MENTAL HEALTH NEWS™
YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES
WINTER 2005 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 7 NO. 1

Women's Issues In Mental Health

Mental illnesses affect women and men differently—some disorders are more common in women, and some express themselves with different symptoms. Scientists are only now beginning to tease apart the contribution of various biological and psychosocial factors to mental health and mental illness in both women and men. In addition, researchers are currently studying the special problems of treatment for serious mental illness during pregnancy and the postpartum period. Research on women's health has grown substantially in the last 20 years. Today's studies are helping to clarify the risk and protective factors for mental disorders in women and to improve women's mental health treatment outcomes.

Depressive Disorders: In the U.S., nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive disorder each year. These figures translate to 12.4 million women and 6.4 million men. Depressive disorders include major depression, dysthymic disorder (a less severe but more chronic form of depression), and bipolar disorder (manic-depressive illness). Major depression is the leading cause of disease burden among females ages five and older worldwide.

Depressive disorders raise the risk for suicide. Although men are four times more likely than women to die by suicide, women report attempting suicide about two to three times as often as men. Self-inflicted injury, including suicide, ranks 9th out of the 10 leading causes of disease burden for females worldwide.

Research shows that before adolescence and late in life, females and males experience depression at about the same frequency. Because the gender difference in depression is not seen until after puberty and decreases after menopause, scientists hypothesize that hormonal factors are involved in women's greater vulnerability. Stress due to psychosocial factors, such as multiple roles in the home and at work and the increased likelihood of women to be poor, at risk for violence and abuse, and raising children alone, also plays a role in the development of depression.

While many women report some history of premenstrual mood changes and physical symptoms, an estimated 3 to 4 percent suffer severe symptoms that significantly interfere with work and social functioning. This impairing form of premenstrual syndrome, also

see Women's Issues on page 5

Personal Journey Through Depression
Provides Inspiration For Helping Others With Mental Illness

By Karen Gormandy, Board Member
NAMI-NYC Metro

Falling into depression was slow and deceptively delicious. All of my actions, thoughts and desires were motivated by a desire to disengage, to become numb. I'm not sure what happened, or how it started, but I remember beginning to feel the inward pull when I was 12 years old when, within months of arriving in New York from Trinidad, my mother moved out. No one said anything for days. She was just not there. Several days later, my father called me into his bedroom and told me she was gone, and he didn't know when she'd be back. I was 15 before it became a full-blown, almost immobilizing depression.

I would get up, go to school, and simply sit—inattentive and spaced out in class—the teachers' voices, when I did hear them, sounded like distorted noise and incomprehensible static. It wasn't long before I wasn't doing assignments; pretty soon I was cutting classes. I would get all the way to school and stand in front of the building, knowing full well I was not going to set foot in there. After the late bell rang and it was my very last chance, when the late arrivals and stragglers shuffled into school reluctantly, I would turn tail and head home.

I would take the subway as far as Lexington Avenue and, without leaving the station, catch a train back to Queens, stop off at the candy store, get a Twix bar for lunch and a monthly Harlequin, sharing the last leg of my trip home on the bus with a smattering of MTA workers returning home from the graveyard shift.

Before I knew it, my father flicked the light on to get me up for school. I would follow the sound of his footsteps down the carpeted stairs, listen for the front door to close and instead of getting up, I'd turn over and go back to sleep.

I don't think anyone noticed that I spent my entire sophomore year of high school in my room. I left only when everyone else was in bed to indulge my one pleasure—the Late and then the Late Late Show. I don't remember how I began to get up and out and back to school. It may have had something to do with a threat from the Board of Education.

My second depressive episode didn't quite last a year. I had started college on a high note. I was excited and expectant.

Karen Gormandy

But there was a part of me that was knotted up. My husband had taken a job out of state and my teenage son was spending more and more time with his friends. I thought my going to school would give me something to replace my lost identity as wife and my dwindling presence as mother. Displacement was not so easy. School could not cover up or replace the shock of being left by my husband and not being needed as much by my son.

I lasted a year, but then my resolve started to collapse. I had studied architecture in San Francisco and at the University of Colorado, and I continued on and enrolled as an architecture major at Montana State University. However, after the second semester, my work was becoming more and more un-architectural and wilder. I drew curves and lines that had no order, and created work outside the perimeters of the assignments.

My son was also falling off the edge of adolescence. He started hanging out with potheads and the high school clique of marginal characters. He was edgy and moody and rebelling against something.

By the time winter came, I was ready to jump out of my own skin. I was agitated, grumpy and unhappy.

I would get up, see Justin off to school, go to class but not do the assignments. After a few weeks, I would go to one class and skip all my other classes, work frantically to catch up on the

see Personal Journey on page 42

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Table Of Contents

From The Publisher: Two Commentaries

Mental Health NewsDesk

In The News At Mental Health News

Columns

Women’s Issues In Mental Health

Women’s Issues In Mental Health

Feature Stories

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From The Publisher: Two Commentaries
The Hope Of Recovery and *California Dreamin'*

The Hope of Recovery:

Reclaiming a Universe Lost During a Mental Illness

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

Like other severe illnesses, the experience of enduring a prolonged or severe episode of mental illness often disrupts many aspects of one's pre-illness world. Things we had always taken for granted are suddenly changed or gone all together. Some are major items in your life and some are minor. I could make a lengthy list, but for discussion purposes a few biggies would include: losing your job, your savings account, your family, your friends, your ability to think clearly, your ability to be hopeful for a brighter tomorrow or no longer feeling that you are a good person.

I don't want to seem presumptuous that everyone has a positive and glorious recovery, because: 1) the idiosyncrasies of mental illness in itself throw many curve balls into the equation, and 2) the bottom line is that we do not live in a fair and perfect world. In other words, mental illness treatment and recovery is not an exact science—so what worked for me might not work for you. The other—the imperfect and unfair world—may enable one out of ten depressed people who attempt suicide to live and, sadly, the other nine to die. On a brighter note, many people with mental illness do have a good recovery and are able to reclaim a universe that they had lost during the time they were sick, but it does take perseverance and a community of support.

This issue of Mental Health News takes a look at women's issues in mental health. Through the many wonderful articles submitted, the theme of parenting comes to the fore. Being a parent with a mental illness—or being the parent of a child with a mental illness—brings an altogether different kind of heartbreak; the challenges of reclaiming loved ones lost or alienated during mental illness is one of the singularly most pivotal pieces that needs to be replaced in the puzzle of reclaiming ones' universe in the recovery process.

Case in point. An educated 35-year-old man—the recently divorced parent of a beautiful five-year-old boy—suddenly, and without warning, begins having symptoms of panic and depression. He knows something is terribly wrong with the way he is feeling; he is having difficulty thinking clearly and completing simple tasks at work. During the day, he experiences inexplicable and terrifying episodes of panic, accompanied by feelings of doom and hopelessness.

In a period of less than a week, he is no longer able to function normally, and retreats to the safety of his home, where he spends most of the day under the covers.

This is just the beginning of what ends up being a 10-year battle with serious depression for this parent. He is in and out of inpatient and outpatient treatment, and although he has periods of relief, the illness continues to return with a vengeance. Over the course of his illness, this parent has lost his career, his savings—and friends and family alike haven't a clue as to what they can do to help.

But remember, he had a 5-year-old son at the beginning of this harrowing experience.

His son was growing up in the shadow of his parent's mental illness. The young boy could hardly explain or understand what was wrong—what was terribly wrong—with his dad. Tragically, during one of the little boy's weekends with his dad, the father sunk into a deeply despondent mood and had to be rushed to the hospital after taking an overdose of medications. How could this young boy or his father ever recover from such a tragic and shameful chain of events?

You must understand that the father deeply cared for his son and loved him very much. He so much wanted to be the old happy and loving father he had been before his illness struck—but the illness was telling him he was a failure and that he didn't deserve to live. The shame and stigma that his illness inflicted on him only served to compound the situation.

This sad story does, however, have a happy ending—even though it took 10 years to happen. The man finally finds the course of treatment that breaks the bonds of his depression. As his depression begins to lift, he is able to think clearly and regains his self-esteem and physical strength. During his recovery, he begins to rebuild his relationship with his now-teenaged son by sharing his deep love and true feelings for the boy—unencumbered by the shackles of his past depression. He is able to explain to the boy that he had a medical illness called depression, and that was what had caused him to behave the way he had.

The man in this story was me, so I know that this story is true. My son and I were blessed by the fact that we were able to reclaim those many years lost to a difficult and tragic mental illness. As my recovery continued, I was inspired to do something for others who would walk the same path that I had—and Mental Health News was born.

My son, a young adult now, has just graduated from college with honors, and is embarking on his own journey down the path of life. Thankfully we are very close, so my son's journey will be shared with support, care and love from his dad.

So to all the parents with mental illness—fathers and mothers—I say with sincerity that there is hope in recovery for reclaiming your lost universe. It takes time, the right treatment, and a community of support.

Ira H. Minot, CSW

To the mental health community, I would like to say; please realize that many people with mental illness are also parents. It is important to address the needs of parents in the course of treating them for their illness. Try to regularly inquire and provide support to them as parents. If you or your agency are able to provide sessions with the parent and their children, please do so in order to address the many losses, misinformation, and interruptions that both parent and children experience during the parent's illness.

California Dreamin'

Can A Proposition 63 Work In Financially Strapped New York

This just in: "The promise of a community system of mental health services will be fulfilled after almost 40 years." Sacramento, California, has just passed Proposition 63 by a margin of 53.4% of voters. What is Proposition 63? It is a new one percent income tax on residents with incomes over one million dollars that will go to support community mental health programs.

Amazingly, with increased federal funds, the amount of new money to care for people with mental illness is expected to exceed $1 billion per year in California. Proposition 63 will fund community mental health programs with voluntary outreach, access to medicines, and a variety of support services for children and adults who suffer from disabling mental illnesses. The investment will produce hundreds of millions in savings by reducing hospitalizations and incarcerations. In pilot projects similar to those that would be funded by Proposition 63, participants had a 56 percent reduction in hospital stays, a 72 percent reduction in jail stays, and a 65 percent increase in full-time jobs.

Following the recent November election decision on Proposition 63, Assembly member Darrell Steinberg, who fought for the proposition's passage, was elated, saying, "I am grateful to everyone for their hard work in passing Proposition 63. Californians can now be assured that tens of thousands of children and adults facing mental illness are going to get the help they need. The implementation of Proposition 63 is a great thing for so many who are affected by mental illness, for their families, and for our communities."

Here in New York, the home of Mental Health News, we have been under fiscal stress and cutbacks to our mental health system for many years—and the trend shows little sign of relief. Mental health programs for adults and children are under-funded. Senior care facilities are in scandalous condition and are often used to house people with mental illness; supportive housing units can't keep pace with demand; and our prison system is warehousing people with mental illness who need treatment—not incarceration. Mental health workers are paid less than workers at fast-food restaurants, so mental health agencies cannot find and keep adequately trained staff.

Why couldn't we (or other states in the same predicament as NY) do what California has done?

Why don't we stop the continued erosion of essential mental health services throughout our state? Why not revitalize our ability to expand successful and vital programs, and invite the creation of innovative new programs through a modest 1 percent tax on millionaires?

Let the call go out to all advocates throughout our state—to work together to get such a proposition on the ballot for New York State voters to pass.

If you have any thoughts on this, write to me at mhnmail@aol.com.

Mark Your Calendars For Our Upcoming Themes And Deadlines!!

Spring 2005 Cover Story Theme:
"Co-Occurring Disorders"
Deadline: February 1, 2005

Summer 2005 Cover Story Theme:
"Mental Health and Senior Adults"
Deadline: May 1, 2005

Women's Issues from page 1

called Premenstrual Dysphoric Disorder (PMDD), appears to be an abnormal response to normal hormone changes. Researchers are studying what makes some women susceptible to PMDD, including differences in hormone sensitivity, history of other mood disorders, and individual differences in the function of brain chemical messenger systems. Antidepressant medications known to work via serotonin circuits are effective in relieving these premenstrual symptoms. Women with susceptibility to depression may be more vulnerable to the mood-shifting effects of hormones.

Postpartum depression is another serious disorder where the hormonal changes following childbirth, combined with psychosocial stresses such as sleep deprivation, may disable some women with an apparent underlying vulnerability. National Institute of Mental Health (NIMH) research is currently evaluating the use of antidepressant medication and psychosocial interventions following delivery to prevent postpartum depression in women with a history of this disorder.

NIMH researchers recently found that women who suffer depression as they enter the early stages of menopause (perimenopause) may find estrogen to be an alternative to traditional antidepressants. The efficacy of the female hormone was comparable to that usually reported with antidepressants in the first controlled study of its direct effects on mood in perimenopausal women meeting the standardized criteria for depression.

Anxiety Disorders

Anxiety disorders, which include panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder, affect an estimated 13.3 percent of Americans ages 18 to 54 in any given year, or about 19.1 million adults in this age group. However, women outnumber men in each illness category except for OCD and social phobia, in which both sexes have an equal likelihood of being affected.

Results from an NIMH-supported survey showed that female risk of developing PTSD following trauma is twice that of males. PTSD is characterized by persistent symptoms of fear that occur after experiencing events such as rape or other criminal assault, war, child abuse, natural disasters, or serious accidents. Nightmares, flashbacks, numbing of emotions, depression and feeling angry, irritable, or distracted and being easily startled are common. Females are also more likely to develop long-term PTSD than males, and have higher rates of co-occurring medical and psychiatric problems than males with the disorder.

Eating Disorders

Females comprise the vast majority of people with an eating disorder—anorexia nervosa, bulimia nervosa, or binge-eating disorder. In their lifetime, an estimated 0.5 percent to 3.7 percent of females suffer from anorexia, and an estimated 1.1 percent to 4.2 percent suffer from bulimia. An estimated 2 percent to 5 percent experience binge-eating disorder in a 6-month period. Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable illnesses. In addition, eating disorders often co-occur with depression, substance abuse, and anxiety disorders, and also cause serious physical health problems. Eating disorders call for a comprehensive treatment plan involving medical care and monitoring, psychotherapy, nutritional counseling, and medication management. Studies are investigating the causes of eating disorders and the effectiveness of treatments.

Schizophrenia

Schizophrenia is the most chronic and disabling of all mental disorders, affecting about 1 percent of both women and men worldwide. In the U.S., an estimated 2.2 million adults ages 18 and older, have schizophrenia; about half of them are women. The illness typically appears earlier in men, usually in their late teens or early 20s, than in women, who are generally affected in their 20s or early 30s. In addition, women may have more depressive symptoms, paranoia, and auditory hallucinations than men, and tend to respond better to typical antipsychotic medications. A significant proportion of women with schizophrenia experience increased symptoms during pregnancy and postpartum.

Alzheimer's Disease

The main risk factor for developing Alzheimer's disease (AD), a dementing brain disorder that leads to the loss of mental and physical functioning and eventually to death, is increased age. Studies have shown that while the number of new cases of AD is similar in older adult women and men, the total number of existing cases is somewhat higher among women. Possible explanations include that AD may progress more slowly in women than in men; that women with AD may survive longer than men with AD; and that men, in general, do not live as long as women and die of other causes before AD has a chance to develop. Research is being conducted to find ways to prevent the onset of AD and to slow its progression.

Caregivers of a person with AD are usually family members—often wives and daughters. The chronic stress often associated with the caregiving role can contribute to mental health problems; indeed, caregivers are much more likely to suffer from depression than the average person. Since women in general are at greater risk for depression than men, female caregivers of people with AD may be particularly vulnerable to depression.

Reprinted from the National Institute of Mental Health: "Women Hold Up Half the Sky—Women and Mental Health Research" located on the Internet at the NIMH Web site www.nimh.nih.gov

MENTAL HEALTH NEWSDESK

Depression Traced To Overactive Brain Circuit

**National Institute
of Mental Health (NIH)**

A brain imaging study by the NIH's National Institute of Mental Health (NIMH) has found that an emotion-regulating brain circuit is overactive in people prone to depression — even when they are not depressed. Researchers discovered the abnormality in brains of those whose depressions relapsed when a key brain chemical messenger was experimentally reduced. Even when in remission, most subjects with a history of mood disorder experienced a temporary recurrence of symptoms when their brains were experimentally sapped of tryptophan, the chemical precursor of serotonin, the neurotransmitter that is boosted by antidepressants.

Neither a placebo procedure in patients nor tryptophan depletion in healthy volunteers triggered the mood and brain activity changes. Brain scans revealed that a key emotion-processing circuit was overactive only in patients in remission—whether or not they had re-experienced symptoms—and not in controls. Since the abnormal activity did not reflect mood state, the finding suggests that tryptophan depletion unmasks an inborn trait associated with depression.

Alexander Neumeister, MD, Dennis Charney, MD, Wayne Drevets, MD, the NIMH Mood and Anxiety Disorders Program, and colleagues, published a report on their positron emission tomography (PET) scan study in the August 2004 **Archives of General Psychiatry**.

The NIMH researchers had previously shown that omitting tryptophan from a cocktail of several other essential amino acids washes out the precursor chemical from the blood and brain, depleting serotonin and often triggering symptoms in people with a history of depression, even in healthy people from depression-prone families. This added to evidence that a genetic predisposition that renders some people vulnerable to inadequate serotonin activity may be at the root of the mood disorder.

The researchers scanned subjects after their blood tryptophan levels were reduced by about three-fourths using a radioactive tracer (a form of glucose, the brain's fuel), which reveals where the brain is active during a particular experimental condition.

They randomly gave 27 unmedicated depressed patients-in-remission and 19 controls either pills containing seven essential amino acids, such as lysine and valine, or identical-looking placebo pills. Subjects received either the active pills or placebos in repeated trials over several days in a blind, crossover design.

Sixteen (59 percent) of the patients experienced a transient return of symptoms under tryptophan depletion; their mood lifted to normal by the next day. Compared to controls, the patients showed increased brain activity in a circuit coursing through the front and center of the brain (orbitofrontal cortex, thalamus, anterior cingulate, and ventral striatum) — areas involved in regulating emotions and motivation that have been implicated in previous studies of depression. Whereas previous studies interpreted the circuit activation as a transient, mood-dependent phenomenon, the new evidence suggests that circuit overactivation is likely an underlying vulnerability trait, say the researchers.

Because of its ability to unmask what appears to be a trait marker for major depressive disorder, the researchers suggest that tryptophan depletion may be a useful tool for studying the genetic basis of depression.

"Since brain function appears to be disregulated even when patients are in remission, they need to continue long-term treatment beyond the symptomatic phase of their illness," noted Neumeister, who recently moved to the Yale University psychiatry department.

Survey Reveals Treatment Goals Of People With Schizophrenia

Life Goals An Important Focus For Successful Treatment

**American Medical Association (AMA)
Science Reporters Conference**

Details from a large-scale survey focusing on treatment goals for schizophrenia shed new light on what physicians and people with schizophrenia feel is important for long-term quality care, according to Ronald J. Diamond, MD, co-author of the study.

"When we treat people with any kind of chronic illness, especially schizophrenia, it's important that we listen to their life goals, what they want out of treatment and what they want out of life," said Dr. Diamond, a professor of psychiatry at the University of Wisconsin at Madison, medical director at the Mental Health Center of Dane County and consultant to the Wisconsin Bureau of Community Mental Health and Substance Abuse, Madison, Wisc. "This study examines the similarities and differences of what schizophrenia patients and their physicians view as primary treatment goals."

Dr. Diamond spoke recently at the AMA's 23rd Annual Science Reporters Conference in Washington, D.C.

In the schizophrenia treatment-goals survey, physicians and people with stable schizophrenia both reported their top treatment goals were improving mental health and improving overall happiness.

"One of the more surprising results of the survey was how similar the goals of both psychiatrists and people with schizophrenia in outpatient settings were," Dr. Diamond said. "The idea of truly listening to patients and questioning their goals has really caught on. As we can see from the survey, the top goal of both physicians and people with schizophrenia parallel each other, which means as psychiatrists—we've got it."

However, some differences in treatment goals remain. People with schizophrenia were more interested and focused on decreasing psychotic symptoms, such as hearing voices. In general, physicians were focused on treating symptoms. According to the survey, people with schizophrenia have shifted their focus to life goals rather than treatment goals. They ranked the following significantly higher than physicians: returning to favorite hobbies and activities, decreasing feelings of being isolated due to schizophrenia, and improving physical health.

The real problem with schizophrenia is the social stigma, Dr. Diamond said. "We aren't afraid of someone who is dangerous, such as a drunk driver, because they could be our neighbor or a cousin. Yet when we see someone who is different and may act strange, we become afraid of them for no real reason," he said. "Decreasing the stigma we have of people with mental illness is a constant battle. It's still just the beginning of acknowledging mental illness and incorporating people with mental illness into society."

Among the patients in the study, males outnumbered females 60 percent to 40 percent, and the overall average age was 46 years. Of those with schizophrenia, more than 80 percent were diagnosed more than five years ago. The majority (70 percent) of schizophrenic patients surveyed were receiving treatment at community mental health centers, with 96 percent being treated on an outpatient basis. Physician participants in the study were 32 percent female. The physicians surveyed were highly experienced. The majority have been treating schizophrenic patients for more than 10 years, and more than half (52 percent) see more than 200 patients per month.

"In order for a psychiatrist to successfully treat a person with schizophrenia, it is necessary to have a respectful listening session where the physician gets to know the person, learn who they are and what they want from life," Dr. Diamond said. "If I don't know this person with or without schizophrenia, I'm not going to know how to direct them. We are trying to help them achieve their life goals rather than impose something on them."

Dr. Diamond has received grant support from Janssen Pharmaceutical and Genaissance Pharmaceutical. He has received honoraria from and serves on speakers bureaus for Janssen Pharmaceutical, Bristol-Myers Squibb, AstraZeneca and Pfizer Pharmaceutical. Dr. Diamond serves as a consultant for Janssen Pharmaceutical, Bristol-Myers Squibb, Eli Lilly & Co., Pfizer Pharmaceutical and Atrix Laboratories. Dr. Diamond has received an honorarium from the American Medical Association to speak at their Reporters Conference.

MENTAL HEALTH NEWSDESK

Psychotherapy And Medications Best for Youth With Obsessive Compulsive Disorder

**National Institute
of Mental Health**

Children and adolescents with Obsessive Compulsive Disorder (OCD) respond best to a combination of both psychotherapy and an antidepressant, a major clinical trial has found. Supported by the National Institutes of Health's (NIH) National Institute of Mental Health (NIMH), the study recommends that treatment begin with cognitive behavior therapy (CBT), either alone or with a serotonin reuptake inhibitor (SRI) antidepressant. The research spotlights the need for improved access to CBT, since most young people with OCD currently receive only the antidepressant, often combined with an antipsychotic medication. John March, MD, Duke University, Edna Foa, PhD, University of Pennsylvania, and colleagues report on the findings of the Pediatric OCD Treatment Study (POTS) in the October 27, 2004, **Journal of the American Medical Association**.

Ninety-seven 7 to 17 year-olds with OCD completed 12 weeks of treatment with either CBT, the SRI sertraline, the combination treatment, or a placebo. Independent evaluators, blind to their treatment status, assessed each patient every four weeks. Patients in the study were typical of patients seen in clinical practice. For example, while industry-sponsored trials commonly exclude patients with more than one condition, 80 percent of study participants had at least one additional psychiatric disorder.

Combining sertraline and CBT was more effective than treatment with just one or the other. CBT alone did prove superior to sertraline, which, in turn, was better than a placebo. By the end of the trial, the remission rates were 53.6 percent for combined treatment, 39.3 percent for CBT, 21.4 percent for sertraline, and 3.6 percent for placebo.

CBT alone was more effective in the University of Pennsylvania site than at Duke University site, but the combination treatment was equally effective at both sites, suggesting that it may be less susceptible to setting-specific variations. The strong showing of CBT at the University of Pennsylvania led the researchers to recommend it as "a first-line option" for initial treatment. They point out, however, that "only a small minority" of children and adolescents with OCD receives such state-of- the-art care.

In the "Treatment of Adolescents with Depression Study," which compared CBT with an SRI and combination treatment for teens with depression, the medication proved superior to CBT. In this case the reverse was true, but in both studies, combination was superior. "This underscores that different disorders in adolescents respond to different treatments," noted NIMH Director Thomas Insel, MD.

