and Adolescent Psychology. 2008 Jan; 37(1): 105-130.

16 Mufson L, Dorta KP, Wickramaratne P, Nomura Y, Olfson M, Weissman MM. A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry. 2004 Jun; 61(6): 577-584.

17 David-Ferdon C, Kaslow N. Evidence-based psychosocial treatments for child and adolescent depression. Journal of Clinical Child and Adolescent Psychology. 2008 Jan; 37 (1):62-104.

18 Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. Journal of Clinical Child and Adolescent Psychology. 2008 Jan; 37(1):215-237.

19 Pelham WE, Fabiano GA. Evidence-based psychosocial treatments for attention deficit/hyperactivity disorder. Journal of Clinical Child and Adolescent Psychology. 2008 Jan; 37(1):184-214.

20 Eisler I, Dare C, Russell GFM, Szmuckler GA, Le Grange D, Dodge E. Family and individual therapy in anorexia nervosa: A five-year follow-up. Archives of General Psychiatry. 1997 Nov; 54:1025-1030.

21 Le Grange D, Binford R, Loeb KL. Manualized family-based treatment for anorexia nervosa: A case series. Journal of the American Academy of Child and Adolescent Psychiatry. 2005; 44:41-46.

22 Leichsenring F, Leibing E. Psychodynamic psychotherapy: a systematic review of techniques, indications and empirical evidence. Psychology and Psychotherapy. 2007 Jun; 80(Pt 2): 217-228.

23 Lewy AJ, Lefler BJ, Emens JS, Bauer VK. The circadian basis of winter depression. Proceedings of the National Academy of Sciences USA. 2006 Apr 28.

24 Koopman C, Ismailji T, Holmes D, Classen CC, Palesh O, Wales T. The effects of expressive writing on pain, depression and posttraumatic stress disorder symptoms in survivors of intimate partner violence. Journal of Health Psychology. 2005 Mar; 10(2):211-221.

25 Gortner EM, Rude SS, Pennebaker JW. Benefits of expressive writing in lowering rumination and depressive symptoms. Behavioral Therapy. 2006 Sep; 37(3):292-303.

26 Nimer J, Lundahl B. Animal-assisted therapy: a meta-analysis. Anthrozoos: A Multidisciplinary Journal of the Interactions of People and Animals. 2007 Sept; 20(3): 225-238.

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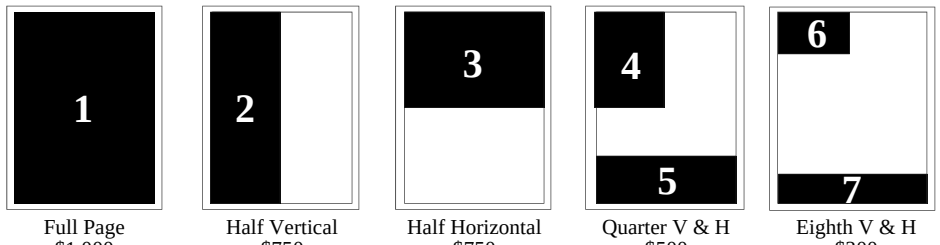

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Learn how Mental Health News can help provide your organization or community group with an affordable and trusted source of mental health education.

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