"We believe that the results of this study will contribute to the appreciation by non-physician mental health clinicians of the strengths and limitations of pharmacological treatments and to the appreciation by physicians of the evidence-based psychosocial treatments," states the article. "It is imperative that the focus of research turn to identifying and testing dissemination strategies for CBT," the researchers add.

There were no episodes of mania, suicidal tendencies, or other serious adverse events during the course of the study.

Also participating in the study were Pat Gammon, PhD, Allan Chrisman, MD, John Curry, PhD, David Fitzgerald, PhD, and Kevin Sullivan, BA, all from Duke University Medical Center; Martin Franklin, PhD, Jonathan Huppert, PhD, Moira Rynn, MD, Ning Zhao, PhD, and Lori Zoellner, PhD, from the University of Pennsylvania; and Henrietta Leonard, MD, Abbe Garcia, PhD, and Jennifer Freeman, PhD, from Brown University. The principal statistician was Xin Tu, PhD, of the University Pennsylvania.

Lieberman To Chair Psychiatry At Columbia University Medical Center Will Also Head New York State Psychiatric Institute

**News Item
Reported on the Internet**

Jeffrey A. Lieberman, MD, will join Columbia University Medical Center in January as chairman of the Department of Psychiatry in the College of Physicians and Surgeons. At that time, he also will join the New York State Office of Mental Health, serving as director of the New York State Psychiatric Institute (NYSPI) and head of the Lieber Center for Schizophrenia Research, housed on the Columbia campus.

In his new capacities, Dr. Lieberman will serve a third role, as psychiatrist-in-chief at New York-Presbyterian Hospital/Columbia University Medical Center.

Dr. Lieberman is currently the Thad and Alice Eure Distinguished Professor of Psychiatry at the University of North Carolina (UNC) School of Medicine.

"Dr. Lieberman will further enhance the leadership of our medical enterprise in psychiatric research and patient care," says Gerald D. Fischbach, MD, executive vice president, Columbia University Medical Center. "His research has enlarged the world's knowledge of schizophrenia, by providing insights into the effectiveness and mechanism of action of antipsychotic drugs."

"The Office of Mental Health is pleased to have someone of Dr. Lieberman's reputation and experience lead the public mental health services research agenda at NYSPI, a premier facility at the cutting edge of mental health research," said Sharon E. Carpinello, RN, PhD, Commissioner of OMH. "Studies of complex psychiatric disorders have led to effective treatment and rehabilitation for thousands of individuals with mental illness, and research in the neurosciences continues to identify the potential for recovery where none had previously been expected or anticipated."

"New York-Presbyterian Hospital, Columbia University Medical Center, and the NY State Psychiatric Institute have a tradition of commitment to high quality psychiatric care, and to engaging in research that has brought hope to thousands of patients and their families. Dr. Lieberman's outstanding record of accomplishment in neurobiology, pharmacology, and the treatment of schizophrenia, will enable us to continue to break through the barriers of mental illness that still prevent so many from enjoying a full life," said Dr. Herbert Pardes, president & CEO of New York Presbyterian Hospital.

"I am extremely enthusiastic about leading a department at the forefront of academic and clinical psychiatry," says Dr. Lieberman. "I am also looking forward to developing a model public-academic partnership with the New York State Office of Mental Health, which will improve the quality of services and mental health care of the citizens of New York," says Dr. Lieberman.

At UNC, Dr. Lieberman is also Professor of Pharmacology and Radiology and director of the Mental Health and Neuroscience Clinical Research Center. He serves as the principal investigator and director of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Research Program at UNC. CATIE is a $61 million, National Institute of Mental Health-funded effort to determine which of the new generation of anti-psychotic drugs are best for treating patients with schizophrenia and disruptive behaviors associated with Alzheimer's disease.

With research focused on the neurobiology, pharmacology and treatment of schizophrenia and related psychotic disorders, Dr. Lieberman has authored more than 300 scientific papers. He is a member of the Institute of Medicine in the National Academy of Science. He has received grants from the NIMH, National Alliance for Research on Schizophrenia and Depression (NARSAD) and the Stanley Foundation.

He holds a bachelor's degree in biology from Miami University of Oxford, Ohio, which he attended on a football scholarship. He earned his medical degree at George Washington University, completed his internship and residency at St. Vincent's Hospital and Medical Center of New York/New York Medical College, and completed a research fellowship at Albert Einstein College of Medicine.

Women And Body Obsession: A Feminist And Cultural Perspective

By Judy Scheel, PhD, Director
Center for Eating Disorder Recovery

*"I look at **Elle** (magazine) or **Elsa** (magazine) and I think, that is the kind of woman men want. I flip through **Shape** (magazine) and think, bikini abs, perfect thighs, that is the route to desirability, oh s—t, I ate too much lunch." (Caroline Knapp, **Appetites**)*

Given what we know about the ill and ineffective consequences of dieting – that diets don't work, that food restriction slows down the body's metabolism, and when an increase in food intake occurs after dieting, weight gain is rapid – why do women, healthy women continue to drive themselves toward achieving bodies that are unrealistic at best, and more than likely impossible to attain? Why is the voice that lives within many women's minds one of self-criticism, inadequacy and never quite feeling good enough? Why do women continue to ridicule one body part or another—or worse denounce their entire body?

These women are not suffering from anorexia nervosa, bulimia or binge eating disorder. They are women who are living in the world with healthy relationships, careers, and children, but who maintain the belief that their bodies are fatally flawed, imperfect and therefore they can never rest, or ever feel satisfied. The fact is that this attitude represents the norm among many women.

Judy Scheel, PhD

Knapp continues, "But it's worth recalling that all of this – the ratcheted-up emphasis on thinness, the aesthetic shift from Marilyn Monroe to Kate Moss, the concomitant rise in eating disorders – is relatively recent, that the emphasis on diminishing one's size, on miniaturizing the very self, didn't really heat up until women began making gains in other areas of their lives."

From a feminist perspective, the increase in dieting, obsession over body size and shape, and the skyrocketing episodes of eating disorders is the consequence of patriarchal control and domination of women. Whereas women have been traditionally oppressed through discrimination in the work force, less pay for equal work, and pressure to remain at home, the more recent focus over the last thirty years has been to control women by controlling women's body size and shape. Fashion magazines tell women constantly how to lose weight, why they should want to look like a fashion model, what is the 'perfect' body size or shape and more importantly, why they should want a particular body shape as the means to please their man.

Eating disorders proper are complicated and complex. They are housed within the social and cultural milieu, but their root cause deals with intra and interpsychic and relational issues. Objectification of women, and the social, political and economic oppression of women, is the milieu in which the disorders develop. Other theoretical perspectives maintain, however, that the social and cultural milieu serves to facilitate, but do not cause eating disorders; other causal factors are at work, including relational issues, depression, and abuse. If the social and cultural messages were the only culprits for the development of eating disorders, then many more women would have an eating disorder, since so many women obsess about their body and their size. Indeed, root causes of eating disorders go significantly deeper. Some feminists rebut, however, and believe that, in fact, most every woman does have an eating disorder because, from their perspective preoccupation and chronic dissatisfaction with weight and body size are seen within a lens of disordered thinking.

Carol Bloom writes, "Thinness, exploited by advertising, became a bogeyman, a judge, an accuser, an impossible standard, a dream of women's emancipatory goals." She discusses how thinness is associated with beauty and health, and these qualities are associated with being a good woman. Advertisers' lure that thin women can have it all (work, freedom, family). Yet the covert message remains that women are still judged on the basis of their body. "They must take up less space, fit into prescribed molds of standardized beauty, restrain their desires by disciplining their hungry bodies. No one wants a fat woman, someone out of control." Slenderness symbolizes greater parody with men; a thin woman has a greater chance of being heard in the boardroom if she is thin.

So within this context, how can any woman ever feel o.k. – forget beautiful! Feminists and non-feminists alike tend to agree that women remain destined to suit the needs of others – to nurture others often and usually at the expense of themselves. Those women whose appetites are full and rich are destined for criticism and control of another sort.

see Body Obsession on page 42

Understanding The Interpretation of Clinical Drug Trials

By Joseph A. Deltito, MD, Alejandra Valencia, MD, Chirag Desai, MD, Gene Lui, DO, Joshua Farber, DO, Julie Suojanen, DO, and Valerie Mildeberger, MD

"the lack of evidence of a positive clinical effect is not the same as the evidence of a positive clinical effect"

When a pharmaceutical company has a new medicine they believe will be of use in treating a psychiatric or other medical disorder, they must provide strong evidence to the Food and Drug Administration (FDA) that this new treatment is effective and safe. At minimum, several "positive" experiments with large numbers of patients are required to establish a record that will allow that new drug to come to market. During this phase of development, some experiments conducted with a new drug may show positive evidence of effectiveness or may fail to do so. When failed trials occur, a pharmaceutical company attempts to determine whether the failure is due to some intrinsic problem with their new drug or an error employed in the design or conduct of the experiments done. If it is felt that the problem was not the drug per se, but the result of a faulty experiment they may repeat the experiment, with modifications that would render it a fairer or more sensitive test of the drugs effectiveness. Eventually, they can either provide a strong body of evidence to the FDA that their new drug is effective, or may fail to do so. Without FDA approval it never comes to the market. Lately, the general media has focused on stories related to specific drugs currently available in the marketplace having had negative trials during their development. We feel many of these stories have been sensationalized and distorted due to a lack of understanding as to what information a negative drug trial truly provides. We will attempt to clarify this issue.

Standing: Drs. Valencia, Farber, Lui, Mildeberger
Sitting: Drs. Desai, Deltito, Suojanen

What does it mean when a pharmacological treatment in development for treating a psychiatric disease fails a clinical drug trial? For example, our new antidepressant (hypothetically we will refer to it as Tiramisu) is compared to placebo, and at the end of a rigorously controlled clinical drug trial the numbers of patients who are considered to have a positive outcome are not significantly higher than those patients having been treated with a placebo. Unfortunately there are many people who believe that this is evidence that Tiramisu does not work. While true ineffectiveness of Tiramisu may possibly be the reason for this outcome, standard methods for conducting such experiments are not able to confirm such a finding. This may seem paradoxical, but it truly is not. They can

see Drug Trials on page 44

Discovering What Matters: Women Confront Retirement

By Marilyn Ogus Katz,
Dean of Studies Emerita
Sarah Lawrence College

When I decided to retire after a career as a college teacher working with underserved populations in Westchester and then as Dean of Studies at Sarah Lawrence College, I had good reasons and good plans. I had reached retirement age, was tired of a demanding job, wanted very much to pursue the writing of fiction, and was fortunate that I could afford to do so. To ease the transition, I agreed to stay on at the college for three additional years working one day a week.

Imagine my surprise when, only a few months later, I discovered myself reeling from the psychological and emotional impact of my decision. After a thirty-year career, I felt sad, empty and unproductive. Some days I couldn't even write—one of the reasons I had retired in the first place. Determined to research the factors that contributed to this unexpected reaction, I joined a friend to form a focus group of retired women and soon found I was not alone. The results of our exploratory discussions appeared as a chapter in Women Confronting Retirement: A Non-Traditional Guide (Rutgers University Press, 2003).

We defined ourselves as women who were members of the "bridge" generation, between our mothers who primarily worked at home and our daughters who consciously prepared for careers. Many of us backed into our careers, learned what we needed on the job, and, in some cases, went back to college and graduate school after we raised families. Strongly influenced by the women's and civil rights movements, we tried to find work that would make a difference in society. But because our independence and autonomy were hard-won, our generation discovered that working for a paycheck had actually come to define us.

Marilyn Ogus Katz

During the initial sessions, we found we had to assess and evaluate our careers and mourn our losses before we could move on. We agreed that, while we had some regrets about our careers and had retired partly because we were tired of what we were doing, we had also accomplished more than we ever imagined. Along the way, we mentored younger women, developed services for women, and demanded greater representation of people of color in our organizations.

While two in our group were settling happily into their new routines, enjoying their families, volunteer work, travel and courses, the rest of us remained puzzled by our discontent, afraid we were beginning to care more and more about less and less.

The most serious and immediate loss we experienced was that of an easily recognizable identity. "What do you do?" is often the first question asked in social situations, and responding with "I used to be" became extremely uncomfortable for former administrators, social workers, politicians and business women. We missed our business cards and eventually dashed off to Kinko to print up others stating that we were "consultants" of one sort or another. We missed the structure work provided and found ourselves unable to keep track of what we had actually done in a day. We missed the excitement and challenges, the daily problem-solving that kept us feeling necessary, appreciated and yes, even important. We missed the diverse community of the workplace, the contact with others who, although engaged in a common cause, were often unlike ourselves in terms of age, sex, sexual orientation and background. A few of us were lonely.

We also discovered that full-time work had enabled us to successfully avoid confronting many of our deepest personal issues. Once retired, we found ourselves worrying more about our health, our aging, our finances, our partners, our grown children, our friends, and the deteriorating state of the world. Having the leisure to actually spend the morning reading the barrage of bad news in The New York Times only added to our general anxiety. Our attempts to continue our political and social activism through volunteer work were often frustrating. Supervised by the volunteer coordinator, usually the most junior member of an organization, we were rarely asked to use our considerable skills. Those, like myself, who retired to do "creative" work were daunted by the unaccustomed hours of isolation and the ultimate difficulty of publishing, performing or exhibiting. For years, I had extolled "process" over "product," but, as a writer, I found that the value society places on demonstrated and public success had become my own.

Women have so often used one another to get through the painful transitions in life, over telephone wires and kitchen tables and most recently, on the Internet. Through honest revelation, the members of our women's group were relieved to discover our common concerns, learn from our differences, and eventually find ways we could help one another move on. For some of us that meant allowing ourselves, without guilt, to enjoy the daily pleasures of our children and grandchildren, of taking better care of ourselves, of traveling and helping loved ones in trouble, of developing new skills, say, in languages or culture, and cultivating long dormant parts of ourselves. We began to network to find appropriate venues for our political and social activism through women's organizations, like The Transition Network, that match volunteers to non-profits, and through our own inventive packaging of our particular skills as freelancers. We discovered the importance of finding new communities of people engaged in a particular interest or involved in a political cause, such as a writing, chamber music or theater group, or a non-profit organization or political campaign.

We recognized that retirement is not static, but rather an ongoing process, and that adjustments and changes must occur, sometimes every few months, to ensure a balance of private time and public involvement that works for each person. And while each of us eventually found this balance of productive work, learning and pleasure, it still required constant tinkering. Indeed, three years after we stopped meeting, we are each engaged in a new and different range of activities.

I came to understand that compelling myself to write a successful novel, a dream I had nurtured all of my life, had actually prevented me from permitting myself to explore other activities and, even worse, had led to a major writer's block. No wonder I was sad. Instead, while I continue to work on a third draft of my novel, I developed other writing projects, including a series of essays about older women and a trail guide to

see Retirement on page 34

Healing Art Exhibit Coming To Hofstra University

Staff Writer
Mental Health News

The Nassau County, New York, Department of Mental Health, Mental Retardation and Developmental Disabilities (MRDD) will sponsor its 16th Annual "Art Expressions" Exhibition in cooperation with Long Island, New York's, Hofstra University, from March 2nd through May 2nd. Art Expressions displays artwork created by persons with psychiatric disabilities and mental retardation, who attend various programs in Nassau County. The artists will receive awards at a reception on Friday, March 11th at 10:30 a.m., and a "coffee house" featuring poetry readings will be conducted on April 29th from 7 – 10 p.m.

Nassau County Mental Health Commissioner Howard Sovronsky states, "I am proud of the extremely talented artists in the Nassau County mental health and MRDD service system. Their work transcends their disabilities, and helps to reduce the public stigma normally associated with mental illness and mental retardation. I am also grateful to Hofstra University for their wonderful support of this exhibit."

"The Cliff" by Miryam Gongora

John Javis, a program director from the Mental Health Association of Nassau County, chairs the Art Expressions 2005 Committee. He shared that a piece from the 2004 show, called "The Cliff," was chosen to be the poster advertising the 2005 show. The artist, Miryam Gongora, suffers from depression. In early 2004, Miryam began to suffer a series of additional medical complications that prevented her from attending a support program sponsored by the Mental Health Association, but thankfully, the art therapist keeps in touch with her by phone. Miryam continues to paint as a way to cope with her illness.

Art Expressions 2005 is open to the public free of charge. The show is housed in the second floor of the Hofstra University Axinn Library in the Scott Skodnek Business Development Center. For more information, call John Javis of the MHA of Nassau at (516) 489-1120 ext. 125, or Mary Beth Jacovides of Hofstra at (516) 463-6812.

The Mental Health Association of Nassau County is a not-for-profit membership organization that works to promote mental health in the community through advocacy, education, program development and the delivery of direct services.

Pregnancy And Managing Mental Illness

By Laura Thompson, PhD
Outpatient Mental Health Services
St. Vincent's Hospital Westchester

Laura Thompson, PhD

Pregnancy and parenting pose significant challenges for women with serious mental illnesses. Women must deal with significant physical and psychosocial stressors, often with few family or social supports. In the outpatient mental health program for pre-and post-partum women at St. Vincent's Hospital in Westchester, New York, education and support are key aspects of our services.

The question of the use of psychotropic medications is an important issue for pregnant women with serious mental illnesses. The severity of the illness is a major determinant in deciding whether a woman should stop her medication entirely, or switch to safer medications as an alternative. Women are instructed to consult their psychiatrist regarding the safety of medications in pregnancy and developing a treatment plan with their physician.

The question of the use of psychotropic medications is an important issue for pregnant women with mental illness, especially whether a woman should stop her medication entirely, or change to another medication as an alternative. Women are instructed to consult their physician regarding the safety of their medications during pregnancy, and to develop a treatment plan with their physician. To help women cope with the physical impact of being without their medication, the St. Vincent's women's program offers extra support in the form of additional group and individual therapy. Throughout the process, we offer education about pregnancy and childbirth, since many of our clients haven't been exposed to it before. In addition, childbirth education may not be available to them due to cost. We try to empower our clients to advocate for themselves and ask questions about their pregnancy.

Since many of our clients may not have had positive parental role models or may not have good family support systems, therapy groups can play a valuable role by connecting women with other women who are facing the same questions and problems. Women can share their concerns and ask questions in a safe and nurturing environment.

Psychosocial stressors present equally difficult challenges for pregnant women with mental illnesses. Many face financial stressors, housing problems, and single parenthood. We assist clients with referrals and linkages to case management services and to community programs such as WIC, Birthright, Good Counsel and others. Many of our clients have histories of abuse or trauma. Childhood abuse and victimization issues often become more intense during pregnancy or early parenthood. Women worry about their own children becoming victims. We attempt to help women break the cycle of victimization with help and support.

The need for support and education is equally important following birth. The postpartum period is a very tough time for new mothers with mood disorders. They need to know what changes to expect due to hormonal fluctuations, and they may need education and medical advice regarding their medications, interactions and the use of medications while breastfeeding.

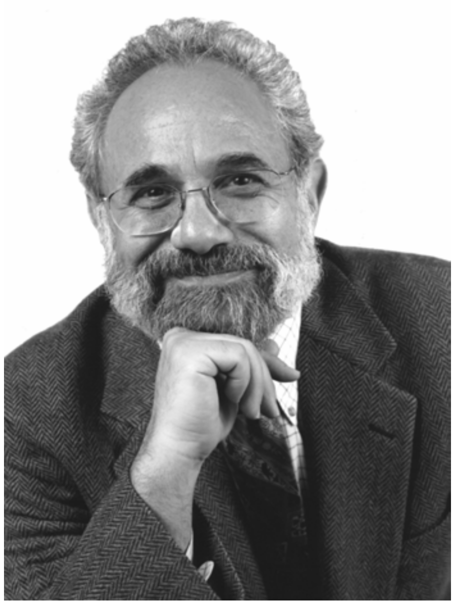
The stresses of being a new parent, such as loss of sleep, fear of not being a good parent, and fear of losing control, are all issues that we deal with through helping women understand that no one is a "perfect" parent, and that all new parents face similar stressors. We provide ongoing support and parenting skills education to help clients deal with the continuing challenges of managing both their illness and their role as new parent.

For more information about St. Vincent's Westchester programs for women, please call (914) 925-5320.

POINT OF VIEW

Use Medicaid For Growth, Not Just To Avoid Cuts

By Michael B. Friedman, LMSW



Michael B. Friedman, LMSW

In recent years, most mental health advocates in New York State, including me, have become realists. We've been buffeted by bad times and have come to believe that not losing ground and getting a few minor gains are successes worth crowing about. It wasn't always that way. We used to expect, and get, major growth in community mental health services, while also getting cost of living adjustments to protect current services. That was a long time ago, I admit, but with a better economy on the horizon, it may be worthwhile to revisit the past to encourage us to raise expectations for the future.

Given the general drift to rely on Medicaid to finance mental health services, it is particularly important to understand that in the early 1990s, New York State's policy regarding the use of Medicaid to support mental health services underwent a major change.

In the late 1970s and the 1980s, Medicaid supported a significant increase in outpatient mental health services at the same time that the state invested its own funding in the development of housing and community support initiatives. Medicaid was used to increase mental health services, not to stabilize them at current levels.

Towards the end of the 1980s the first major change took place. The state decided to control the establishment of new programs using Medicaid by introducing the "Medicaid neutrality cap." This regulatory provision released New York State from the prior regulatory requirement to approve needed, fiscally viable new program development, even if it relied on Medicaid to be fiscally viable. Under the new provision, the state could block new program development if the provider could not show a source of the state share of Medicaid funding for the program, other than increased state spending. In some cases, local governments adopted the same approach.

The Medicaid neutrality cap did not stop outpatient program development using Medicaid, but it slowed it considerably.

In the early 90s an even more profound change took place. New York State discovered that it could replace state and local funding with federal funding by using Medicaid more extensively for existing programs. First, the state introduced Comprehensive Outpatient Program Services (COPS), a supplemental Medicaid rate for mental health clinics so as to replace some state, local, and philanthropic financing with federal funds. Later, the state extended COPS to other outpatient programs. It also moved to use Medicaid to fund some community residences—again making it possible for state and local governments to cut their expenditures while maintaining services at current levels. Soon, a new form of Medicaid licensure will be introduced—Personal Recovery Oriented Services (PROS)—which will make it possible to once again supplant state funds with federal funds, this time for rehabilitation programs.

The critical point is that in the early 90s, New York State, and its local governments made a vast change in their fundamental policy regarding the use of Medicaid—from a policy of program growth in response to unmet need, to a policy of holding the line by substituting federal funds for state and local funds.

Because mental health spending has grown over the past decade, some people will probably take issue with this analysis. But let's take a look at the big picture. According to OMH planning documents, gross spending in the public mental health system has increased in New York State from approximately $4 billion in 1993 to $4.8 billion in 2002, and perhaps something over $5 billion today. However, due to inflation, $4 billion in 1993 is equivalent to $4.98 billion in 2002, suggesting that public spending on mental health in New York State has not kept pace with inflation over the past dozen years or more.

This may seem mysterious. After all, the state provided additional funding of $200 million when Kendra's Law passed; there are 9000 more housing units now than in 1993; and there have also been increases in case management, assertive community treatment, peer support, and other community services.

But in fact, new program development has been funded in two ways other than overall growth of funding: (1) via redistribution, and (2) by failing to provide adequate cost of living adjustments to existing programs, many of which are now on the verge of crisis.

Redistribution makes sense. The shift from an institution-based mental health system to a community-based mental health system should result in substantial redistribution, and I have been a strong proponent of the Reinvestment Act, through which savings from reductions in state hospitals have funded new community services.

But the goal of the original Reinvestment Act was to fund *new* programs with savings from state hospitals, while state and local governments maintained funding for current services, including funding to cover inflation. Sadly, that is not what happened. Funding for existing services has consistently eroded when the costs of inflation are taken into account, despite the use of federal Medicaid funds to replace state and local funds.

Over the past decade, New York's state and local governments have, in essence, rejected the obligation they previously accepted to provide funds for the service system to grow, while also providing adequate funding to sustain existing programs.

But isn't it clear that we need funding for both stability and growth? And, as the economy improves, shouldn't we advocates call for state and local governments to once again accept their responsibilities to people with mental illnesses?

To do so, New York's funding policy needs to change in four ways.

1. Medicaid should be used to support program growth as it was in the 70s and 80s.

2. When Medicaid can be used to replace state and local funds, freed funds should be used to support new mental health program development.

3. State, local, and Medicaid funding should keep pace with inflation, preferably by instituting an automatic annual cost of living adjustment ("trend factor") like that used in the health system.

4. The Medicaid neutrality cap should be eliminated.

I know I sound wildly unrealistic. But I am old enough to remember when it was the basic policy in New York State to provide stability *and* growth. And I am optimistic enough to believe that it can be done again.

Michael B. Friedman is the Director of the Center for Policy and Advocacy of The Mental Health Associations of New York City and Westchester. He can be reached at center@mhaofnyc.org. The opinions in this article are his own and do not necessarily reflect the positions of The Mental Health Associations.

A Voice of Sanity

A Column by Joshua Koerner

Consumer Advocate and Executive Director
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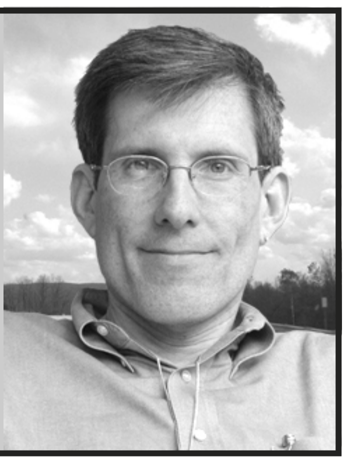


Now They're Stealing Our Brains

By Joshua Koerner

The Halloween Episode of **Law & Order: Criminal Intent** had the following plot synopsis: "It's heads up when detectives go underground. When the bodies of several murdered homeless men are sold to medical labs, Detectives Goren and Eames descend into abandoned subway tunnels …" Even if you didn't catch the show, you may have seen the teaser, in which Goren, in the midst of interrogating a lab technician, says, "Cat got your tongue? Because I have one right here," motioning to a tray containing the aforementioned body part. The ease with which dead bodies are dragged in, cut up and then resold to tissue banks defies credibility.

In fact, it's ripped from the headlines, if you live in Maine and read the Portland Press Herald. Their investigation found that the brains of 99 deceased residents of Maine had been harvested at the medical examiners office, for profit, and, in nearly a third of the cases, without any written proof of family consent.

The Stanley Medical Research Center in Bethesda, Maryland had a price list for brains: $1,500 a pop for brains diagnosed with severe depression and two grand if the donor had either schizophrenia or bipolar disorder. They would throw in an extra $500 for the donor's psychiatric records.

This lucrative cash incentive was set up by the center's founder, E. Fuller Torrey, MD. Torrey paid the Maine state funeral inspector, and he in turn would call the medical examiner's office every day to see if they had any suitable brains. But that wasn't enough for Torrey: he suggested his brain snatcher "might also increase the number of cases of schizophrenia and manic depressive illness by obtaining the list of large group homes from the Department of Mental Health," and leaving then leave a number they could call if a suitable resident croaked. Torrey also suggested paying off an employee of the ME's office so that their official stationary could be used in making the request for the confidential psych records.

Torrey's head shop was ethically compromised from top to bottom. The Stanley Center is not accredited by the American Association of Tissue Banks. The consent forms used in Maine did not make clear that the Center was seeking the entire brain and not just a sample. In those instances where consent was obtained, in virtually every case it was verbal, witnessed by the live-in girlfriend of Torrey's hired hand, a ghoul who was shameless about calling grieving families on the day of a loved one's passing. Contrast this with the practice of the Harvard Brain Tissue Resource Center, which encourages donations prior to death and waits to hear from family members, never vice versa. Of course, Torrey's pay-per-brain scheme is ethically questionable for the very reason that it leads to such abuses.

And just who is E. Fuller Torrey? Cue the spooky music: Whooeeeoo. In addition to founding the Stanley Medical Research Center, Torrey, a psychiatrist, is also the founder of the Treatment Advocacy Center; in his role as president he advocates nationally for the use of coercive and involuntary mental health techniques. In a briefing paper on stigma, Torrey argues that "the public's association of mental illness with violence is a major cause of stigma." That's a reasonable position. He goes on to state "the association of mental illness with violence is very strong and has increased in recent years." OK. Now here's the ooga-booga-Holy-Christ-he's-a-madman moment: Torrey's position is that "the most likely reason for this increasing stigma is an increasing number of violent crimes committed by individuals with severe psychiatric disorders," and that the only way to reduce this stigma is to reduce the number of violent crimes committed by them. Torrey says stigma will be reduced when, to quote the Daily News, we "get the violent crazies off our streets!" Never once does Torrey indict sensationalistic and distorted news coverage or exploitative Hollywood productions as the source of stigma. It's us! We bring it on ourselves because we avoid treatment! So of course, to stop stigma, you need to treat us—by force.

He isn't the only one who thinks so. Sally Satel, MD, sits on the National Advisory Council to the Center for Mental Health Services and is charged with transforming the national mental health care system to ensure that it actively supports and facilitates recovery. According to the minutes of the June 2004 meeting, Dr. Satel "noted that stigma regarding severe mental illness may be addressed by early coercive care that then migrates into other, less coercive systems. She asserted that some people need intrusive, highly paternalistic, lifesaving care."

The final report of the President's New Freedom Commission on Mental Health, stated as its second of six major goals that "consumers, along with service providers, will actively participate in the designing and developing of the systems of care in which they are involved." Yet extreme right-wing physicians like Sally Satel are attempting to influence, and even defund, the Center for Mental Health Services; E. Fuller Torrey is flying around the country telling any one who will listen that "1,000 homicides per year in the United States are committed by individuals with severe mental illness;" and the Stanley Center is paying cash for stolen brains.

All together now: Whooeeeoo!

A tip of the hat—atop a brain that's not for sale at any price—to David Oaks at www.Mindfreedom.org, who brought these issues to my attention, as well as to David Gonzalez who is located on the Internet at www.cinemaniastigma.com.

The NYSPA Report

The Need For Transparency In Clinical Drug Trials

By Barry B. Perlman, MD, President
NYS Psychiatric Association

Occasionally there are critical events that crystallize an issue and set off a cascade of actions that propels change. Such was the case when, on June 2, 2004, Eliot Spitzer, the New York State Attorney General sued the pharmaceutical maker GlaxoSmithKline (GSK) under consumer fraud statutes for concealing clinical data relevant to the prescribing of Paxil®, an antidepressant for children. The New York State Psychiatric Association (NYSPA) was proud to be asked to be part of the process by which the Attorney General conveyed information about the suit to the press. No professional society other than NYSPA participated, and our press statement was linked to Spitzer¹s press release on the Attorney General's Web site. While NYSPA did not endorse the merits of the suit, we firmly endorsed the need for transparency of clinical research findings as a necessary precondition for the ethical and efficacious practice of psychiatry and all medicine.

Within days of the announcement of Spitzer's action, newspaper articles announced an astounding series of "aftershocks." The AMA adopted a resolution, with the strong support of the psychiatric delegates to the AMA's House of Delegates, calling for the creation of a database of all clinical drug trials undertaken in this country. The editors of several prestigious medical journals, members of the International Committee of Medical Journal Editors, announced that they were considering a requirement that pharmaceutical companies register clinical drug trials at their inception as a precondition to their publication in the journals. The actual plan for implementation was announced soon thereafter. Leading Democratic Senators were said to be considering legislation that would require the creation of a national database in which trials would be registered and the results of which would be publicly available. Remarkably, a major pharmaceutical company, Merck, announced support for the creation of a federally supported drug trial database.

Within months of having brought suit against GSK a settlement was announced by the Office of the Attorney General, and NYSPA offered congratulations for the successful outcome. In the Consent Order and Judgment, GSK agreed to disclose previously unreleased data related to the prescribing of Paxil® for the treatment of depression in children and adolescents. In an accompanying Assurance of Discontinuance, GSK agreed to make available to the public on an accessible database all clinical drug research conducted under their auspices. (The NYSPA press releases related to the suit and its settlement may be accessed at www.nyspsych.org, the NYSPA Web site: and the complaint and settlement may be viewed at the Web site of the Office of the Attorney General at: www.oag.state.ny.us). NYSPA hopes that this settlement will establish a precedent for the pharmaceutical industry and for all clinical researchers. We urge all of those conducting clinical research to insist on public access and the right to publish their research without restrictions imposed by the company or entity that sponsored or paid for the research, and to decline to participate in research that includes broad prohibitions or restrictions on public disclosure of the research findings. Finally, on October 15, 2004, the FDA announced that all antidepressants would be required to carry a "black box" warning, the government¹s strongest safety alert, thus drawing attention to the possibility of increased suicidal thoughts and behavior in children and teens taking them. It was also announced that the FDA would also be drafting an informational booklet for parents to advise them of the potential risk.

Attorney General Eliot Spitzer and Dr. Barry Perlman

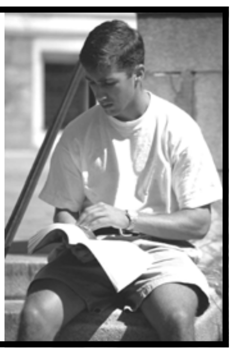
The need for effective responses is as important to we psychiatrists as it is to those we treat. The bedrock foundation of our relation with our patients is trust. As psychiatrists and physicians, we must be able to rely on the clinical data available to us when we read the professional literature published in peer reviewed journals or hear new data presented at psychiatric meetings. Without that confidence, we cannot assure those for whom we prescribe of the soundness of our judgments. For these reasons, it has been discomforting to learn that important clinical evidence may have been withheld when the outcomes of pharmaceutical company research weigh against the drug sales. Likewise, we are dismayed when pharmaceutical companies misrepresent claims about the safety of medications in promotional material. Unfortunately, when patients and their families learn that they have been deceived, or even possibly endangered, by taking medications purchased at considerable expense whose benefits may be marginal or non-existent, it breeds cynicism and distrust of the pharmaceutical industry, but also by extension of the health care system. It is clear that we physicians, dependent as we are on a relation of trust with our patients, cannot tolerate deception to rend the whole cloth of the health care system of which we are a part.

As an editorial in the **New England Journal of Medicine** began, "For many years, the registration in a public data bank of all clinical trials—from start to completion and reporting of results—has seemed a quixotic quest of some academic researchers, medical-journal editors, and librarians." (2004; 345:315-317). The possibility of a constructive resolution to a long recognized and simmering problem no longer seems "quixotic" in the wake of the AG's action. It is incumbent on all of us, both those whose primary concern is our ability to care for our patients to the best of our ability, and consumers and their concerned families alike, to act in concert to assure that the current momentum is not dissipated. If this issue is allowed to disappear from our "radar screens," it would be at our peril and that of our patients and the bond which unites us. Professional associations such as the American Psychiatric Association (APA) and American Medical Association (AMA) along with family and consumer advocacy organizations such as The National Alliance for the Mentally Ill (NAMI) must work vigorously towards the creation of mandatory, national clinical drug trial registries by letting members of the Congress know how important this matter is, and for our ability to provide and receive quality health and mental health care.

Barry B. Perlman, MD, is the President of NYSPA and is Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York.

The Campus Report

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



"The Vital Need To Address Campus Suicide"

By David B. Spano, PhD
Vice Chancellor, Health Programs and Services, University of North Carolina at Charlotte

In my last column, I described a piece of legislation that, at that point, had been introduced in the United States Congress; the Campus Care and Counseling Act. I am pleased to report that this bill, which was amended and renamed the Garrett Lee Smith Memorial Act, passed both houses of Congress and was signed by the president on October 21, 2004. The law is named to honor the late son of Senator Gordon Smith (R-Oregon). Garrett Lee Smith, a college student who struggled with bipolar disorder, committed suicide on September 8, 2003, one day before his 22nd birthday.

Along with provisions for early intervention and prevention of youth suicide, the bill authorizes competitive grants to colleges and universities to improve services for students with psychological concerns that impede academic success. Section 520E-2 of the law, entitled "Mental and Behavioral Health Services on Campus," authorizes grants to colleges and universities to "enhance services for students with mental and behavioral health problems that can lead to school failure, such as depression, substance abuse, and suicide attempts, so that students will successfully complete their studies." Grant funds are being made available for (1) educational seminars; (2) the operation of hotlines; (3) preparation of informational material; (4) preparation of educational materials for families of students to increase awareness of potential mental and behavioral health issues of students enrolled at the institution of higher education; (5) training programs for students and campus personnel to respond effectively to students with mental and behavioral health problems that can lead to school failure, such as depression, substance abuse and suicide attempts; or (6) the creation of a networking infrastructure to link colleges and universities that do not have mental health services with health care providers trained to identify mental and behavioral health issues." The bill is now in appropriations.

By all accounts, the floor debate on the bill in the Senate was remarkable. Not only did the Senate cease more acrimonious debate on other issues in order to discuss the bill, several senators made touchingly personal pleas for the bill's passage. Senator Smith spoke emotionally and openly about the circumstances of his son's death, and other senators told personal stories as well. Senator Harry Reid (D-Nevada), for example, told the story of his father's suicide in 1972. The Senate's unanimous approval of the bill came on the day that the young Smith would have turned 23.

The findings section of the senate bill acknowledges what those of us who work in college mental health all know: that there's been an increasing urgency to assist the growing number of students who seek psychological assistance on our campuses. The bill notes that 85% of college counseling centers have reported increases in the number of students they see with serious psychological problems. There are widespread feelings of hopelessness and depression among students, and suicidal thoughts are common. Drug and alcohol abuse on campus remains a serious concern, and counseling centers are feeling their resources stretched significantly.

This law also comes at a time when campuses are making a concerted effort to enhance suicide prevention programs. At the same time, college student suicides are being reported with what seems like increasing regularity. New York University has experienced a wave of apparent suicides during the past two academic years, and other campuses struggle to cope with completed suicides or enhancing their prevention and treatment efforts.

The suicide rate among college students is estimated at approximately 7.5 per 100,000, according to several studies, including the Big Ten Student Suicide Study in 1997. Contrary to what one might assume from media reports, suicide rates among college-age persons have remained stable or even declined slightly over the past twenty five years, according to Dr. Allan J. Schwartz, Associate Professor of Psychiatry and Senior Staff Psychologist at the University of Rochester, in a paper given at the American College Health Association meeting last June. This is no way diminishes the seriousness of student suicide, however. As Schwartz points out, the suicide of a young person is always disturbing, especially since death among the college-aged population is so rare. And suicide is the second leading cause of death, after accidents, among this group.

The data do indicate that being in college offers some protection for young people. While Schwartz's interpretation of suicide data indicates that the best "suicide prevention program" universities currently employ is the ban of firearms on campuses, and that efforts to reduce access to other means of suicide such as poison and jumping may reduce the rate even further, he cites evidence that counseling services are doing an effective job in treating their highly at-risk clients.

David B. Spano, PhD

In the meantime, however, depression, anxiety, and other debilitating disorders continue to take their toll on students' sense of well-being and ability to function in the academy. Data from the spring 2004 administration of National College Health Assessment to over 50,000 students at 74 diverse campuses throughout the United States describes the breadth of these concerns. The survey revealed that over 93% of students felt overwhelmed at some point during the past year, and nearly 30% felt that way more than 10 times. Forty-five percent of students reported feeling, at least once in the past year, that they were so depressed it was difficult to function.

Over 10% of students reported seriously considering attempting suicide during the past year, and 1.3% indicated that they attempted suicide. It is especially alarming to convert these percentages to whole numbers: on a campus of 10,000 students, you would expect that over 1,000 students contemplate suicide during an academic year, and 130 of them would make suicide attempts. While there is convincing evidence that college and university counseling centers do help students at risk to cope with their problems, these data suggest that efforts to further improve our suicide prevention efforts are vital.

There are a number of organizations working to prevent suicide in this country, and one group in particular, the Jed Foundation, is working to reduce the incidence of suicide on college and university campuses specifically. The Jed Foundation was created by Phillip and Donna Satow in memory of their youngest son, Jed, who was 20 years old and a university student when he committed suicide in 1998. The Foundation is committed to creating greater public awareness of suicide among college-age individuals, advocating for stronger mental health services on campuses, working to link academic research on suicide to practitioners on campus, and producing Ulifeline.com, an Internet-based intervention system for college students.

Ulifeline is an innovative Web site aimed at encouraging students to get information about suicide and other mental health issues, and link them to the appropriate helping resources on their campuses. The creators of Ulifeline believe that, by giving students a resource they can visit anonymously in a medium popular with young people, students will more readily access the information they need. College and university counseling centers have been invited to link to Ulifeline so that students who visit the site have access not only to up-to-date mental health information, but can also link back to their home school's counseling service. By my count, over 400 colleges and universities had linked to the Ulifeline Web site by early November.

Partnering with the National Mental Health Association, the Jed Foundation has published a helpful workbook entitled *Safeguarding Your Students Against Suicide*. This document summarizes the proceedings of a roundtable discussion of college student suicide that convened after Surgeon General David Satcher released *The National Strategy for Suicide Prevention: Goals and Objectives* in 2001. This book disseminates facts and figures related to suicide rates among students, offers a summary of risk factors that make some students vulnerable to suicide, and presents a summary of what can be done to reduce the incidence on campus.

Suggested practices include; screening programs, education and training for campus personnel such as faculty, coaches, clergy, and residence hall staff; widely disseminated public education efforts; programs for parents and families, adequately staffed and well-trained counseling centers on campus, on-site medical facilities; programs designed to reduce stress on campus; support networks, emergency services, and off-campus referral networks. Campuses are offered a checklist to help take inventory of their strengths and gaps in reducing suicide on campus.

Persons interested in learning more about the Jed Foundation or Ulifeline are encouraged to visit their respective Web sites: www.jedfoundation.org and www.ulifeline.org.

Dr. Spano is a licensed psychologist and Associate Vice Chancellor for Health Programs and Services and Director of the Counseling Center at the University of North Carolina at Charlotte. He was the director of the Counseling Center at Ithaca College from 1995-2003.

THE MENTAL HEALTH LAWYER

Voluntary and Involuntary Admissions To Acute Care Psychiatric Facilities

By Carolyn Reinach Wolf, Esq.

Carolyn Reinach Wolf, Esq.

Today, the need to plan for the unexpected is more important than ever before. We buy insurance, save for our children's education, execute wills and save money for retirement—all in an effort to ease our family's burden in a time of need.

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

The concept of the Psychiatric Advance Directive (PAD) is not specifically defined by the federal statute, but is believed by many to be a natural progression in the trend to allow individuals to plan in advance for their care and treatment. To date, most states have developed their own laws to create the process by which individuals can execute advance directives for general medical health care decision making, but only 14 states recognize the PAD.

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

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

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

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

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

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

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

The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

By Constance E. Lieber, President NARSAD

Constance E. Lieber

Women And Mental Illness Research

It is only within the past twenty-five years or so that medical science has fully come to recognize the fundamental, physiological differences that exist between men and women. Complex hormonal fluctuations occur throughout a woman's lifecycle – during menstruation, childbearing, nursing, perimenopause, and menopause—and influence the very nature of disease in the female half of the population. Women have different patterns of arthritis and heart disease than men, and are much more likely to suffer from multiple sclerosis and autoimmune diseases, such as lupus. Mental illnesses, now recognized to be neurologically based, also affect men and women differently – some disorders are more common in women, and some express themselves with different symptoms than in men. Pregnancy and the postpartum period can be highly susceptible times for mental illnesses to surface in women, or for women previously diagnosed with one to suffer relapse. Now, in addition to seeking better knowledge of mental illness in general, scientists are turning their attention to teasing apart the unique puzzle of women and mental illness. Dedicated to funding innovative, cutting-edge research on mental disorders, the National Alliance for Research on Schizophrenia and Depression (NARSAD) is proud to support researchers' investigations of mental illness in women.

Many women suffering from psychiatric disorders go on to have children, and countless other women with no previous diagnosis develop a mental illness either during pregnancy or after giving birth. This gives rise to urgent questions regarding the effects of a mother's mental disorder on her children. How do drug treatments impact on a developing fetus or nursing infant? What adverse effects might the disorder itself have on these babies – either biochemically for a developing fetus, or in terms of a mother's ability to appropriately care for her child after birth? Mary Cannon, MD, PhD, of King's College London (NARSAD 2002 Independent Investigator), is conducting a study of the fetal growth and development of children of women with schizophrenia. Earlier studies have shown that infants born to women with schizophrenia have lower birth weights, and face ten times the risk of the general population for developing the disorder later in life. Through her research, Dr. Cannon hopes to shed light on the earliest origins of schizophrenia and reveal more about the mother-child connection of this disease. Also looking at conditions in utero is D. Leonie Welberg, PhD, of Emory University (NARSAD 2003 Young Investigator), who is studying how prenatal stress can create a later vulnerability to affective disorders.

The weeks and months after giving birth are widely recognized as a period during which many women suffer from depression, caused by hormonal swings and the major life transition into parenthood. At the mildest end of the spectrum are the "baby blues," leaving new mothers feeling sad, anxious, afraid, or unexpectedly weepy. More severe is full-blown postpartum depression (PPD). A woman suffering from PPD has feelings similar to the baby blues – sadness, anxiety, irritability – but she feels them much more intensely and with a greater sense of despair. PPD often affects a woman's ability to function and perform day-to-day tasks and, according to the U.S. Department of Health and Human Services, if left untreated, can worsen, and be long-lasting. Samet Kose, M.D., of the Medical University of South Carolina (NARSAD 2003 Young Investigator), is undertaking a novel study of women with PPD and their responsiveness to their infants. Previous studies have shown that certain regions of the brain are associated with mothers reacting to the cries of their young. Depression can alter these areas of the brain, and may be the reason that studies show depressed mothers responding less urgently to their crying babies than healthy mothers do. Dr. Kose intends to use MRI brain imaging techniques to look at what actually happens in the brains of mothers – both healthy and those suffering from PPD – when they hear the cry of an infant in need. Also studying PPD is Eydie L. Moses-Kolko, MD, of Magee Women's Hospital, University of Pittsburgh (NARSAD 2003 Young Investigator), conducting an imaging study to better understand the fluctuations of brain hormones that occur during PPD. She hopes that her findings will help pave the way to better treatments for women's depressive syndromes.

The most serious of mental illnesses affecting new mothers is postpartum psychosis. With an onset often within the first three months after childbirth, women can lose touch with reality, experience auditory hallucinations ("hear voices") and become delusional. In 2002, the Andrea Yates murder case tragically thrust this postpartum mental illness into the headlines; the fact that Ms. Yates' antipsychotic medication had been discontinued figured prominently into the story. Bernard L. Harlow, PhD, of Brigham and Women's Hospital, Harvard University (NARSAD 2003 Independent Investigator) is examining this very issue, conducting a study on postpartum psychosis in women with prior psychiatric hospitalizations. Dr. Harlow's goal is to identify possible prenatal, obstetrical, or other lifestyle factors that can contribute to a heightened risk for postpartum psychosis. This knowledge could help obstetricians and psychiatrists recognize and more closely monitor pregnant women who are most in jeopardy of developing this dangerous mental health condition.

While the risks associated with antidepressant and anti-psychotic medications during pregnancy and nursing continue to be studied and hotly debated, some researchers are delving into treatments for pregnancy and postpartum depression that are not based on drugs at all. D. Jeffrey Newport, MD, MDiv, of Emory University (NARSAD 2003 Young Investigator), is running a clinical trial using Transcranial Magnetic Stimulation (TMS) to treat postpartum depression. TMS is a recently developed, nonmedical treatment for depression, and is based on painlessly stimulating the cerebral cortex with time-varying magnetic fields. Also exploring a novel treatment approach is former NARSAD researcher Katherine Wisner, MD, of the University of Pittsburgh School of Medicine (previously of Case Western Reserve University and NARSAD 1998 Independent Investigator). Dr. Wisner seized upon the idea of trying light therapy – already used successfully for treating seasonal affective disorder (SAD) – to alleviate the suffering of women with depression during pregnancy. Dr. Wisner reports that the results to date have been truly compelling, with the number of patients responding to treatment – and the speed of their response – similar to drug studies.

Even after the childbearing years, however, mental health challenges unique to women continue to arise. Further along in the life cycle, osteoporosis presents itself as a serious medical condition that can lead to bone loss and fractures. It is an area of concern for all women as they age, but disproportionately targets those suffering from bipolar disorder. Claudia F. Baldassano, MD, of the University of Pennsylvania (NARSAD 2003 Young Investigator) seeks to better understand the connection between osteoporosis and bipolar disorder, and has embarked upon a study aimed at assessing the risk of osteoporosis in bipolar women taking anti-epileptic drugs. The disorder itself may increase women's risk for osteoporosis, and the antiepileptic drugs widely administered to this population are associated with bone mineral loss. Through a controlled study, Dr. Baldassano aims to measure bone density loss in bipolar women treated with these drugs, compared with a group of healthy women. The results of this important work could impact on future treatment approaches for bipolar women. Also studying mental health issues of older women is Laura D. Baker, Ph.D., of the University of Washington (NARSAD 2002 Young Investigator). She will study the effects of estrogen on the response to stress in postmenopausal women. Recent studies have indicated that women's stress response may be linked to the increased prevalence of certain conditions in women, such as depression. Dr. Baker believes that administering estrogen to postmenopausal women could negatively impact on their mood and ability to handle stress. Her findings may help illuminate conditions under which the benefits of estrogen therapy in older women may be outweighed by other factors.

In times past, the scientific community often dismissed mental illnesses' unique expressions in women; however, researchers today have made enormous strides in understanding the various biological and psychosocial factors that contribute to mental disorders in both men and women. Their increasingly focused investigations on areas specific to women only deepens this body of knowledge. With our continuing support of their research efforts, these tireless scientists will carry us forward into the next century of mental illness treatments and cures.

The National Alliance for Research on Schizophrenia and Depression (NARSAD) is the largest donor-supported organization in the world, devoted exclusively to supporting scientific research on brain and behavior disorders. Since 1987, NARSAD has awarded $162.1 million in research grants to 1,902 scientists at 323 leading universities, institutions and teaching hospitals in the United States and in 22 other countries. By raising and distributing funds for research on psychiatric brain disorders, the pace has accelerated, resulting in greater knowledge of brain functioning, neurochemistry, new/improved treatments and genetic origins. Constance E. Lieber has served as President of NARSAD since 1989.

NARSAD *Scientific Achievement Prizes in 2004*

The Lieber Prize for Outstanding Achievement in Schizophrenia Research

Joseph T. Coyle, M.D., *Harvard University*

Dr. Coyle was unanimously selected by the Prize Committee for his pioneering, internationally acclaimed research into the critical role of N-methyl-D-aspartate mediated synaptic transmission in schizophrenia, utilizing multiple techniques to elucidate the pathophysiology of this disorder.

The Nola Maddox Falcone Prize for Outstanding Achievement in Affective Disorders Research

Harold Sackeim, Ph.D., *Columbia University,* **Joseph R. Calabrese, M.D.**, *Case Western Reserve University*

Dr. Sackeim has been a pioneer in new treatment methodologies. He made seminal contributions to a better understanding of mechanisms of action of ECT. He has also worked on development of alternative modalities including transcranial magnetic stimulation vagus nerve stimulation, and magnetic therapy. Most recently, he led a broad scale and promising effort in transcranial magnetic stimulation.

Dr. Calabrese has made a major impact on the modern treatment of bipolar illness and those with rapid-cycling, co-morbidity, and other forms of treatment resistance. He made critical contributions to the documentation of efficacy of valproate in acute mania and of Lamotrigine in prophylaxis of mood episodes.

The Ruane Prize for Outstanding Achievement in Child and Adolescent Psychiatry

Magda Campbell, M.D., *New York University,* **C. Keith Conners, Ph.D.**, *Duke University,* **Rachel G. Klein, Ph.D.**, *New York University*

Dr. Campbell is one of the pioneers in the detection and treatment of childhood psychiatric disorders. She has pioneered drug treatment trials for autistic and psychotic children and was among the first to develop guidelines for antipsychotic usage in children.

Dr. Conners is a renowned teacher and mentor for one of the important university departments focusing in this field at Duke University. He was the first to conduct a controlled trial of stimulant medication, documenting that hyperactive and impulsive behaviors could be dramatically helped by stimulants. He became known for research design in pediatric psychopharmacology and for developing medication-sensitive rating scales, especially the nature, diagnosis and treatment of ADHD.

Dr. Klein has built a career achievement in understanding and overcoming childhood learning disabilities, particularly attention-deficit disorder. Her studies were landmarks in, for example, the first medication trial in the treatment of school phobia. She has studied the long-term outcome of childhood anxiety disorders in ADHD.

The Dr. Patricia Goldman-Rakic Prize for Outstanding Achievement in The Cognitive Sciences

Michael Posner, Ph.D., *University of Oregon,* **Marcus Raichle, M.D.**, *Washington University*

Dr. Posner, in collaboration with **Dr. Raichle**, fundamentally altered the way that we approach the study of brain function by merging principles of cognitive science and neuroimaging techniques to form the discipline of cognitive neuroscience. Cognitive neuroscience in its mature form was born with seminal positron emission tomography studies carried out by Drs. Posner and Raichle at Washington University that created functional brain imagining as we know it today. The application of this technique to brain imaging was a catalyst for the explosion of functional brain imaging studies in the past decade.

NARSAD *Humanitarian Prizes*

Lifetime Achievement Prizes

Mogens Schou, M.D., *Århus University, Denmark,*
Beatrix A. Hamburg, M.D., *Weill Medical College at Cornell University,*
David A. Hamburg, M.D., *Weill Medical College at Cornell University*

Dr. Schou has discovered that the seemingly ordinary salt, lithium, has enormously beneficial effects for mood disorders. His careful analysis, his trials and his study of its effects and its life-enhancing qualities since the 1950s is a renowned achievement transforming the therapeutics of bipolar illness.

Drs. Beatrix and David Hamburg are both psychiatrists with a vast clinical experience. Each has taken that experience, and their understanding of aspirations for better lives, to serve society in unique and productive ways. Betty has headed a powerful philanthropic organization, the W.T. Grant Foundation, utilizing the knowledge and skills of her distinguished psychiatric career. David, recently retired after 15 years as head of the Carnegie Endowment for International Peace and the Carnegie Foundation. He used that position to bring together leaders from the principal countries potentially engaged in dangerous hostilities, to enhance understanding of the nature of human conflict and the ways in which we can correct or educate for a better society. Together, Betty and David have written remarkably and instructively about the structure of human social growth and the ways in which we can build a healthier, more peaceful world.

In seventeen years, NARSAD has awarded a total of $162.1 million for 2,412 grants to 1,902 scientists in 323 universities and medical institutions in the United States and 22 other countries.

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The NAMI-NYS Corner

Providing support to families and friends of individuals with mental illness and working to improve the quality of life for individuals with mental illness.

Helpline: 800-950-3228 (NY Only) • www.naminys.org • Families Helping Families

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

J. David Seay, JD

Women's mental health issues are a special concern to NAMI New York State. The national NAMI organization's Web site (www.nami.org) has a wealth of information on women's mental health issues, and I summarize some of it in this column.

In any given year, 10 to 14 million Americans suffer a clinical depression—and women age 18 to 45 years make up the largest portion of this group. Clinical depression is a serious medical illness that is far more than just temporarily feeling down or sad. It involves mood disturbances, sleep disruption and decreased activity level, interests, appetite and social behavior. Clinical depression knows no gender barrier and can strike anyone regardless of gender, socio-economic class or culture. However, research shows that women are significantly more likely to suffer from clinical depression than men. Clinical depression is highly treatable, but it is often also a lifelong condition with periods of wellness interspersed with illness. A full 60% of persons with depression experience a second episode, and of these, 75% to 80% experience recurrent depression. And with each subsequent episode, recurrence risk increases and the chance of a full remission decreases.

Two to three times as many women as men suffer from clinical depression. This is true in many countries around the world as it is here in the United States. According to the best research estimates, one in eight women will experience clinical depression in her lifetime. Also, women have higher rates of seasonal affective disorder (SAD) and chronic depression (dysthymia) than men. And while the rate of bipolar disorder, also known as manic depression, is roughly the same for the sexes, women have higher rates of the depressed phase of the illness and are three times more likely to have the rapid-cycling form of the disorder.

Why is this? Scientific research points to a complex set of causal factors, including biological, genetic, psychological and social issues.

Reproductive health events and mood changes appear to be linked as hormonal factors seem to play a role in mood disturbance in women. Gender differences in rates of depression emerge when females reach puberty and stay high through the childbearing years into middle age. Twenty percent to 40% of menstruating women experience premenstrual mood and behavior changes. About 2% to 10% experience Premenstrual Dysphoric Disorder (PDD), a severe form of premenstrual syndrome that results in severely impaired behavior and mood disturbances. As many as 10% to 15% of women develop a clinical depression during pregnancy or after the birth of a baby. Gender differences in thyroid function may also play a role.

Circadian rhythm patterns – the complex 24 hour sleep "clock" system – is another biological factor that may cause gender differences in depression rates. For example, depressed women report more hypersomnia – excessive sleeping – than men do. And gender differences in neurotransmitter activity may also correlate with the gender disparity in rates of serious depression.

Genetics plays a role, too, as some forms of depression run in families. There is a 25% rate of depression in the first-degree relatives (mother, father and siblings) of persons with depression and greater prevalence of the illness in first-degree and second-degree female relatives. The genetic component for the risk of depression is not unique to women, and both men and women from families with depression are at greater risk than those from families with no depression.

Environmental or psychosocial factors are also at play. The stress of multiple work and family responsibilities, sexual and physical abuse, sexual discrimination, low self-esteem, general tendencies towards stress, inadequate social supports and poverty can all contribute to women's increased vulnerability to depression. One study discovered that 100% of women who had been subjected to severe childhood sexual abuse developed depression later in life.

Many forms of treatment are available for women who suffer from serious depression. They include psychotherapy and antidepressant medications (and some research suggests that the two work much better in combination than either do separately), bright light therapy and some "alternative" treatments such as acupuncture and nutritional therapies. Women should always consult with qualified medical mental health professionals before beginning any treatment for their depressive symptoms. NAMI firmly believes in the scientific and medical model for the diagnosis and treatment of any mental illness, and that recovery is real. Because most all of the advances we have seen in recent years in mental illness treatment have come from rigid and properly supervised and published scientific research, NAMI also firmly believes that research is our hope for the future.

The NAMI Web site also has valuable information on other women's mental health topics, including some very important and useful information on Managing Pregnancy and Bipolar Disorder. The information summarizes an article with that title in a recent issue of the **American Journal of Psychiatry** (Yonkers, K.A., Wisner, K.L., Stowe, Z., et al [161, 608-620, 2004]. It reviews methods of managing pregnancy and bipolar disorder and the various medications that may be used in treatment, including lithium, depakote, tegretol and the first- and second-generation antipsychotic medications, as well as tranquilizer and sedative medications. Other sources of information and Web site links can be found at the NAMI New York State site at www.naminys.org.

NAMI-NYS held a very successful 22nd Annual Meeting and Educational Conference on October 29 to 31, 2004, Achieving the Promise: Transforming Mental Health Care for New Yorkers, at the Crowne Plaza Hotel in White Plains, New York. Over 300 members, professionals and friends attended the conference, which featured medical, scientific and Office of Mental Health plenary sessions, a dozen hands-on workshops, and a keynote address by Charles Curie, SAMHSA Administrator, and the nation's top federal mental health officials. We were also extremely pleased to have our own New York State Commissioner of Mental Health, Dr. Sharon Carpinello, address the audience.

The NAMI-NYS 23rd Annual Meeting and Educational Conference will be held at the Desmond Conference Center in Albany, New York, on October 28 to 30, 2005. Please mark your calendars now and make every effort to attend.

Also while you have your calendars out, please mark Tuesday, February 8, 2005, for the NAMI-NYS Legislative Breakfast and Conference, also in Albany, at the Legislative Office Building. Come to Albany and hear our elected officials and other government leaders tell of their plans for New York's mental health system. The event also offers you the opportunity to join with other NAMI members in making our own voices heard on the mental health issues of the day.

Many of our top issues this past year will carry over into the next legislative session, including the fight for more housing for New Yorkers with mental illnesses; the fight for Timothy's Law—mental health parity in health insurance, HMOs and other health plans; the fight to "boot the SHU" by banning the use of the 23-hour solitary confinement lockdowns in state prisons (also known as "the hole" and "the box") for persons with mental illness; the fight to preserve access to needed psychiatric medications under Medicaid by opposing any "preferred drug list" (PDL) and the fight for research and core local community-services funding.

In NAMI we are passionate and we are fighters. We will never cease our advocacy efforts until we get what is just and right for all New Yorkers with serious mental illnesses and their families.

We owe them no less.

A Mental Health News Personal Message:

You May Sometimes Feel Like Giving Up Because You Are Feeling Hopeless Right Now.
This Is Common During A Mental Illness - It Is Not Your Fault - It Is Your "Illness Talking."
Call Your Treatment Professionals Today, And Tell Them You Need Extra Help.
Don't Ever Give Up - This Crisis Will Pass - You Are Needed In This World!

The MHA Connection

Mental Health Association in New York State

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Phone: (518) 434-0439 Fax: (518) 427-8676
Glenn Liebman, MA, President & CEO Website: www.mhanys.org

Women Living With Mental Illness As Consumers Of Medical Services

By Helena Davis, Director
Anti-Discrimination Programs
MHA in NYS

Initially, this seemed like a relatively easy topic to tackle. However, the more I thought about it, the more I realized that there are many issues to address and they each cross several lines. That being said, it seems useful to address three different categories:
1) women as consumers of physical health services, 2) how medical personnel react to mental illness, and 3) women living with mental illness as consumers in the medical establishment.

Women as consumers of physical health services

Women of my generation were trained to defer to authority figures of both genders. We naturally believed and obeyed anyone with the title of "doctor" or anyone dressed in white. Back then, nurses wore starchy white dresses, caps with wings, white hose, and spotless white shoes. We assumed that the doctor, and his messenger the nurse, were always right, and our own "knowing" about our bodies was incorrect or imagined. Furthermore, we were taught to ignore our bodies and to rise above whatever was bothering us until it became acute. During this era, nobody thought about the body/mind connection, let alone the relationship of the spirit to the mind and body, or if they did, they were afraid to share their ideas.

Next came the Women's Movement, which gave us permission to value our rights and our thoughts. Like most new movements, this one began with a lot of rage and polarization, but once it settled down, the outcomes that emerged were tremendous. We read **Our Bodies Ourselves**. We learned to question authority. We learned it was useful to value and trust our inner knowing. Along the way, we began to learn that we were responsible for our physical well being, not the medical profession. As I see it, we are still evolving in this realm – still learning that we should be as careful about selecting a medical practitioner as we are about buying a car. We are still learning that medical personnel are human beings like us and they are neither omniscient nor overly endowed with benevolence and compassion. When the doctor veneer wears thin and the doctor says something that is hurtful or disrespectful, we have both a right and a responsibility to assert our needs in appropriate ways. That is often easier said than done.

The problem is that the awareness of medical providers has not kept pace with the evolution of their patients' awareness. Many doctors still feel they must be "in charge" rather than be human partners and consultants or technical advisers. We, as patients, are still in the process of figuring out how to create empowered partnerships with our medical providers instead of win/lose scenarios.

The medical community's reaction to mental illness

There is a perception that many professionals in the medical community (with a few exceptions) are as put off by mental illness as any ordinary citizen. This perception is based on stories told by my private practice clients over the years, articles in professional journals and newsletters, plus public media coverage. While younger medical personnel may have had a course on mental illness in school, it has most likely only included a litany of symptoms for each diagnosis, how to use decision trees for assessment, and when to refer to a psychiatrist. Chances are, nobody has taught these individuals how to reality test their assumptions, how to separate fact from stereotype, and how to support and work in partnership with a patient living with mental illness. The service provider's greatest fear is that the patient will go out of control—and that the provider won't know how to control the situation. Most medical personnel have had experience as interns with an individual with mental illness who is having a flashback or hallucination and begins to lose control. In many cases, the personnel who try to gain the upper hand in the situation are ignorant of how to help. As a result, the situation gets worse before it improves. Since, as human beings, we tend to generalize from our experience, medical personnel may assume after one experience that all people living with mental illness can potentially lose control without warning and wreak havoc on their surroundings.

Recently, a newsletter from a well known psychiatric hospital was circulated in our office. In a cover article, a psychiatrist was quoted as feeling stigmatized because his patients were all mentally ill! How can a physician with this kind of attitude follow the Hippocratic Oath: "First do no harm?" Imagine the harm that is done to the self esteem of his patients! Imagine the shame he projects on his patients who already carry far more shame than they can manage! Imagine how this negative attitude robs patients of the capacity to hope, to strive, and to recover.

Women living with mental illness as patients

Women living with mental illness carry a triple challenge when they enter a physician's office. First, they carry the learning

see Medical Services on page 40

Glenn Liebman Appointed New CEO At MHA In New York State

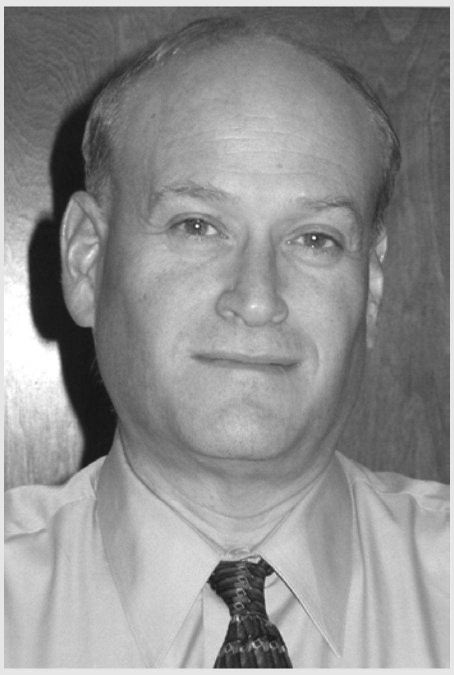
Staff Writer
Mental Health News

In August of this year, Glenn Liebman became the new CEO of the Mental Health Association (MHA) in New York State (NYS). Prior to his current position, Liebman was Director of the Adult Home Initiatives at the New York State Department of Health, and was the former Project Director for Kendra's Law at the New York State Office of Mental Health.

Mr. Liebman also served the mental health community of NYS as the Executive Director of NAMI-NYS, the largest family-based mental health organization in NYS, from 1994 to 1998.

According to Liebman, "The jobs I have had over the last several years have provided me with a perspective on how things work both inside and outside state government. There continues to be a disconnect between the innovative work of the people in the field, the financing that currently exists and, most importantly, the tools necessary for an individual's recovery. The Office of Mental Health (OMH) has worked hard to create stronger linkages through increased emphasis on Evidence-Based Practices, including ACT teams and family psycho education, as well as other initiatives, such as suicide prevention, increases in housing slots and additional case management. We look forward to partnering with OMH and other mental health organizations to create a greater atmosphere of recovery for individuals with psychiatric disabilities."

Under Liebman's direction, the advocacy aims of MHA in NYS will be diverse. "We will continue to push for Timothy's Law, the law with the simple but profound premise that people with mental illness should have the same insurance coverage as those with physical illness. To not cover mental illness to the same degree that you cover physical illness is discriminatory. Led by Tom and Donna O'Claire, the parents of Timothy, we will work hard for passage of this law."



Glenn Liebman

Other strong advocacy items for the MHA include expansion of existing housing slots, including incentives for increased property acquisition for mental health housing providers, full access to medications, including mental health- related medicines, as well as side-effect medications, a psychiatric hospital closure commission, and reform of the jail and prison system.

Aside from advocacy, the MHA in NYS does a lot of work in other areas, including: Parents with Psychiatric Disabilities Work, the Voter Empowerment Project, as well as the MHA in NYS Business Advisory Council.

Liebman has a deep respect for the membership and staff of the MHA. "In my new capacity, I look forward to working with our organization and other mental health organizations to improve the lives of individuals with psychiatric disabilities, and I want to personally thank Ira Minot at Mental Health News for his tireless efforts on behalf of individuals with psychiatric disabilities."

You can reach Mr. Liebman by e-mail at gliebman@mhanys.org, and all are invited to visit mhanys.org for more information.

A Comprehensive Overview Of Women's Health Issues

By Lisette Rodriguez, APRN, BC, Patient Care Manager and Kathleen McCarty, MD, Chief
The Women's Program, NewYork Presbyterian Hospital, The Westchester Division
Payne Whitney Westchester

Lisette Rodriguez, APRN, BC
Kathleen McCarty, MD

Voices drifted in the background as Joan struggled to open her eyes. What's this tube in my mouth? Where am I? Over the next weeks she learned the hard answers to these puzzling questions. She was on life support in an ICU after a massive overdose of every pill she could find in her home. She hovered near death for two days. But why had this highly successful, once-vibrant 42-year-old dentist and mother of two decided that her life wasn't worth living? In the preceding weeks, she had berated herself for feeling stressed, edgy and exhausted all of the time, as though she were supposed to be able to juggle with ease the competing demands of work, home, and managing the care of her mother who was in a nursing home in the terminal stages of Alzheimer's Dementia. She would lay awake at night for hours critiquing all that she had done wrong each day. She hardly noticed her lack of appetite or the fact that pounds were melting off her effortlessly. When she broke down in tears at the office between patients for no apparent reason, she felt embarrassed and ashamed for her weakness. But when she started to resent her twin four-year-old boys, who formerly were her delight, she seethed with self-loathing and eventually came to believe that they would be better off without her. As though in a dream, she remembered walking into the bathroom and emptying pill bottle after pill bottle as she hoped that at last she would fall asleep and be out of her misery. By chance, her husband came home earlier than expected from a business trip to find her unresponsive and tragically near death.

Joan's journey back to mental, physical and spiritual health is a familiar one to the mental health providers who care for women with depression, bipolar disorder, and other serious mental illnesses. Her recovery began with a 14-day psychiatric hospitalization on a women's inpatient unit; medications for her specific form of depression; cognitive therapy to address her distorted, negative thinking; group therapy to learn coping skills, stress and anger management strategies; leisure activities to re-prime the pleasure pump; family therapy to address her unrealistic expectations of herself; and pastoral counseling to help redefine her personal, marital and family values and priorities. But she also needed a crash course in women's mental health. This is what she learned.

Mental illness most often affects women during the reproductive years, ages 15-44, when role expectations exact the greatest physical and emotional toll. Working outside of the home is no longer a choice for a woman but a necessity. Yet women are still expected to run the home and remain the primary caregivers for their children and ailing parents. Sadly, single parenthood is now commonplace, creating further hardship since women still do not receive equal wages. Many single mothers and their children barely subsist. The largest increase in the homeless population consists of women and children. These significant external stresses may leave women more vulnerable to psychiatric illnesses, such as anxiety disorders and depression. Hormonal factors are also thought to be an internal stress, since gender differences in rates of depression are not present before puberty and decrease after menopause.

Additionally, many women are more vulnerable to mental health problems because they also carry the hidden tragedy of violence against them as children and adults. Domestic violence is an "equal opportunity" crime occurring in all socioeconomic classes, ages, races, educational and religious backgrounds. Two to four million American women are seriously injured annually, resulting in 2,000 deaths. More women are injured as a result of domestic violence than the combined total from muggings, car accidents, and rapes. The most vulnerable are often pregnant or physically disabled women and their children. Two million children are seriously abused each year, resulting in more than 1,000 deaths. Twenty percent of children will be sexually abused. At least 1 in 5 women are raped in their lifetime. Fifty four percent are under the age of 18 at the time of the first rape; 83% under the age of 25. With this backdrop of human misery, many women turn to alcohol or drugs for temporary relief from severe emotional or physical pain, disturbing flashbacks, or insomnia. These drugs only worsen their predicament.

Researchers have known for decades that the incidences for certain psychiatric disorders are increased in women. Dramatically, twice as many women as men suffer from depression. The majority of people with anorexia or bulimia are women. And women outnumber men suffering from panic disorder, post-traumatic stress disorder, or generalized anxiety. Equal numbers of women and men have bipolar disorder, schizophrenia, obsessive-compulsive disorder or social phobia. However, even for these disorders, there are gender differences in the course of illness and symptoms. For example, women with schizophrenia are usually diagnosed 10 years later than men, most often having their first difficulties in their late teens or early twenties. These women also have more symptoms of depression than men. Similarly, women with bipolar disorder often have more depressive episodes and are more prone to the rapid cycling form of bipolar disorder, which is much more difficult to treat.

Not surprisingly, reproductive events also impact women adversely. As is well known, some women experience severe depression, irritability, marked anxiety, mood swings and other physical and emotional difficulties during the week prior to menses and ending within a few days of the onset of menses. Many women experience pregnancy and the first months of motherhood as a time of great anticipation and joy. However, many women can't because of the onset of depression. Following delivery, many women believe that they should experience an almost metaphysical bonding with their infant and are stunned when this does not happen. Instead of accepting that their feelings for their infant may need to grow as they care for their child, many new mothers are exhausted by the incessant demands of an infant, overwhelmed by their lack of competence in handling their role, and find themselves sinking from the "baby blues" into clinical depression, or worse. Fortunately, very few mothers experience the most serious of illnesses following delivery, a psychosis, in which they may hear voices telling them to hurt themselves or their baby, become immobilized by depression, or become unable to care for themselves or their baby. When this happens, this is a medical emergency requiring immediate psychiatric treatment!

Recovery from mental illness can only begin when a woman, her family or friends recognize that there is a problem as well as a solution. For Joan, neither she, nor her family, nor her coworkers recognized that she was suffering from a life-threatening depression. Warning signs were ignored or misunderstood. Unfortunately, many health care professionals are not skilled in recognizing the signs and symptoms of depression or anxiety, and therefore fail to treat the underlying psychiatric conditions with highly effective medications and/or therapy.

The Women's Health Movement of the last decade has resulted in the development of comprehensive health care services for women, integrating quality clinical care with research and education. An impact of this movement is the fact that now women of reproductive years, have been included in clinical drug trials. Because a disproportionate number of women than men suffer from depression and anxiety, they receive the majority of prescriptions for these conditions. Previously, all information on medication side effects and adverse events was obtained from only male patients. Iris Cantor is a pioneer in this field and an inspiration to all women for her generosity and commitment in opening the Iris Cantor Women's Health Center, a collaboration between New York-Presbyterian Hospital (NYPH) and Weill Cornell Medical College in Manhattan, as well as the Iris Cantor Women's Health Center-UCLA on the West Coast. NYPH has made a further commitment to women's mental health by opening the first all-women's psychiatric inpatient unit – the Women's Program—in White Plains in 2002. In early 2005, it will become the first comprehensive cognitive therapy women's unit in the country. For many women who suffer from depression and other psychiatric conditions or have severe life stressors, there is hope and compassionate, effective treatment readily available!

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212-305-6001

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

Weill Cornell Psychiatry

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

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

Pro Bono Partnership Offers Free Business Legal Assistance To Nonprofits

Staff Writer
Mental Health News

In March of 2004, CHOICE of New Rochelle needed some expert legal advice concerning revising its payroll procedures. CHOICE, a Westchester nonprofit organization that provides a wide range of free social services to Westchester County residents who receive mental health services, knew just where to turn. For most nonprofits, the decision to consult an attorney about business decisions is a difficult one, because of the potential impact on already tight budgets. For CHOICE's Executive Director, Joshua Koerner, the decision was easy. CHOICE was already a client of Pro Bono Partnership, a nonprofit organization that provides free business legal services to qualifying nonprofits in Westchester and Fairfield Counties, as well as in New Jersey.

Says Koerner, "Pro Bono attorneys have addressed a number of policy and personnel issues for us. The CHOICE staff is predominately persons with disabilities, and balancing their legal rights with the needs of the agency requires knowledge, skill and foresight, all of which were shown by the attorneys. Pro Bono attorneys were instrumental in revamping the entire personnel manual as well as our bylaws."


Maurice Segall and Richard Hobish

Since 1997, the Pro Bono Partnership, with offices in White Plains, NY, and Stamford, CT, as well as in Newark, NJ, has provided free business legal assistance to more than 690 nonprofit organizations in the tri-state New York area. It accepts nonprofit clients that serve the disadvantaged or provide important social services, but are unable to pay for legal assistance without significantly impacting their ability to provide services to the community.

The Partnership's corps of more than 800 volunteer attorneys from major corporations and leading law firms are experts in the areas of employment, contracts, corporate, tax, real estate, environmental, intellectual property, e-commerce and technology, as well as nonprofit law. Four full-time staff attorneys, Executive Director Richard Hobish, Deputy Director for New York and Connecticut Maurice (Mo) Segall, Deputy Director for New Jersey Jennifer Chandler Hauge and Senior Staff Attorney Nancy Eberhardt, recruit and support attorney volunteers, screen and monitor client matters, field inquiries and resource calls from area nonprofits and also provide direct representation to about 25% of clients.

Helen Rosenberg, General Counsel of Westhab in Elmsford, NY, a Westchester nonprofit that designs, builds and manages affordable housing and manages four homeless shelters for the Westchester County Department of Social Services, also called the Partnership this year for specialized legal advice in connection with Westhab's responsibilities under HIPAA, the Health Insurance Portability and Accountability Act of 1996. She says, "The Partnership has been advising us on the launch of a job training/potential business program for a small group of clients who are homeless women residing in one of our shelters. The training program will give them job experience and job skills training with the goal of assisting them to be self-sufficient and getting off welfare. The Partnership has also put us in touch with a volunteer attorney to advise us about HIPAA, so that we remain in compliance with federal law as we provide contracted services for the County Department of Social Services. We have been delighted to work with Rick and Mo, as well as the outside attorneys they have provided for us."

Target Autism Genome, in Fairfield, Connecticut, works to accelerate and facilitate research leading to therapeutic interventions for autistic people. Co-Founder and Director Ramzi Bishuti first

see Pro Bono on page 42

Women Awarded For Helping People With Mental Illness

Staff Writer
Mental Health News

Westchester, New York's County Executive, Andrew J. Spano and Dr. Jennifer Schaffer, Commissioner of the Department of Community Mental Health, honored this years' recipients of the County's Mental Health Awards. The Mental Health Awards were established twenty-two years ago by the mental health department as a way to give special recognition to individuals and exemplary programs for enhancing the lives of individuals who have mental illness, developmental disabilities, and alcohol and/or substance abuse problems. What makes this particular award so unique is that the honorees are not part of the traditional service delivery system. Instead, these individuals have volunteered their time, talent and energy providing services to our residents. Several organizations have carved out new boundaries to provide a humanitarian approach for others, and to enhance the quality of their lives. This year's recipients are strongly represented by women living, working and volunteering in our County.


Dr. Jennifer Schaffer


Andrew J. Spano

Lori Tatarsky is a volunteer at New York Presbyterian Hospital. She teaches patient education classes on mental illness and treatment, as well as serving as a member of the Consumer Advisory Committee. As a teacher she is upbeat, energetic, and creates a trusting atmosphere for her students where they can be open and willing to learn and explore feelings related to their illness. As a member of the advisory committee, she is a strong advocate for improvements in the hospital system. She is persistent and true to what she believes in and does not shy away from conflict. Lori is well respected and an extremely valuable advisor and teacher to the hospital administration.

Jacquie Butera is the Dean of Student Life and Peer Leadership at Rye Country Day School in Rye, New York. For the past five years the students of Rye Country Day School, under Jacquie's direction, have organized, collected and donated Thanksgiving dinners and holiday gifts to families living in the shelter system. All of these families have a parent who has a serious mental illness. The Peer Leadership group continues their relationship with these families, providing meals as some families begin to transition from the homeless shelters into permanent housing. Their generosity has made a significant impact in the lives of these families.

Susan Weinreich is an artist and a strong advocate for persons living with mental illness in Westchester County, New York City and New York State. Susan worked with the Westchester Association of Retarded Citizens for a number of years. Last June, however, she decided to share her mental illness with the world at an art exhibit—the opening of her one-woman show in Mount Kisco. Susan was recently the keynote speaker at Grand Central Station, for *Services for the Underserved,*

see Women Honored on page 43

Support Abounds For Latina Women At Drop-In Center

Staff Writer
Mental Health News

It's 8:30 a.m. on a bright autumn day with just a hint of a chill in the air, and already a number of women have begun to gather outside the door of the a local center in New Rochelle, New York. Other than the fact that the conversation is in Spanish, there is no hint that this is a group of women who have something in common. What they have in common, however, is not necessarily their language, but that they are all participants in a dynamic and innovative program sponsored by The Guidance Center. The fact that the doors will not open for another half hour indicates the meaning of this program to these women.

Each week a group of some 25 women from such countries at Mexico, Brazil, and Colombia make arrangements to participate in a program that lasts for an hour and a half. This is quite a remarkable testament, for many of these women are hourly workers, and many are young mothers with several children. Attending this weekly program requires rearranging an already demanding life, yet for these women this weekly opportunity provides them with a rare chance to open up and share their life experiences.

The coordinator of the program, Angélica Guel, is a warm and highly energized young Latina who knows the many problems faced by these women. With extraordinary commitment, she provides guidance, support, and often a shoulder for women who have experienced far too many problems in their lives. Over coffee and a discussion about nutrition and diet, it becomes obvious that the conversation is moving in another direction.

One woman shares with the group that although she is only 25 years old, she has several children and has been the frequent victim of family violence. Her life has not been an easy one, and when she noticed a flier at a local school, she decided to become part of the group and to do something about her life. After attending a few sessions, she slowly began to open up and share her life experiences. The incidents she related were not unknown to many of the women, who shared with her their experiences and the means of getting help. But beyond this, they provided her with a bond and friendship that had been lacking. For Latinas, the feeling of isolation is ever-present, and this separation from friends and community further exacerbates the potential for violence.

As the weeks go by, we find this young woman becomes more open and takes part in a special program, in which six women from the group participate in a workshop on "Women's Rights," sponsored by a local sister organization—Westchester Jewish Community Services (WJCS). Through her strength and the support of the group, she has received help with her family situation, and the change in her is most encouraging. This is not unique, for a major strength of the Latina Drop-In Center is the ability of women to help women.

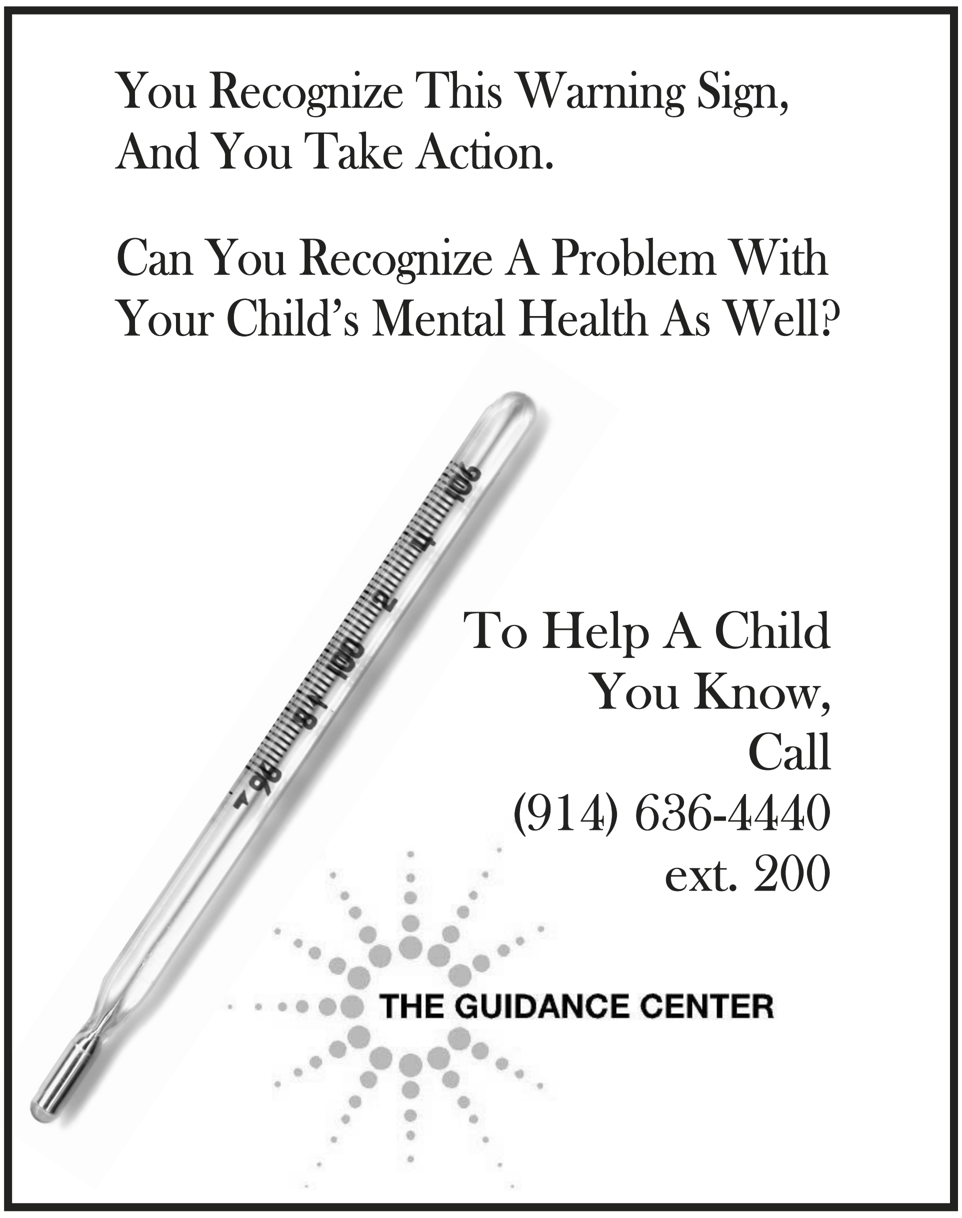
The subject material on Tuesdays is often broad, yet always focuses upon issues of concern to these women. Currently, the topic has been health and nutrition. The women have elected to take greater control of their lives and, partnering with the Cornell Cooperative Extensive, they have embarked upon an 8-week fitness program. The close of this program will include a group "weigh in" and plans for continuing the fitness program.

Yet, the conversation continues to come back to personal issues. For most of us, it is difficult to imagine what life might be like living in another country, unfamiliar with the language, and isolated within a few blocks. Without the means of exploring new life options and meeting new people, life can quickly become limiting and vulnerable to abuse. The Guidance Center offers an alternative to this fate, and results have been extraordinary. The strength of these women, along with their compassion and support, becomes quickly evident to anyone who sits in on a meeting.

A young woman who has been attending the sessions for a while, but who remained mostly silent, recently opened up to the group. In a voice barely above a whisper, she shared with the group that last year her husband was killed on the job, leaving her with their children, no family resources, and left to struggle financially. With tears in her eyes, she announced that this has been the first time she has been able to spend an hour or so without thinking about her husband and her problems. She tells the group that for the first time she has begun the process of hoping and looking to the future. The hugs she receives say it all. As she shared with the Coordinator, she has found a new family.

The challenges to the Latina Drop-In Center continue to exist. Such needs as child care services and more staff would greatly help. And during the holidays, gifts would be particularly appreciated. The support of The Junior League has been a blessing and The Guidance Center has re-affirmed its commitment to these women.

Anyone wishing to be of assistance or to learn more about the program is invited to contact The Guidance Center at (914) 636-4440.



Women And Sex Addiction

By Diane E. Russo
Associate Executive Director
Putnam Family & Community Services

Sex is everywhere in our society. Just turn on your television, go to the movies, rent a video game, or pick up a magazine. We just can't avoid it. Our culture encourages women to attach all sorts of erroneous meanings to the sexual act. Some women are taught that sex is a commodity for trade, something that "belongs to men" and that women have to give it. Many women associate shame with sexuality. Instead of its being a natural part of themselves, sexuality becomes a dishonest act associated with duty, security or a means to have power over someone. Sex is tremendously distorted by our culture. Our preoccupation with sex reflects an underlying uneasiness and discomfort with it. We are a culture obsessed with sex, yet we talk very little about sex in a positive way.

There are very few models of healthy sexuality for women in our culture. We have Victoria's Secret models who grace the covers of catalogs that arrive in our mailboxes way too often. Women are besieged with ads to remove unsightly hair and to have fat sucked out of their bodies, not to mention plastic surgery for almost every part of their anatomy. Just look at the images of women on television, advertising and pornography. It is no wonder that some women turn to alcohol, drugs, develop sex addictions, and eating disorders. Our society is totally out of whack.

Addiction has become a popular term because it gives us a concrete way to describe an experience most of us recognize—an obsessive dependency on people, substances, money, material goods, or situations. If you have ever violated your values and ignored responsibilities to pursue an overpowering desire, then you understand the feeling of addiction. When a women separates sex from love and care, it can become addictive. Rather than bringing her close to someone, it becomes a block to intimacy. We must not see sex addiction as negative, but rather to understand that the underlying intention of addictive behavior is to find love and to feel good. Such behavior actually comes from a desire to fill a profound inner emptiness, anesthetize pain, and avoid feelings. The purpose of understanding women's addictive sexual behavior is to raise awareness about sexuality so that women can make conscious choices that affirm their highest selves.

Many women, in an attempt to bury their sex addiction and the chaos it creates, bury their sexuality. In essence, the addiction goes underground and wreaks internal havoc in the woman's body, mind and spirit. We, as health professionals, continually treat such cover-up symptoms as depression, anxiety, compulsive eating, compulsive smoking, alcoholism, ulcers, migraines, digestive difficulties, and so on. A woman's sexual shame remains an unresolved dilemma churning away inside. She is trapped in an emotional desert of her own life…she longs for partnership, but sex and intimacy are so fraught with fear that she withdraws whenever a potential partner comes on the horizon. She has fallen from healthy people who could genuinely love her. Instead, she tends to try to attract and flirt with people who are physically or emotionally unavailable.

Diane E. Russo

There are harmful consequences to this addictive behavior. Work and career can be jeopardized by sex addiction, as it can affect some women's ability to function on a daily basis, and prevent them from seeking a career equal to their talents and education. Sexually addicted women do not develop safe, trusting relationships with people who can nurture them emotionally. Some addicted women throw their money away while others hoard it and dole it out in tiny bits. Women with a sex addiction can be irritable, irresponsible or emotionally unavailable to their children while acting out their addiction. Some lose their children due to a lack of parenting skills. The majority of addicted women do not develop their talents or skills or pursue education because they do not believe in themselves, were too busy with their addiction, or are constantly lost in a fantasy world. The denial system used to blind oneself to sex addiction operates similarly in the physical realm. Women who are sick or hurting often fail to recognize or postpone taking care of physical problems. Women have far fewer legal consequences as a direct result of sex addiction than men do. They might be arrested for prostitution. They are more likely to have legal problems related to the unmanageability aspects of sex addiction particularly in the area of chemical dependency. Sexually addicted women most frequently jeopardize their safety by putting themselves in dangerous situations. They go to bars alone, walk in unsafe neighborhoods, and go home with men that they don't know.

A myth exists in our culture that women are not violent. It is a myth that leaves many women painfully alone, feeling ashamed about their secrets of self-abuse, abuse of others and participation in violent or sadomasochistic sexual relationships. Underlying female self-abuse is female oppression. Some women are taught to take care of men's egos by playing stupid, acting afraid, and by accepting male definitions of female sexuality as passive and masochistic. If women internalize such "norms" then they do not see them as oppressive. Female violence associated with sex is an incredible secret. Psychologically, we are conditioned to accept these women as victims, but rarely as perpetrators, of abuse. We have shelters for battered women, but where are the treatment programs for violent and abusive women? Violence done to a woman's mind, body and spirit inevitably manifests itself in some way. All too often, this violence is released through physical, verbal or sexual violence toward herself or toward a less powerful group, namely children or other women.

Self-abuse is learned. It is violence turned inward, often as a result of feeling shame. If we consider self-abuse as anything we do to abandon our body, mind or spirit to please others, we can consider a wide spectrum of behavior on a continuum for self-neglect to abuse.

In therapy, it often emerges that these women have deeply buried pain and anger and they fear it will be released if they open up their hearts to another human being. Many are sexual abuse survivors or are children of alcoholics. Some fear touch because it arouses a sexual feeling that brings on feelings of shame. Once women have some recovery time behind them, the issue of the effect of their addiction on their spirituality elicits strong responses. They realize how dead they were inside.

Women who are addicted to sex are challenged to look at the ways they have falsely engaged in sex for security, power or nurturing at the cost to their souls. Maybe there wasn't any exchange of money, but there may have been a covert exchange nonetheless. And if mind, body and spirit are one, there is no difference. Whether a woman sacrifices her soul for a classy marriage, becomes a swinging single, or engages in prostitution, she is acting out of the mistaken belief that sex is the way to secure what she needs.

Acculturation And Latina Women

By Ana Paula Naon, MSW
Family Services of Westchester

Adela Salazar (not her real name) needed to talk to someone about her feelings and problems. She felt she did not have the right to live because of her guilt feelings regarding coming to the United States in search of "The American Dream." Minimally, she had hoped to earn enough money to send back to her family in her native Colombia, where she had left her three children in the care of their grandmother. In the meantime, her maternal instincts and feelings of abandonment of her children led to thoughts of hurting herself to relieve suffering. She was beset constantly by dread and fear, with thoughts that something terrible would happen to her children back home. Since she did not know anyone in the U.S., she could not talk about these oppressive feelings. She felt lonely, depressed, guilty and isolated all the time.

Mrs. Salazar called Family Service of Westchester (FSW) to find help. When she arrived for her first therapy appointment at FSW, Mrs. Salazar produced two cassettes of Colombian music because (in her opinion) it was important for her therapist to understand the kind of music that seemed to fit her feelings of nostalgia and present circumstances. The unmistakable issue arising from Mrs. Salazar's case is the issue of acculturation—the process of adapting into a new culture here in America.

The experience of migrants moving to a new socio-cultural system provides practitioners with the opportunity of studying the fundamental process of adaptation. Migration disrupts attachments to support networks from the home country. We find that individuals vary greatly in their ability to adapt to the new culture based on factors such as level of education, financial means, and pre-existing social and family networks already established here.

In the case of Mrs. Salazar, the psychological trauma of abandoning her children interfered with her coping skills in getting settled here. Learning a new language, finding employment, housing and new social support networks were made that much more difficult with the emotional burden she carried.

As someone who has personally experienced the acculturation process as an immigrant from Argentina, I am able to understand feelings of loneliness and depression that immigrants feel. This experience has helped me to a better understanding of the needs of Latino clients and how be sensitive to these issues. If the practitioner fails to identify the key psychological and acculturation factors that Latino clients face, there is a greater likelihood of failure in the acculturation process, which often leads to a person returning to their country of origin.

Many immigrants open themselves to questioning their realities, including the pain and unhappiness of their lives and are able to mobilize their inner strengths to change. Only after fully confronting the extent of their unhappiness and dissatisfaction can they begin exercising a new power within themselves—the power to act with others to effect change. This is a process of empowerment which can be viewed as the "pleasure after the pain." Through this empowerment process, the individual's self-esteem is enhanced as others will perceive them in a new light and acknowledge and respect their new strengths. Practitioners need to employ culturally sensitive approaches that focus on helping Latino clients empower themselves toward positive change.

A Mental Health News Holiday Message:
The Holiday's Can Be An Especially Difficult Time
When You Feel Hopeless And Detached From Loved Ones
Always Remember That There Is A Caring Community Around You
That Stands Ready To Provide Support When You Need It Most

Happy 110th Birthday NYPH !

The Westchester Division of New York-Presbyterian Hospital in White Plains, New York has celebrated its 110th Birthday, proudly recognizing the dedication and efforts of their 1000 staff and faculty members. The hospital opened its doors on its White Plains campus on October 18th, 1894, with a commitment to provide enlightened and humane psychiatric care. On its 110th birthday, the hospital continues to serve the mental health needs of children, adolescents, adults and the elderly with comprehensive outpatient, day treatment, partial hospitalization and inpatient services.

Self-Help Clearinghouse Celebrates 25 Years Providing Roadmap To Area Support Groups

Staff Writer
Mental Health News

The Westchester Self-Help Clearinghouse, a program of Westchester Jewish Community Services (WJCS), recently celebrated its 25th anniversary at a reception honoring the leaders of the various self-help groups in the county. At the event, Clearinghouse Director Lenore Rosenbaum of Hartsdale and Clearinghouse founder Leslie Borck-Jameson of Chappaqua read a Proclamation from County Executive Andrew Spano citing the Clearinghouse for being "effective in helping our citizens with everyday problems and connecting people with others who have gone through similar experiences…" Since 1979, the Clearinghouse has been reaching out to county residents with an array of support groups aimed at helping people help themselves and one another. The Clearinghouse can put people in touch with any of 280 mutual support groups in the county. The groups meet on a regular basis, providing an opportunity for people to share feelings and concerns with others who have walked or are walking a mile in the same shoes.

In The News At The Office Of Mental Health News

Verizon Foundation Funds Web Site For "Salud Mental" Our New Bilingual, Bicultural Publication That Premiers This Winter

Staff Writer
Mental Health News

A lot of excitement and activity is building at the office of *Mental Health News*. It has to do with the upcoming premier of the award-winning publication's new bilingual and bicultural quarterly newspaper, *Salud Mental*.

"Putting the pieces together to launch a new publication—and in Spanish—is proving to be another wonderful challenge," reports Ira Minot, Executive Director of Mental Health Education, Inc. "To help us meet our goals, we are blessed with the support of our Board, and of many outstanding leaders from the Latino mental health world. To cap off many months of preparation for the upcoming winter premier, the Verizon Foundation has announced their decision to fund a new website for *Salud Mental*."

John Butler, Regional Manager for Community Affairs at Verizon states, "We are pleased to help support the growth and development of this new project that is designed to bring mental health education and resources to the Latino community. "Today," Butler continued, "the Internet has become part of virtually every home in our community, and we are excited to help bring the valuable content of *Salud Mental* to individuals, families and treatment professionals virtually everywhere in the world."

Mental Health News has a wonderful Web site (www.mhnews.org) where anyone can read and print out the complete version of its quarterly publications for free. Now, with the support of Verizon, *Salud Mental* will have it's own site to fill the same vital need. Now under construction, the bilingual *Salud Mental* Web site (www.mhnews-latino.org) will enable us to provide full, readable versions of each issue of *Salud Mental*. In addition, we will have links to other valuable sites that offer educational information for the Latino community.

"Verizon has helped us enormously in our ability to put (our sometimes) 60-plus page newspaper onto our Web site," says Minot. "These are very large Adobe PDF files that require visitors to have a high-speed connection to read. When we realized this was going to be a challenge for us, we signed up for Verizon's DSL high-speed Internet connection package. It makes uploading and downloading large files a breeze, and we are also able to share the DSL phone line with our fax machine, making for a seamless and cost-conscious office environment."

Board Chairman Dr. Alan Siskind stated, "We are truly grateful to Verizon for recognizing our mission of providing mental health education to the community. As a young and rapidly growing organization, finding corporate support such as Verizon is a real plus, and lets us know that our work in the community is making a difference in the lives of so many people."

If phone calls and e-mails are any indication of interest in the launch of *Salud Mental*, the staff at *Mental Health News* is anticipating a large and positive response from the Latino community. Communities from across the New York and northeast region—and from cities as far as Laredo, Texas and San Diego, California are already expressing interest in receiving Salud Mental to use in their mental health education programs.

Dr. Peter C. Campanelli Joins The Mental Health News Board Of Directors

Staff Writer
Mental Health News

Mental Health News Education, Inc. (MHNE), is pleased to announce the appointment of Dr. Peter C. Campanelli to the Board of Directors. The announcement was made by Janet Z. Segal, CSW, Chief Operating Officer of Four Winds Hospital, who is Chairman of the MHNE Nominating Committee.

According to Mrs. Segal, "We are extremely honored and excited to have Dr. Campanelli join our Board. He is an outstanding and respected leader of the mental health community who we know will bring a wealth of experience and talent to our young and growing organization."

Dr. Campanelli is currently the President and Chief Executive Officer of the Institute for Community Living (ICL), an award-winning, multi-faceted and full-service mental health agency based in New York City. He joined ICL as Associate Executive Director in 1986 and was named President and Chief Executive Officer in 1987.

As President and Chief Executive Officer, Dr. Campanelli is responsible for the overall operation of the institution and has led the growth of the agency to a nationally recognized agency serving over 5,000 people per year with an annual budget of $52,000,000.

Dr. Campanelli is a licensed clinical psychologist in both New York and New Jersey, and is the recipient of numerous local and national awards, including the Peterson Prize awarded by the Graduate School of Applied and Professional Psychology of Rutgers University, two Gold Awards from the American Psychiatric Association, as well as various congressional and legislative awards.

Prior to joining the staff at ICL, Dr. Campanelli served as Chief of Service of the Community Residential Service for South Beach Psychiatric Center, a New York State psychiatric hospital. He has served on the faculty of Pace University, Rutgers University and Metropolitan College of New York within their graduate training programs.

Dr. Campanelli has been the Chair of the Board of Directors of the Association of Community Living, Inc., a statewide residential group of providers consisting of over 120 residential providers, and is currently serving as Chair of the Coalition of Voluntary Mental Health Agencies, an agency which is comprised of the majority of mental health care providers in New York City.

Dr. Peter Campanelli

Campanelli currently serves at the pleasure of the State Commissioner of Mental Health on the Families and Children Committee of the Commissioner, and is a member of the Executive Committee of the Human Services Council of New York City.

Dr. Campanelli received a Bachelor of Arts degree in Psychology from St. Francis College, Brooklyn, New York, in 1972, a Master of Science degree and a Professional Diploma in Educational Psychology from St. John's University in 1974 and 1975, respectively, and a Doctorate in Clinical Psychology with a specialty in Public Administration and Health Care Delivery and Behavioral Medicine and Health Psychology from the Graduate School of Applied and Professional Psychology at Rutgers, the State University of New Jersey.

According to Dr. Campanelli, "I am delighted to be joining the Mental Health News Board. The mission of this organization, which is to provide free and readily available mental health education, is pivotal to everything we do as service providers for people with mental illness and their families. When Mental Health News arrived on the scene only few short years ago, we quickly realized that it was providing a vital service as a roadmap to information and resources in the community. In addition, the publication provides an additional service as an advocate and voice to the needs of the mental health community, and as a beacon of hope to people with mental illness in their personal recovery efforts."

The Mental Health News

New York City Section

Dr. Jorge Petit Joins NYC's Division Of Mental Hygiene

Staff Writer
Mental Health News

Jorge R. Petit, MD, has joined the Division of Mental Hygiene as the Associate Commissioner for Program Services. Dr. Petit will oversee the Adult and Child Program Services Offices and the Office of Program Development. The Child and Adult Program Services offices manages the Division's mental hygiene contracts and the Program Development Office oversees new program development.

Dr. Petit is Clinical Associate Professor in the Department of Psychiatry at Mount Sinai School of Medicine. Dr. Petit has been co-director of the Mount Sinai Department of Psychiatry: Social and Community Psychiatry teaching program for residents. He is the author of the **Handbook of Emergency Psychiatry**, published last year. Dr. Petit is bilingual and bicultural, and has been a leader in working to bridge the gap of disparities that exist for Latinos in the U.S. He also published in 2003 **The Seven Beliefs * A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression**, a book on depression and Latinos, which is also available in Spanish (**Las Siete Creencias * Una Guía Para Ayudar a Las Latinas a Reconocer y Superar la Depresión**). He has written articles and has lectured in both English and Spanish on many topics, mostly related to Latino mental health issues and emergency psychiatry. For several years, he appeared regularly on mental health topics for CNN-Radio en Español, NY1, WNBC, CNN-Español, Court TV, Univision: Aquí y Ahora, and Primer Impacto.

Dr. Petit was most recently the acting chairman of the department of psychiatry at North General Hospital. Prior to that, he was director of psychiatric emergency services for four years at Mount Sinai Medical Center. Dr. Petit's commitment to teaching was recognized in 1998 by The Greta Herman, M.D. - Educator of the Residency Award and The Medical Student Teacher of the Year Award at the Mount Sinai School of Medicine.

Dr. Petit received his medical school diploma from the University of Buenos Aires in 1990. He completed his internship and residency at Mount Sinai Medical Center - Department of Psychiatry. He then completed a fellowship in public psychiatry at Columbia University/ Psychiatric Institute, with field placement at Bellevue Hospital Center in the Bilingual Treatment Program.

Jorge R. Petit, MD

According to Petit, "I am excited about my new role as the Associate Commissioner of Program Services. This position will allow me to further my efforts in making sure that everyone has access to professional, timely, high-quality and culturally-sensitive mental health services, and is a wonderful opportunity to continue working and increasing my input as a patient advocate with a strong desire to make a change for New Yorkers needing mental health services. I look forward to working closely and collaboratively with providers, consumers and other agencies to further enhance and improve the large number of existing programs and new initiatives that the Division of Mental Hygiene's Program Services is involved in. Additionally, mental health disparities, barriers to access, and stigma, are other areas of concern that I anticipate concentrating on, as we continue to move towards more consumer-friendly, data and outcomes driven systems processes."

Domestic Violence And Mental Health

By Sue Parry, PhD
Mental Health and Chemical Dependency Program Coordinator
New York State Office for the Prevention of Domestic Violence

Victims of domestic violence – the great majority of whom are women abused by male partners[1] - make use of mental health and chemical dependency services in substantial numbers. While the presence of domestic violence does not, by itself, mean that either the victim or the batterer has a mental health problem, the fact that victims often seek mental health services means that clinicians have opportunities to give meaningful assistance to many abuse victims.

To best assist victims, it is important to resist the temptation to attribute the abuser's behavior to mental illness, substance abuse, a personality disorder or inability to control his anger. Abusive behavior results from the abuser's choice to use violent and coercive tactics to control his partner. His felt entitled to do is based in our history of gender inequality, in the social norms and values that maintain it, and in responses from acquaintances, authorities and service providers that condone and even support it. Those who doubt that abuse is goal-driven, intentional behavior need only consider how differently abusers act toward other people and how rapidly they turn such behavior off when they have sufficient incentive to do so (e.g., when the police are at the door). A major implication of this understanding is that interventions aimed at individual behavior change, like psychotherapy, chemical dependency treatment or batterer groups, are not likely to effectively change an abusers' behavior when his access to resources gives him power, and the responses of authorities reinforce it.

Sue Parry, PhD

Neither experiencing domestic violence nor remaining with an abusive partner represents a mental health problem in the victim. In fact, no problem in the victim explains why her partner abuses her or causes him to act abusively. Domestic violence is behavior that one partner engages in toward the other, not something to which the victim contributes.

Victimization can lead some battered women to act and think in ways that make clinicians suspect a pre-existing mental health problem. It is crucial to understand that these responses result from victimization; they do not cause it. A victim may, for instance, mistrust her own perceptions, experience and feelings. She may internalize her partner's negative view of her, even when it clashes dramatically with her real strengths and competencies – many abusers work hard to destroy their partners' self-esteem. She may think one thing and say another and withhold her real feelings – especially her anger – in an effort to appease her partner. She may pay closer attention to his wishes, feelings, moods and needs than to her own.[2] A clinician who sees these behaviors as self-defeating and tries to help the victim give them up may unintentionally be depriving her of strategies that actually help keep her safe. (For instance, attending to her partner's feelings and needs more than her own may make her better able to predict and avoid incidents in some cases, thereby increasing her safety). The clinician may also be unintentionally replicating, in the therapy relationship, how her partner treats her at home – thinking he knows best, telling her what's wrong with her, and destroying her self-confidence.

The clinician should never minimize a victim's fears or assume that she is exaggerating the threat posed by her partner. However, since some victims understate or deny their partner's

see Domestic Violence on page 43

the mental health association
of new york city, inc.

When Children Struggle With Mental Illness Parents Need Just As Much Support

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

Giselle Stolper

By the time Helen entered the Manhattan Parent Resource Center at the Mental Health Association of New York City (MHA of NYC), her challenges seemed insurmountable. A mother with five small children ranging from 11 years to 11 months old, Helen was shuttled from one housing shelter to another. The children's father recently suffered a debilitating stroke. Then her 11-year-old son began to act out at school, fighting with the other children and interrupting classes. He was diagnosed with epilepsy in addition to an emotional disorder, but the school threatened to expel him if his behavior remained disruptive. It was more than any mother could bear.

Helen's story is not unusual among those we hear in our child services programs. When a child struggles with an emotional disorder, it places extraordinary stress on the family, often exacerbating other problems, such as tense housing situations, financial woes or already strained relationships.

At the MHA of NYC, we have learned that we cannot view a child's mental illness in a vacuum. Our extensive child services programs offer multiple levels of support to parents, helping them address difficult living situations, teaching them to optimize the use of New York City's systems that touch their child's life, and giving them tools to find their own strength to stay focused, centered and emotionally healthy. This three-pronged approach helps the family unit grow stronger and more effective in dealing with stress and adversity.

First Priority: Attaining A Healthy Quality Of Life

If the family's living situation is untenable, parents simply don't have the wherewithal to address a child's emotional concerns. Our job is to look not just at the child, but to identify the family's most pressing needs. The first step in assisting Helen was to secure adequate space in a stable housing environment.

The MHA of NYC Coordinated Children's Services Initiative (CCSI) helps parents develop a consistent, individualized mental health plan for their child. To do so, they bring together the family members and professionals working with the child so they can coordinate their services smoothly. These planning sessions often include the child's doctors, teachers, and representatives from other New York City agencies, including the justice system and child welfare. The parents must be intimately involved in this process. They are the final decision makers for all plans affecting their children, which underscores CCSI's family based philosophy: Nothing about us without us.

In Helen's case, CCSI brought in representatives from the Epilepsy Institute and the Brooklyn Parent Resource Center, but they also called on Helen's caseworker and housing supervisor from the shelter where the family was staying, as well as professionals from Partnership for the Homeless. Working with them and CCSI caseworkers, Helen was able to secure a three-bedroom apartment in Brooklyn through Section 8 housing. The team helped her register the children for school, and they ironed out some difficulties Helen was having with public assistance and Social Security. A CCSI caseworker taught Helen how to manage a budget to make the best use of the family's limited income. Then more basics: the caseworker took her clothes shopping for the family, and another caseworker accompanied her to the supermarket to advise her on healthy foods and economic choices. We also found a GED course for Helen's partner to take as he recovered from his stroke, so he could gain new skills and find a part-time job.

Equipping Parents To Become Advocates

A child with special needs requires the expertise and clout of medical professionals, social workers, and the multiple agencies within New York City that interact with the families. But the MHA of NYC believes that the ultimate decision-maker for the child must be the parent, and she needs knowledge and resources so she can make informed decisions about medication, treatment, or school-based programs, for instance, that will affect her child's recovery.

The MHA of NYC's Parent Resource Centers, based in Manhattan and the Bronx, provide such support. Staffed with trained parent advocates who have their own children with emotional disorders, our parent advocates bring empathy and dedication, enabling them to build trust among parents who are struggling with their children's issues, giving those parents the strength, and a source of information, to take the actions that will serve their children's best interest.

Once Helen's family settled into their new home, Helen was free to evaluate her children's educational situations. She knew she needed to make some changes. One son, whom the school had recommended she place in a special needs class, was actually quite articulate when he talked one-on-one with an adult. Helen knew he needed just a little extra help, but she hesitated to speak up for him.

When a parent in the Resource Center knows what's best for their children but their voices are not heard, our parent advocates step in to provide validation and coaching. Frequently, they accompany parents to meetings with teachers, in court, or with child welfare agents, to strengthen their case and fight for the best outcome for the child. The Centers also offer training seminars to help parents navigate the school system and to know their children's rights. **The Parents' Guide to Children's Mental Health Services**, a booklet published by the MHA of NYC, offers tips, phone numbers and information for parents who need to advocate on their children's behalf within New York City's various systems.

Helping Parents To Stay Strong For Their Families

The analogy of the flight attendants' advice, about putting on your own oxygen mask first, before you put the mask on your child, is often used to remind caregivers to tend to their own needs first so they can take better care of those around them. All mothers need a break, but it is especially true of mothers who are raising children with emotional challenges. The MHA of NYC knows it's a difficult role to play 24/7, so we offer services so parents can take a break and rejuvenate.

The Parent Resource Centers offer a place for parents to meet other parents, with built-in playmates for the children. Having a child with an emotional disorder can be an isolating experience, so the Center welcomes new parents into the fold, offering a safe, non-judgmental environment. Those who live nearby occasionally drop their children off for a short while so they run quick errands. The Centers also sponsor field trips for the families, giving them an opportunity to have fun and enjoy experiences they might not be able to have on their own due to the difficulty of travel, or the expense. Two years ago a group of parents and children from the Manhattan Parent Resource Center took a four-day trip to explore historic Williamsburg and Washington DC. This past Halloween, the Resource Center and the Gouverneur Family Support Program joined up to take 50 families to Great Adventure for "Fright Fest," a trip the children are still talking about.

Sometimes parents simply need a break to go food shopping, do laundry, or attend appointments on their own. The MHA of NYC's Respite Care program can help out by offering a trained adult to look after the children, giving parents time off to tend to their own needs. Respite care is offered on a one-time or ongoing basis. The program is free of charge to parents of children with emotional disorders.

Support Makes All the Difference

In August 2004, CCSI designated Helen's case closed. She no longer needed our services, though she continues to work with a parent advocate in Brooklyn, an educational advocate, and the Partnership for the Homeless. Our caseworker dropped in on Helen and found her at home, doing laundry with her partner's mother. It hasn't been entirely easy: since she left the MHA of NYC, her five-year-old son was diagnosed with mild autism. Still, he finished kindergarten in June and now attends first grade. Her oldest son, on the verge of being expelled once, now walks his brothers and sisters to school nearby. He finishes his homework and then shows it off, because he's happy and proud of what he has done. So is Helen.

For more information about the MHA of NYC children's services, contact 212-254-0333. For a copy of The Parent's Guide visit www.mhaofnyc.org to download a copy, or send requests to helpdesk@mhaofnyc.org. An updated version will be available in January 2005.

The Special Needs Of The Female Mentally Ill Offender

By Vanda Seward, Director NYC Link Program, Diana Brathwaite, Sr. Forensic Clinic Specialist, and Laurie Jackson, Forensic Clinic Specialist F.E.G.S.

Over the last decade, women have entered the criminal justice system in record numbers, with histories of mental illness, substance abuse, domestic violence, poor education and/or no work skills. At the same time, society continues to struggle with the image of women as criminals and/or incarcerated. As a result, women who have been incarcerated seem to be a forgotten population.

Paradoxically, women involved with the criminal justice system are still expected to meet society's traditional notion of them as housewives and mothers—indeed, society expects the criminal justice system to restore the female inmate to its unrealistic definition of "womanhood." Many of the women who enter the criminal justice system have histories of mental illness and substance abuse that have been untreated. The loss of significant familial bonds makes incarceration especially traumatic.

In our experience, many woman in prison are responsive to treatment. Women often spend part of their day planning their future—taking steps toward reunification with their children, establishing a drug-free life and avoiding re-victimization. Their desire to succeed and change is great, making them willing to examine histories of rape, incest, mental illness, and homelessness. At discharge, the women often have established goals for their lives outside prison and feel excited and ready to go.

Once discharged, however, they find that accomplishing these goals is not easy. In addition to the challenges of being reunited with their children, abstaining from substances, developing positive relationships, and pursing educational and vocational training, women with mental illness have the added burden of managing their illness while maintaining a law-abiding lifestyle.

At F.E.G.S. we know that ex-offender women face enormous social and economic barriers. It is often very challenging to find the forensic client the services they need, but if women are to be successfully reintegrated into society, they need to be linked to a variety of community-based services, and these services need to be coordinated.

Some consumer goals may not be realistic; these must be discussed openly, collaboratively, and with sensitivity. And some of the goals or needs of the consumer may fall outside of the realm of the mental health provider and may require the assistance of parole and/or probation officers or others. Many providers mistakenly utilize these resources only during times of crisis, but both parole and probation officers can be very effective in setting goals and helping the consumer to succeed.

At F.E.G.S. we have adapted Dialectical Behavior Therapy (DBT), a cognitive behavioral treatment model, in treating formerly incarcerated women who have a mental illness. Clients are seen in individual DBT sessions and also participate in a 10-to 12-week DBT skills-training group. The components of DBT skills training focus on emotion regulation, interpersonal effectiveness and distress tolerance, and are extremely useful in helping women learn skills to help them handle the demands of the community, their families and their mental illness.

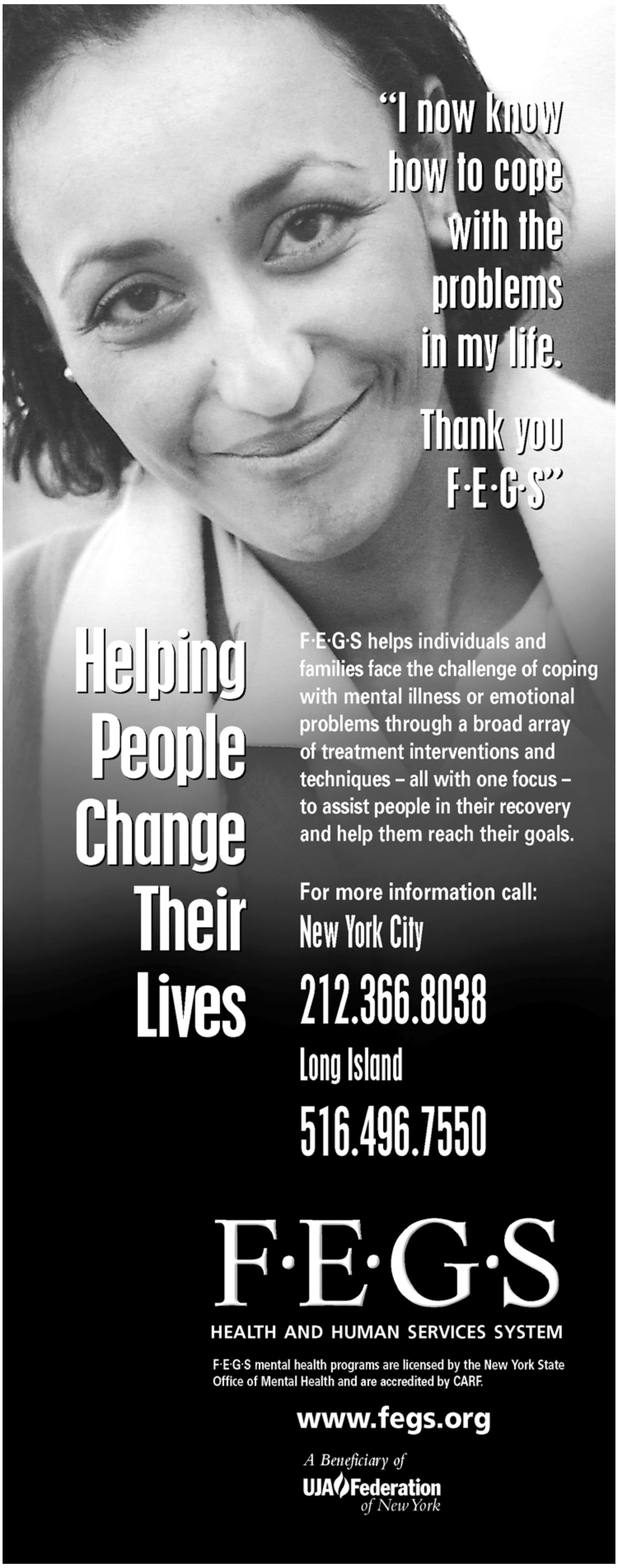
M.M., a 37-year-old Latina, is a client who faced many of the difficult issues that lead to recidivism. M.M. had a history of multiple suicide attempts and self-harm behaviors, which resulted in multiple psychiatric hospitalizations. She also reported "no knowledge" of her biological family and was placed in foster care from birth. M.M. is the mother of three children who also all ended up in foster care and were adopted. M.M. was also clearly suffering from poor concentration, anxiety, low self-esteem, sleep disturbance, alcohol abuse and childhood sexual and psychological abuse.

M.M. not only had a very traumatic childhood and a history of mental health treatment since approximately age 8, she was also a long-term patient at Creedmoor Hospital, from 1988 to 1999. She was also incarcerated for a drug sale and served a year and a half in prison.

Upon the client's re-entry into the community, she was referred to the F.E.G.S. Forensic DBT treatment program for mental health services. She was linked to the F.E.G.S. Intensive Case Management (ICM) program and continues to utilize these services. At first, M.M. displayed symptoms of anxiety, suicidal ideation, and depression; she was having difficulty adjusting to life in the community and was a victim of domestic violence.

M.M.'s treatment consisted of attending weekly individual therapy, DBT skills-training group and monthly medication management. Treatment was not immediately successful, but has gradually taken hold. During the early part of treatment, M.M. experienced a relapse as a result of domestic violence, financial difficulty, and the stress of re-entry into the community, but treatment has gradually taken hold. M.M. has now successfully completed parole, enrolled in a VESID vocational training program, and completed 2 DBT modules, which increased her self-esteem and enabled her to end the relationship with her abuser. M.M. no longer requires intensive individual therapy sessions 2-3 times weekly. Instead, she currently attends weekly DBT Alumni group sessions, goes to a monthly medication management meeting, and continues to meet with her ICM worker weekly for extra support.

Not every client's re-entry to the community is successful. On discharge from prison, the woman ex-offender needs support from the provider community as she strives to attain her goals. Providers need to help clients set reasonable goals and understand the special needs of the female mentally ill offender re-entering the community.



Parenting And Mental Illness

By Stella V. Pappas, LCSW, ACSW
Senior Vice President
Child & Family Mental Health Services
The Institute for Community Living

One of the most important roles in a woman's life is often that of mother. It is an important role, and unlike many other roles in a woman's life, such as daughter, sister, wife, friend, etc., it comes with a tremendous amount of responsibility. Some may argue that all roles carry responsibility. Of course they do; however, none quite to the degree and magnitude of being a mother.

The demands of parenting are often challenged by day-to-day competing priorities and routine stress. It is even more difficult to parent in the face of mental illness. According to Nicholson, Biebel, et al., (2001) in their review of the literature, "Nearly half of the women and men in the United States report a lifetime prevalence of psychiatric disorder, and 30% report the prevalence of at least one disorder in the previous 12 months (Kessler, et al., 1997). Two-thirds of these women are parents (Nicholson, Larkin, Simon, & Banks, 2001, p. iii)." Clearly, the number of moms struggling with mental illness is in the millions.

Many parents suffer from chronic medical diseases; however, unlike other illnesses, the diagnosis of a mental illness carries with it a great deal of stigma, shame, and fear. These families are often, and with good cause, reluctant to reach out for help or support from family, friends, or society. Moms often fear that their children will be taken away from them and choose to isolate, leaving their mental illness untreated. Mental health providers, researchers, the families themselves, and society as a whole have all traditionally focused on negative predictions for children whose mother has a mental illness rather than on individual strengths and resilient capacities.

It is well accepted that children are naturally resilient, and with love and support can overcome many challenges. Additionally, many women who battle mental illness, and its often ravaging consequences, develop a huge reservoir of internal resources, skills, and strengths. They become survivors in a frequently dangerous and scary environment. With little support from loved ones or "the system," these women often face a multitude of traumatic events, such as the loss of their children to foster care or other placements, domestic violence, homelessness or abuse. Despite these severe factors, many women persevere and work hard on their recovery. They often site their children as the single most important motivating factor toward their recovery. Once stable, they often search for support and services that will assist them in caring for their children.

The Institute for Community Living (ICL) operates under two basic, albeit sometimes controversial, premises: one, all parents care about their children and want the best for them, and two, children do best when able to live with their parents. There are times, however, when it is not possible for children to remain in the care and/or custody of their parents due to issues including abuse, neglect, homelessness, and parental substance abuse. At times, these issues are a direct result of the mental illness. However, with proper treatment and support, moms are often able to maintain or regain custody of their children.

It is important that service providers build on the strengths of these moms and their families. Providers need to view the mother with mental illness in her entirety, not only as a "patient," but as a mom as well. The parenting role must be supported and encouraged in order to ensure that the mom takes proper care of herself as well as her children. For example, a mom may decide not to take her medication exactly as prescribed if her morning dose, which makes her sleepy and lethargic, interferes with getting her children ready for school. It is critical that this be discussed with the prescribing clinician so that alternatives can be considered, such as a different medication regimen or a different schedule of taking the medication. Such alternatives would support the mom's desire to effectively parent her children and would build on this strength while ensuring proper treatment for her.

Mothers with mental illness may also be in need of affordable housing and integrated social service supports in order to be able to adequately care for their children. ICL's Child and Family Services Division operates a continuum of family preservation programs ranging from support, linkage, and advocacy programs to clinical and residential programs. The family unit becomes the focus of the interventions and supports in these programs. "Interventions that focus on ensuring a safe, stable home environment, reducing parent-child discord, enhancing parent-child communication, developing parenting skills, reducing environmental stressors, and supporting children's resilience can improve outcomes for parents and children," (Nicholson, et al, 2001, p. iv). Focusing on the needs of individual adults with a mental illness is inadequate since many of these individuals are, or wish to be, living within a family.

"Despite innovative and promising efforts, there are few programs for parents with mental illness and their children, relative to the need, that are driven by theory and research, have stable funding, and are well-evaluated (Nicholson et al., 2001, p. 55)." Targeted efforts must be made to integrate the fragmented adult and child mental health systems allowing for family centered and strength-based care of mentally ill parents and their children.

"The challenges of parents with mental illness have a great deal in common with those faced by all parents…" (Nicholson et al., 2001, p. 52). Many such individuals have the potential to be excellent parents, once the necessary supports are in place to sustain psychiatric stability and sobriety. Parenting and mental illness do not have to be mutually exclusive.

References

Nicholson, J., Biebel, K., Hinden, B., Henry, A., Steir, L. (2001). **Critical Issues for Parents with Mental Illness and their Families.** Prepared for the Center for Mental Health Services Substance Abuse and Mental Health Services Administration Office of Policy, Planning and Administration, Rockville, MD.

The History Of ICL

The Institute for Community Living (ICL) was founded in 1986 with the opening of its first 150-bed residential program in downtown Brooklyn. This program served adults with serious and persistent mental illness. Since its inception, ICL has been committed to providing high-quality services and supports to the people it serves, permitting them to achieve their full potential while living in the community of their choice. In furtherance of that mission, ICL has developed a comprehensive array of support and treatment services for citizens with both mental illness and developmental disabilities. ICL now serves over 4,000 people per year throughout Brooklyn, Bronx, Manhattan and Montgomery County, Pennsylvania.

Over its brief history, ICL has been recognized by the American Psychiatric Association as a Gold Medal award-wining agency in year 2000, and was recognized as Agency of the Year by the New York City Department of Mental Health, Mental Hygiene and Alcoholism Services in the same year.

Services

ICL's comprehensive array of services consists of congregate-site as well as scattered-site apartment programs for adults with serious mental illness and for families where one parent has a mental illness. Support services are offered to families and children through an array of programs, including: the Parent Advocacy Program in Brooklyn and the Family Support Program, as well as clinical treatment services located in clinics throughout Brooklyn.

Services for adults include: vocational services, integrated substance abuse treatment, and assertive community treatment.

ICL subscribes to the provision of Evidence-Based Treatment at all of its programs. All of ICL's programs can be reached by calling their toll-free number: 1-866-ICL-Access.

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VOLUNTEER. We are looking for young adult mentors to provide support and information to teens hospitalized for emotional and/or behavioral disorders. Training is provided. Please call our Helpline at 212.684.3264 or visit our website to find out about this and other volunteer opportunities.

www.naminycmetro.org

Retirement from page 9

the New Jersey Highlands. While fostering my old interest in writing, retirement also allowed me to explore my new interest in the outdoors. I have participated in a new community, a weekly writers workshop, all women and all ages. I also do freelance editing. To continue my activism, I joined the New York Women's Foundation, a group that assists grass-roots organizations of low-income women throughout New York City. And I realize I also love being available for spontaneous jaunts and for the unexpected visits of friends and family. Some days and months, this mix doesn't work. But as a good editor, I expect I will have to revise my life, and to do so without apology.

My friends and I replaced the satisfaction of a paycheck with the freedom to say, "No. I don't really want to do that." Unlike work, with its daily demands and urgencies that are often beyond our control, reflective retirement responds to our own demands and urgencies. It opens up possibilities that have never been explored, particularly if one is willing to slow down, join others, and engage in a continual process of adaptation.

Dean Katz recently delivered a Grand Rounds presentation at Four Winds Hospital, titled "Women Confronting Retirement: A Non-Traditional Guide." She is available as a consultant or speaker, and can be reached by e-mail at marilyn.katz@att.net

Four Winds is a psychiatric hospital located in Katonah, New York, which provides inpatient and outpatient mental health treatment services for children, adolescents and adults.

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committee in formation

Sanctuary In A Domestic Violence Shelter: A Team Approach To Healing

By Libbe H. Madsen, MSW, Lisa V. Blitz, MSW, David McCorkle, MSW, and Paula G. Panzer, MD, JBFCS

For survivors of domestic violence, the ongoing effects of trauma are compounded by the context of their abusive experience. Injury caused by a person one has loved and trusted damages beliefs about oneself, other people, and the world. Staff members of various disciplines and educational backgrounds who work in domestic violence shelters are dealing with this damage, as well as the impact of trauma on shelter residents. They face the challenge of observing and responding to the effects of recent and past abuse, to traumatic re-enactments within the setting, and to their own secondary trauma reactions. This paper explores the process of implementing the Sanctuary® model in a domestic violence shelter. The Sanctuary model was chosen because of its focus on teamwork, and the guidelines for treatment it provides that are accessible to all members of the treatment community.

Shelters must respond to a range of demands in the context of the constant need for twenty-four hour security. Staff members with different levels of training and skills must work together smoothly, even as their schedules may limit face-to-face contact. An intervention model for this setting must provide a safe haven so that abused women and their children can heal from abuse and move forward. The best solution found at Genesis was Sanctuary®, a milieu-based model developed by Dr. Sandra Bloom, who spent a significant amount of time helping Genesis implement this treatment model, which addresses trauma and its impact on clients and staff, and also offers guidelines for intervention.

Stress and Secondary Trauma

Residents in a domestic violence shelter continue to experience and express the effects of their abuse in various ways. Residents' own post-traumatic reactions are often triggered by the behaviors of others, and further contribute to the dynamic. They need a way to understand their own feelings, as well as to contain their reactions to others. Sometimes, the staff can lose their perspective, and may slip from understanding to blame; they need a way to sustain an awareness of this process and to support each other. We needed a model that provides tools to recognize and respond to these effects of trauma.

Implementing The Sanctuary Model

The Sanctuary Model is based on theories of trauma and attachment, and looks at the physical, cognitive, emotional, social and behavioral responses to danger as well as at people's need for a safe, nurturing, and predictable social environment. The model rests on a basic commitment to safety and nonviolence, and consists of two key components: the creation of a therapeutic milieu designed to help people develop healthy attachments, and psycho-education geared toward emotional, social, cognitive, and behavioral recovery from trauma.

Therapeutic Milieu

Women who have survived domestic violence are commonly considered to be marginalized by both gender and victim status. In addition, many survivors are further marginalized by race, ethnicity, and economic status. A primary goal in the process of empowering those who have been oppressed is to bring the marginalized voices to the center, ensuring that all individuals are heard and respected. This is done by talking about the individual's experience in her family, community, and the world at large, in order to understand the social, political and historical context of her experience. The healing potential of this process is a reflection of the quality and depth of exploration the staff is engaged in and becomes a central feature of milieu treatment as the community works toward empowering its members.

Multiple Perspectives

The fact that staff members come from different cultural backgrounds and have had different educational and other life experiences provides a foundation for exploring different points of view. The principle of multiple perspectives is also essential in working with clients about the abuse experience. Family violence is often spoken of in terms of victims and perpetrators, evoking a kind of conceptual and emotional splitting, and compelling others, including professionals, to take sides. However, despite their experience of abuse, women and children often continue to feel a strong attachment to the person they have come to the shelter to escape. In order to hear clients' stories in all their complexity, it is necessary to listen for, and actively elicit, the full range of feelings associated with these relationships. The staff, working as a team, can represent the multiple perspectives of the family experience and thus more fully understand and offer help.

Issues of Confidentiality

Residents also need to be assured that their privacy and confidentiality are respected. Survivors of domestic violence have often experienced violation of their personal boundaries and betrayal of their personal information. Because sharing information between staff is necessary to maintain safety and

see Sanctuary on page 43

The emotional, behavioral, and psychiatric health care needs of adolescents and their families are unique, and are best cared for in a specially designed treatment program. That is why Bridgeport Hospital, a 425-bed teaching hospital in Bridgeport, Connecticut, provides both Intensive Outpatient (IOP) and Inpatient services to meet those needs.

The REACH Adolescent Service, an afternoon, community based, IOP program for adolescents between 13 and 17 years old with emotional and behavioral difficulties, offers an intensive outpatient program that includes group therapy, multi-family group work, medication management, and case management.

Adolescents can also be admitted to Bridgeport Hospital's JCAHO-accredited inpatient psychiatric unit. This unit is staffed by a dedicated psychiatric healthcare team and supported by the same professionals who provide outpatient services at REACH, ensuring continuity of care between inpatient and outpatient services.

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Left to Right:
Karen Parniawski, Psych Tech; Jyll Souto, LCSW;
Margaret McGovern, Art Therapist; Kathy Graziano, APRN;
Rafael Valentin, Psych Tech

Referral Process

For referral to the outpatient program, please call (203) 384-3377 and ask for an evaluation appointment.
For referral to the inpatient program, please call (203) 384-3709 and speak to the charge nurse.

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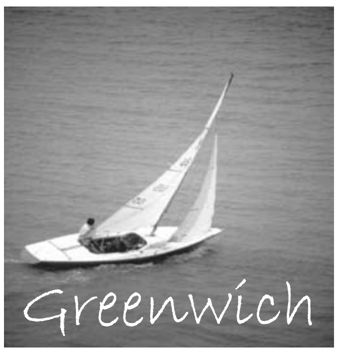

Mental Health News

The Connecticut Section

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A Holistic Approach To A Women's Jail Diversion Program

By Rocio Chang, PsyD, ABD, Katherine Henry, MSW and Karen LeBlanc, MA, Department of Psychiatry University of Connecticut Health Center, Capitol Region Mental Health Center - Hartford , Connecticut

Connecticut is recognized nationwide for being a pioneer in jail diversion programs. The function of a jail diversion program is to provide defendants who have been charged with non-violent minor offenses with access to appropriate mental health and substance abuse services. Jail diversion staff provide assessment, make appropriate referrals, and have the ability to access immediate treatment. They also provide on-going treatment monitoring of those who enter into these services. Diversion staff also assist the courts with plans to decrease the amount of time a defendant may be incarcerated. Jail Diversion Programs are currently located at all of twenty-two geographic court sites.

The Connecticut Department of Mental Health and Addiction Services (DMHAS, Capitol Region Mental Health Center), in collaboration with the University of Connecticut Health Center, the Judicial Branch Court Support Services Division and the Community Court Session in Hartford, was granted a three-year federally funded Women's Treatment and Support Diversion (WTSD) program. The program provides gender-specific services, culturally appropriate case management, trauma treatment, and integrated mental health and substance abuse treatment services, using the Relational Cultural Model, to women with histories of trauma and substance abuse disorders who are involved in the criminal justice system.

Women within the criminal justice system face additional obstacles when courts are unaware of the unique life experiences of women. Challenges within the judicial and criminal court environment involve, but are not limited to, confidentiality, compliance reports, and bridging the differences between agency missions while building program credibility and maintaining clinical integrity. Respect for a person's desire for privacy and the statutorily mandated right to confidentiality is a tremendous balancing act when a person is court ordered to a program and the court requires compliance information. As a result, the program developed a clinical definition of compliance that encompasses a person's participation, attitude toward treatment and overall benefits from the program.

The WTSD program differentiates itself from other jail diversion programs by directly providing treatment to its members rather than strictly facilitating referrals to other providers. Referrals to the Women's Jail Diversion Program come from a variety of sources, including public defenders, bail commissioners, probation officers, state's attorneys, and judges. A statewide mental health information system, which contains the names of all people who seek mental health and substance abuse services through a State of Connecticut facility or a DMHAS-funded provider, is an additional referral source. Clinicians then conduct a mental health assessment to determine and make recommendations based upon the severity of mental health impairment and a person's need for mental health treatment.

see Holistic Approach on page 38

Strengthening Our Ability To Prevent And Treat Substance Abuse In Connecticut

By Thomas A. Kirk, Jr., PhD
Commissioner, DMHAS
Connecticut Department of Mental Health and Addiction Services

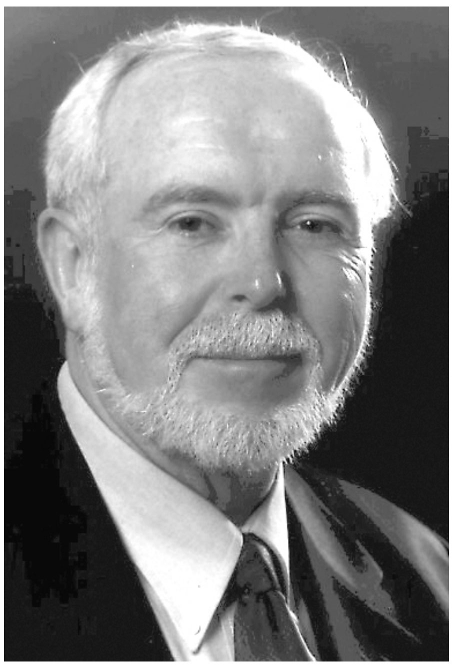
The Department of Mental Health and Addiction Services (DMHAS) has just been awarded approximately $15 million in competitive federal grants to prevent and treat substance abuse disorders. Through contracts with private non-profit providers, DMHAS will funnel these funds into the service system to support a range of effective interventions that can avert the onset of substance abuse or successfully treat problems of this type. The three grants include:

Connecticut Strategic Prevention Framework Initiative – $12 million to conduct a systematic assessment of substance abuse and mental health needs on a statewide and regional basis. This assessment will be used to direct implementation of scientifically proven strategies designed to prevent the onset and reduce the progression of substance abuse problems in Connecticut communities. One of the program's principle areas of focus involves preventing underage drinking. Finally, the grant will fund service implementation and evaluation efforts.

Connecticut Screening and Brief Intervention Initiative – $1.5 million to expand the state's capacity to perform screening and brief interventions designed to identify and treat young adults with emerging substance abuse problems. The funds will be used to support services provided in the emergency department of Saint Raphael's Hospital and at Hill Health Center, a federally qualified health center, in New Haven. In addition to brief interventions for adults with early indications of addiction problems, the proposed strategy will also help people with more serious conditions connect to longer-term substance abuse treatment. The Connecticut Screening and Brief Intervention Initiative is a collaborative effort involving DMHAS, the University of Connecticut Health Center, Yale University, and health care providers in the New Haven community.

Preventing Use of Ecstasy and Other Club Drugs – $1.5 million to develop, implement, and evaluate the Skills Mastery and Resistance Training (SMART) Moves program, an evidence-based prevention intervention model. These funds will be used at two sites in the Greater Bridgeport Community (Shelton and Bridgeport Boys and Girls Clubs). The overall purpose of the SMART Moves Plus is to expand delivery of culturally competent interventions designed to prevent use of ecstasy and other club drugs by enhancing protective factors and minimizing risk factors for drug use among 12-to 15-year-olds. In addition, the project will determine program effectiveness, document implementation, and determine steps necessary to replicate the service in other communities.

These significant grant awards come close on the heels of a $22 million competitive federal grant to DMHAS for the Access to Recovery program. These awards represent DMHAS' commitment to working with service providers on strengthening substance abuse prevention and treatment in Connecticut.



Thomas A. Kirk, Jr., PhD

Holistic Approach from page 37

The Women's Jail Diversion Program staff rely primarily upon the Relational Cultural model as a theoretical framework. Staff have been trained in a variety of intervention techniques including Motivational Interviewing Skills (MIS), Trauma Adaptive Recovery Group Educational Therapy (TARGET), and Dialectical Behavioral Therapy (DBT). Participants receive comprehensive mental health and substance abuse assessment, twenty-four hour Crisis Intervention Services, a full time Advanced Practice Registered Nurse for medication management in conjunction with part time psychiatric cover, group therapy. Case management services are available providing linkage to housing, work opportunities, appropriate medical care as well as other identified services.

Groups topics include relationships, substance abuse, relapse prevention, coping with trauma and spirituality. The Relational Practice in Action: A Group Manual (Jordan & Dooley, 2001) as well as Helping Women Recover (Covington, 1999) modalitities encourage women to articulate their experiences evaluating the social, cultural and political influences. Relational Cultural Theory validates a women's need for connection and interdependence to foster further growth (Jordan & Dooley, 2001). Additionally, providers from the community serve as guest speakers sharing information about such topics as domestic violence, sexual assault and substance abuse treatment programs.

Case management services are essential as women have reported access to housing, financial assistance programs and medical care as obstacles to recovery. Due to recent budget cuts, many aid programs have either been decreased or discontinued, limiting eligibility for and access to services. Affordable apartments are in areas that are rampant with drugs and crime and may trigger relapse. A participant's lengthy criminal history, bad credit, and either eviction or non-rental history make obtaining appropriate housing an enormous barrier to recovery. Case managers act as advocates, helping women navigate the system to ensure they receive all the services to which they are entitled.

Peer support is also utilized to provide encouragement and assistance. Many women report that sobriety entails establishing connections with healthy, stable people, distancing themselves from former friends and forging new relationships. Since peer support is crucial to maintaining sobriety, as participants graduate from the program they are invited to continue as peer mentors. Additionally, program staff sponsor a weekly Women For Sobriety Group which is a gender-specific peer support group that address women's unique recovery issues (Kirkpatrick, 2001). Encouraging connections amongst the women as well as between support based community providers has established a foundation for women to build upon.

Spirituality and a connection to a higher power has emerged as a common theme in the recovery process. Staff have invited representatives from various organizations in order to encourage members to explore faith-based supports available to them. Members have been given the opportunity to participate in a community Labyrinth Walk as well as a Shawl Ministry Program.

Implementing innovative programs is both a challenge and an opportunity. As the program progresses past the implementation phase incorporating innovative interventions such as staff training in specialized treatment modalities, involvement in grant-writing for housing and designing a substance abuse group for women combining spirituality and psychotherapy provides opportunities for continued growth and development of the program. The addition of an innovative Jail Diversion treatment component, focusing on gender-specific, co-occurring disorders, as well as multiculturalism, continues to demonstrate that the Connecticut Jail Diversion Program is a leader in this field.

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Medical Services from 19

from cultural norms and models they experienced in society and their own families. These early models may still render them reticent in the face of authority or, perhaps, they may swing to the other pole and behave rudely or aggressively when they feel too vulnerable. In addition, women who live with mental illness carry a burden of stigma that creates a feeling of being "not okay" or "damaged goods" – a person others find despicable or frightening. Patients then perceive that others do feel this way about them. Now, couple these challenges with sitting on a cold, hard table in an ill-fitting paper gown with an open back. When, due to the stress of a visit to the doctor, the patient's mental illness symptoms become exacerbated, the nurse and/or doctor are likely to view the patient as incredibly immature, out of control, and inconsiderate of the doctor's precious time—never realizing that the patient is now in excruciating emotional pain because her mental illness symptoms are becoming quite noticeable!

Solutions

These challenges are stress-provoking, but not hopeless. There are steps women can take to ease such situations for themselves, as well as for the medical personnel.

1) Go online and get a copy of the "**Patient's Bill of Rights.**" Study it; think about how it applies to your situation. Carry it and quote it, if necessary. Utilize what you learned in the doctor's office.

2) When medical personnel act disrespectful, inconsiderate or inappropriate, view them as ignorant and see the situation as an opportunity to educate them.

3) Several days prior to an appointment, begin using visualization and deep breathing to mentally rehearse attending the appointment and using self talk and relaxation to manage anxiety as soon as it begins.

4) Once you have mastered these techniques, you can use them at scheduled, or even unexpected, medical appointments.

5) Bring an advocate, or explain to the staff yourself, that you have a mental health diagnosis and that prior unpleasant experiences in doctors' offices have left you traumatized. Explain that you can help yourself by taking a minute to do deep breathing, or if you get too anxious and forget, it would help to have the medical staff take a moment and coach you by reminding you to breath. This will go a long way in helping both you and the staff feel more at ease, because now they understand what to do if you have a crisis.

6) If possible, have a consultation visit with new physicians before seeing them on a regular basis. Tell physicians what works best for you and find out if they are agreeable.

7) Always bring a list of questions. Note all symptoms, including intensity and duration, medications and doses, medication sensitivities or allergies, and other questions or concerns you may have. This is very important because it saves time and prevents you from relying on memory alone, which may falter during times of stress.

8) If possible, bring issues about the doctor's office into therapy sessions. Ask for help in creating a situation that will be positive for you and your doctor.

Coming Soon At Hall-Brooke:

Outpatient Program Designed Especially For Women

Staff Writer
Mental Health News

A program providing evaluation and treatment alternatives for women is being developed at Hall-Brooke Behavioral Health Services, located at 47 Long Lots Road in Westport, Connecticut. This new service recognizes that many women require a structured, intensive, and tailored-to-the-individual program to meet their individual treatment needs.

Hall-Brooke's new program is designed to involve community and referring-care providers from the point of a participant's admission through planning for her discharge.

An interdisciplinary team will integrate individual, group, and family therapy with medication management for each woman in the program.

The program meets Monday, Wednesday, and Friday, from 10 a.m. to 12:30 p.m. Among the group therapies being offered are:

Symptom Management: to help participants identify and cope with their symptoms. This involves changing negative thought patterns and developing positive forms of emotional expression, as well as interacting with others in a new way.

Relationship Issues: addresses how these impact in a positive or negative way on growth and healthy functioning. With genograms, participants explore family patterns and the impact of these on their health.

Coping with Loss: helps participants deal with the inevitable losses and changes that transpire in an adult's life span. This topic also addresses traumatic loss.

Mind, Body, and Spirit, a dominant theme at Hall-Brooke, stresses the use of all a participant's internal skills to develop and protect her mental health. In line with the concept of "wholeness," participants learn the value of a healthy lifestyle with appropriate sleep cycles, exercise and proper nutrition. They also participate in meditation and journaling exercises.

The development of this program, geared specifically to women, recognizes that mental illness affects men and women differently. A number of disorders are more common in women, and some—which are suffered by both sexes—express themselves with different symptoms. Scientists only now are beginning to assess the contribution of biological and psycho-social factors in mental health and mental illness as these apply specifically to men and women, according to Thomas E. Smith, MD, Hall-Brooke's Medical Director.

Women's mental health, mood changes and physical symptoms, can be related to female hormonal imbalances. Postpartum depression and menopausal depression are two prime examples. Care for the mental health of women definitely is a discrete undertaking from that of the general public, Dr, Smith noted.

Persons interested in the Women's Mental Health Program, offered by Hall-Brooke Behavioral Health Services of Westport, Connecticut, should call 203-221-8878 for information.

Hall-Brooke is a wholly-owned subsidiary of St. Vincent's Health Services of Bridgeport.

Hall-Brooke is affiliated with the Department of Psychiatry of Columbia University's College of Physicians and Surgeons.

Personal Journey from page 1

schoolwork, and when it became too hard to catch up, I stopped going. Justin moved out at 16, and I stopped getting up in the morning.

Days went by, and aside from getting out of bed to go to the bathroom, or to watch **Mystery** or **Oprah Winfrey** on TV, my attention span lasted only an hour or so before I got drowsy and went back to bed. I stayed under a cocoon of covers. When Justin dropped in, I got out of bed and pretended to be a mother. I can't remember where the time went; I hibernated and lost track of days and nights.

I started to cry. I cried a lot. I cried in front of the university bursar when he asked me why I hadn't paid the rent. Too much in shock to think of a polite answer, I just blurted out the truth—that I wasn't sure if I was married, that I was unsure what was happening with my son. He recommended a university therapist. He was a compassionate, sensitive therapist with red hair and the old 1970s trick of wearing a full beard so that he wouldn't be mistaken for a student. My moods were easy to read: invisible—when I stuffed my wild hair under a baseball cap and kept my eyes trained to the ground: or defiant—I let my wooly mane loose and uncombed, glared at all the young, hopeful students (who I was furiously jealous of) in the eye and defied them to stare back. I got brave enough to insist Justin see a doctor. The doctor said he tested positive for marijuana, otherwise he was fine.

After four session's I was on Zoloft and academic probation instead of being suspended. I could reapply for financial aid and get myself back into the university's good graces.

With my therapist's help I re-thought my future and changed my major from architecture to film, enrolled in summer art classes, and spent the spring alone. I went for long walks and drives, borrowed VHS tapes of **I Claudius** and watched the series two times all the way through. I watched **Rebecca** three times in a row, and rented every available film written by Tennessee Williams that the local Blockbuster carried. I laughed again, thanks to **Ace Ventura, Pet Detective**.

My fall was slow and almost sensual. My journey up and out is a daily decision. The inclination not to give up and to shut down is like fighting a powerful force of nature that is as strong and as unyielding as gravity. Many African-American women as solitary caretakers of family and children do not have many choices. We get out of bed and make a pretense of being functional while succumbing to psychosomatic illnesses, zoning out, being constantly irritated, having no vision for ourselves, a lack of hope for our children and doing just enough to get by.

Looking back at my childhood, my mother returned to the family when I was 17, after her 5-year absence. I was firmly ensconced under sheets and blankets that had not been changed in weeks and surrounded by books that got me as far away as I could from anything that resembled my world. All my mother could think to do was sprinkle holy water in my room and pray that whatever force was having its way with me would leave. Even though she never said a word to me, her behavior seemed to indicate that she believed I was suffering from a teenage malady that I would soon grow out of—and at most, that I was possessed by some unspeakable force, or was suffering from an unfortunate character flaw.

It was all she knew. Fortunately, none of these are true. Things have changed a lot since those days. It took my son getting ill before I could jump with both legs into an exploration of mental disorders. It was a long journey through a miasma of ignorance, blame, superstition, denial and anger to the understanding of a disease whose symptoms are behavioral. It was not anything my mother had done or did not do, but a predisposition to sink and withdraw when faced with certain circumstances—circumstances that no one has any control over.

Getting help requires an army, albeit a small one, but one armed with knowledge, support, understanding, patience, spunk and plenty of love. Statistics show that more than 54 million Americans have a mental disorder in any given year, depression and anxiety disorders affect 19 million adults annually, and that approximately 12 million women in the United States experience depression every year. I urge friends, family members, and coworkers to encourage anyone exhibiting the signs of depression to seek help. There is a very good chance that, given the magnitude of these numbers a plea for help will not fall on deaf ears.

Karen Gormandy is a board member at NAMI-NYC Metro. Her son, originally diagnosed with schizophrenia, has been re-diagnosed as having bi-polar disorder. She has been trained to teach NAMI's Family-to-Family Course, which is in the planning stage in conjunction with NAMI Harlem, has been on the ***Today Show's*** *segment on Women and Depression, and has spoken at NAMI National's African-American Symposium, "Recovery is Possible."*

Pro Bono from page 22

contacted the Partnership in 1999, when TAG needed an attorney to review its certificate of incorporation and bylaws. This year, TAG Consultant Sandra Prendergast called for assistance with drafting grant guidelines for funding autism research that would give the organization the right to retain the intellectual property rights to the findings. A Pro Bono corporate attorney from Fairfield County was able to provide the right assistance.

Prendergast, who has also attended the Partnership's workshops on Board Member Roles and Responsibilities and Legal Issues in Volunteer Program Management, says, "Ongoing help from the Partnership has enabled TAG to create grant guidelines that were essential to its ability to fulfill its mission. The Pro Bono lawyers have been exceptional in their assistance, advice and promptness. We are very grateful."

To help nonprofits avoid crisis management and determine when they should request professional legal assistance, the Partnership provides regular capacity-building workshops on topics such as: Sexual harassment; Fundraising and revenue generating activities; Employment law; Board member roles and responsibilities; Lobbying and political campaign activities; Insurance and liability issues; Legal issues relating to the use of volunteers; Legal maintenance; Basics of HIPAA for nonprofits; Website, technology and fundraising issues for nonprofits; and should you apply for tax exemption.

Nonprofit organizations can find information about upcoming workshops on the Pro Bono Partnership's Web site, www.probonopartnership.org. This highly informative site also contains an online form to request legal assistance and provides timely information about legal issues, legal publications for nonprofits and volunteer attorneys, as well as copies of the Partnership's free e-newsletter.

For more information, you can call the Pro Bono Partnership at (914) 328-0674 from New York, (203) 351-4123 from Connecticut or (973) 273-0600 from New Jersey; send e-mail inquiries to information@probonopartner.org.

Body Obsession from page 8

Women who are assertive, take charge, driven, determined, competitive, and competent and who love to eat continue in the 21st century to be subject to ridicule. Carol Knapp discusses this duality. She highlights the prevailing view that the hardworking, self-oriented man is praised in our culture, while a hardworking, self-oriented woman is vilified. "…if you need a single example of the double standard at work here, think about Bill and Hillary Clinton. Bill's pudginess and fondness for McDonald's was seen as endearing, his sexual appetite criticized, but ultimately forgiven by most Americans, or at least considered irrelevant to his abilities on the job; Hillary got no such latitude, the focus on her appearance (hairstyle, wardrobe, legs) was relentless, the hostility released toward her ambition venomous."

To live against the grain is the risk woman take – by this, I mean to live as your body is destined to be. Eating too little as a means to find acceptance in the social and cultural norm is as conflicted as eating too much as the means to rally against the societal dictum.

What if women were to listen to the voice within their own body? What if they listened to their internal cue, which told them what they needed, how much, when they had enough? Within a feminist context, women have never had their own voice. Feminist writers within a psychoanalytic frame suggest that women are doomed from birth, because the messages they get from their mothers and fathers is to be subservient, to suppress their voice, to not be too angry, too assertive, too determined or too competitive. Girls learn how to be women by observing their mothers. They learn about the rules for their bodies from a very young age. Little girls hear the mantra from parents, television, and other little girls to not eat too much. Prepubescent girls, whose bodies are supposed to be fuller and rounder until puberty sets in and the body naturally redistributes weight, are put on diets because parents are panicked that their child is fat or will become fat if they don't take action now.

It is difficult, some say impossible, to shift the prevailing thinking en masse. It may be too late to significantly change the public mindset for women of this generation, but perhaps the messages to our daughters and sons can be different. In an effort in the 1990s to help young African-American males to better care for, respect and not objectify their female counterparts, a slogan was introduced – "Don't diss your sis." The focus was not primarily on changing the young women to become more empowered, but on helping to change the thinking and behavior of the young men. We have this same opportunity at our fingertips in changing the messages that we as adults deliver to our children, all children – that weight, body size and shape is not dictated by our culture, but rather by our genetics and how we feed and take care of our bodies. And, in using body image as the metaphor, we can deliver the message that the right of assertiveness, competitiveness, motivation, competency and determination ought not to be dictated by a cultural or societal view that is gender biased against women. We can teach girls and boys that—just like our bodies—our minds, opinions, qualities and creativity come in different shapes, sizes and genders.

Judy Scheel, Ph.D. is the Director and Founder of the Center for Eating Disorder Recovery (CEDaR), providing treatment for men and women, with offices in Mt. Kisco, (914) 244-1904, Scarsdale & Mamaroneck (914) 472-4019, and Nyack (845) 348-7660. She is also President of the Eating Disorder Foundation, Inc., a not-for-profit organization dedicated to raising funds to support eating disorder prevention and education. She has authored numerous articles on eating disorders and is a frequent speaker to professional and community groups.

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Bloom, Carol. Eating Problems: A feminist psychoanalytic treatment model. Basic Books, NY. 1994

Domestic Violence from page 29

abusiveness, it is also important for clinicians to trust their own perception of danger even when the client disagrees with it. She may want to believe her partner when he promises to change. It may be quite clear to you that he is only promising to change to manipulate her into staying with him. Gently challenge the credibility of those promises and help her evaluate the pros and cons – both for her safety and for her emotional well-being – of continuing to put her faith in them.

It is not uncommon, of course, to see similar behaviors in women who are not victims of domestic violence, but who have been abused earlier in their lives (or have simply internalized the most negative aspects of female socialization). This helps to underscore the importance of routine domestic violence screening with all female clients, not only adult, married women, but also:

- Adolescents—The rate of relationship violence against adolescent girls appears to be about one in five.[3]
- Elderly women—some older men abuse their partners and have done so for many years.
- Lesbians—Women with female partners may be abused about as often as heterosexual women.[4]

Clinicians should take particular care in screening women with symptoms of traumatic brain injury or mental illness, which often overlap with those of abuse and may have resulted from it.

To avoid endangering the victim further, screening should always be done in private, not when both partners are present. Women whose language the therapist does not speak – including deaf women – should only be asked about **domestic violence through an interpreter who is not a member of their immediate** community and has no connection with their partner. This would help to minimize the possibility of information about her disclosure leaking back to the abuser.

Domestic violence screening should also be routine with all clients requesting couple counseling. The clinician who identifies domestic violence in a couple should refuse to provide couple or family counseling, both of which imply that the abuse is somehow the victim's fault and may endanger her. If the abuser has not acknowledged his behavior, the clinician should find a reason unrelated to domestic violence to give him for that refusal.

Most victims actively seek alternatives to living with violence. However, they often realistically conclude that safety strategies, which have failed or led to increased violence in the past are unlikely to be useful in the future. It is important to understand the client's reasons for using or rejecting specific strategies and to assume that her choices do not simply reflect poor judgment. If a woman once called the police and they arrested her, she is unlikely to want to do so again. And if she is an immigrant, a woman of color or a lesbian, the experience of her community may have taught that it is better to avoid contact with the criminal justice system whenever possible. The clinician who simplistically assumes that calling the police or leaving an abusive partner is the right thing to do, without understanding what such an action means to the individual victim, is likely to make negative judgments about her that further discourage her.

Choices about whether to leave an abusive partner, and when and how to do so, have many realistic safety and economic consequences, including an increased risk that the victim and/or her children will be killed by the abuser when she attempts to leave. (Research shows that victims of intimate partner femicide are much more often separated or divorced than still living with their partner and that the immediate post-separation period is the most dangerous time).[5] The single most common mistake clinicians make is to assume that it is obvious that a victim of domestic violence should leave her partner, and the sooner the better, and to conclude that her "failure" to leave is evidence of irrational thinking, passivity or an underlying mental health problem or personality disorder. Contrary to popular belief, leaving does not guarantee safety, and it should never be seen as a cure-all. This is not to say that clinicians should never work with a battered woman to help enable her to leave if she wishes, but that getting her to leave should not be their goal unless it is her goal.

While both pre-existing mental illness and the common mental health effects of abuse – PTSD, depression, anxiety, chemical dependency – can make it more difficult to get free of an abusive partner, victims who choose to remain in the relationship generally do so for more practical reasons. Fear of how the abuser will respond to being left and lack of financial resources are the main considerations leading victims to remain in relationships with abusers. Other factors that can lead a battered woman to stay with her partner may include positive aspects of her relationship with him, financial security, the needs of her children, and a lack of alternative caregivers for children or elderly parents. If she herself is chronically ill or disabled, the abuser may also be her caregiver, and she may see no alternative. Finally, her own feelings of guilt about leaving and love for the partner she first knew may combine with difficulty finding and holding a job to make her vulnerable to her partner's attempts to manipulate her into staying with him. The last thing she needs is for a clinician to insist that leaving is the answer.

What should clinicians do?

- Assess whether therapeutic intervention is needed – don't assume that it is. In a given case, it may or may not be.
- Be familiar with local resources for victims, including domestic violence services, legal assistance, police intervention, orders of protection and other community resources.
- Make it your business to know the limitations of local laws and institutional practices (e.g. of police and the courts), so you can help prepare the victim for negative responses she may encounter.
- Collaborate with advocates who are working with her, while continuing to provide her with appropriate mental health services.
- Leave control in the victim's hands as much as possible and respect her autonomy. Respect her decisions even when you disagree with them.
- Remember that mental health treatment by itself will not solve the problem of domestic violence or enable the victim to solve it. Her access to resources and support, the responses of other service providers and authorities, and family and community attitudes toward her disclosure of abuse are likely to play a larger role than therapy in whether she successfully gets free.

Information can be obtained at any hour from the New York State Domestic Violence Hotline at 1-800-942-6906 (English) or 1-800-942-6908 (Spanish). In New York City, call 1-800-621-HOPE (English and Spanish). Domestic violence training for mental health professionals is available at no charge from the New York State Office for the Prevention of Domestic Violence: Contact Dr. Sue Parry at (518) 457-5958 or you may send an e-mail inquiry to sue.parry@opdv.state.ny.us

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Women Honored from page 22

with an audience of over 800 individuals. She is an emotional, courageous and inspirational speaker. She has been asked to speak at NYAPRS (the New York Association of Psychiatric Rehabilitation Services), and "Clinical Psychiatry" profiled her in their August edition on schizophrenia. Susan has become a role model for others suffering from mental illness, and provides hope to consumers that they, too, can have a good outcome to their devastating illness. She is a remarkable woman who is recognized not only for her contributions to the art world, but also for her individual perseverance and willingness to share her struggles to help others.

The First Presbyterian Church, located in Ossining, New York, opened its doors two years ago to members of the Jawonio Drop-in Center when they were looking for a new space to meet. The members, who are consumers of mental health services, were looking for a place that was aesthetically pleasing, that would allow them to have some feeling of ownership, and where they could feel safe and secure. Members say that church members and the Reverend Susan Pfeil go out of their way to offer assistance and provide real camaraderie. The consumers feel this is a positive environment, which fosters recovery and hope. There is no stigma or judgment put upon them, but rather, helping hands, listening ears and giving hearts. We are fortunate to have people in our community who are so willing to give.

Zanaro's Italian Restaurant in New Rochelle, before their grand opening in 2001, contacted the Job Placement and Retention Program at the Guidance Center to help them find four employees to provide cleaning and maintenance services. Currently, the general manager, Angelique Santana, oversees this program. Four years later, with the opening of the new White Plains restaurant, Zanaro's continues to hire vocational program participants to work in even more complex positions in the kitchen. Zanaro's is to be commended for their willingness to give consumers a chance to become productive members of the work force here in Westchester County. Consumers report an increase in their confidence and competency level as a result of their work experiences. Most important, they feel proud to be active members of our community. Congratulations are wished to all of the recipients of this year's awards.

Sanctuary from page 35

promote healing, we make distinctions between secrets, privacy, and confidentiality. Staff are clear with residents that there will be no secrets between staff and between staff and residents, but that all information is confidential and some is considered private. Confidentiality is strictly maintained as a firm boundary.

Conclusion

Implementation of Sanctuary at Genesis has been a gradual process over the course of three years. This pace is the result of the significant cultural change entailed in the model. Although full implementation is still in process, the basic concepts and philosophy of the model are now part of the language of the program and familiar to all staff.

The function of the shelter as a safe dwelling has expanded to become a living-learning environment for clients and for staff. The psychoeducational framework helps clients to recognize the impact of trauma on their current functioning, and to engage in a staged model for moving forward. The therapeutic milieu helps staff work collaboratively with increased effectiveness and respect for all members. The basic commitment to safety and nonviolence supports a community that offers experiences of individual and social healing from the effects of domestic violence. The transformation of Genesis into a Sanctuary therapeutic community continues, and is an ongoing process of "creating sanctuary."

Libbe H. Madsen is director of staff development for the Center for Trauma Program Innovation of Jewish Board of Family and Children's Services (JBFCS) and consultant to the JBFCS domestic violence shelters. Lisa V. Blitz is director of Genesis, a JBFCS domestic violence shelter. David McCorkle is the former assistant director of Genesis and current on-site Project Coordinator of Sanctuary at JBFCS residential treatment programs. Paula G. Panzer is Deputy Chief Psychiatrist of JBFCS.

Excerpted from an article which appeared in Psychiatric Quarterly, Vol. 74, No. 2, Summer 2003 (© 2003)

Clinical Trials from page 8

only state that they failed to supply evidence that Tiramisu in reality is effective. The failure to demonstrate a positive effect is not the same as evidence of a negative effect. This has to do with the way these standard experiments are conducted: the methods, strengths and weaknesses of these types of experiments are not usually apparent to a lay audience attempting an interpretation of its outcomes. Failure to find a positive drug effect can be influenced by hundreds of factors that may render a given experiment unable to make a definitive determination of the superiority of an investigational drug over placebo. Some of the more common reasons for a negative drug trial occurring for a "truly" effective pharmaceutical agent include: inclusion of incorrectly diagnosed patients, failure on the part of the patients to actually take the medicines with regularity, outcome measures not sensitive enough to demonstrate effectiveness, an unexpectedly elevated response to placebo, or too small a population of subjects to allow the computation of proper mathematical calculations.

As an analogy, imagine a zoologist wants to know if there are chipmunks in Central Park. Certainly if a chipmunk is found by whatever methods are employed, it establishes their presence in the park. However, a failure to find any chipmunks does not establish that none actually exist within the park. Perhaps the Central Park chipmunks are a nocturnal variety and remain underground during the day. The researcher may have hundreds of sub-investigators systematically searching the park, but if this is done only during daylight hours they might not find any, despite hundreds of chipmunks sleeping in subterranean burrows. Simply put, it becomes impossible to prove the negative, and for this reason special mathematical models have been developed for determining the likelihood of a new psychotropic agent being effective. For most submitted to the FDA for approval, the research relies on rejecting the "Null Hypothesis."

Such experiments generally start with an assumption or hypothesis. The hypothesis in our example of the testing of our new antidepressant Tiramisu is that there is essentially no difference in the overall effectiveness of placebo from Tiramisu. This is our Null Hypothesis. We will reject the Null Hypothesis only if, after conducting an appropriate experiment without any bias effecting Tiramisus potential superiority, we receive a compelling finding that would only occur by chance alone at an extremely low probability. For example in our study we will only accept a positive effect of Tiramisu on depression as compared to Placebo if it would only occur by chance alone 1 in 1000 times. Without getting into all the mathematics of these computations, which would be beyond the scope of this publication, let us say that among researchers these computations are absolutely agreed upon and not controversial in their usages. An analogy would be the flipping of a coin to determine if the coin was biased in some way towards coming up heads more than tails. If we flip the coin 4 times we might have a finding of a) 4 heads, b) 4 tails, c) 3 heads and 1 tail, d) 3 tails and 1 head, or e) 2 tails and 2 heads. We now flip the coin 4 times and receive 4 heads. As each flip has a 50% chance of being heads or tails (if unbiased), we know the chance of getting 4 heads in 4 consecutive flips is 1/2 x 1/2 x 1/2 x 1/2 = 1/16. Therefore, if our coin was unbiased, we would receive this finding only 1 in 16 times when we flip the coin 4 times. Would you then judge the coin to be biased in some way? I personally would feel that 1 in 16 times by chance is not so remote that I would deduce the coin to be biased. As such, we have a negative finding, and I do not reject the Null Hypothesis that the coin is not biased towards heads. Perhaps the coin really is biased, but we have an insufficient number of flips in our experiment to reach a compelling conclusion. If I now take the same coin and flip it 100 times and receive 100 heads and no tails I know that that outcome could occur by chance alone 1 in ½ to the 100th power (an astronomical number)! As a good scientist, I would feel that the Null Hypothesis—that the coin is not biased—can logically and easily be rejected. Something is different about that coin, which makes it behave that way.

In our development of Tiramisu as an antidepressant, I may conduct 5 separate studies of its effectiveness versus placebo. Each may have slightly different methods and populations from which they draw their patients. We take the generally recognized precautions not to introduce bias: random assignment of patients to receive either Tiramisu or placebo, and double-blind conditions on the part of the patients and researchers as to their not knowing which group they have been assigned. We find that in 3 studies the Tiramisu group did not do compellingly better (from a statistical point of view) than placebo. In fact, the analysis of these studies reveals that errors were made in correctly recruiting truly depressed patients, or there were too few patients included to made strong statistical conclusions, or that in one study (conducted in a prison) the subjects actually failed to take the medicines assigned to them. In the next two studies these errors are corrected, all bias is removed, and we find that in each separate study many more patients in the Tiramisu group get well compared to those in the placebo groups. In fact, in each study, such findings can occur only by chance at less than 1 in 1000 times. We have 3 negative studies and 2 positive studies. Remember that negative studies do not prove that a drug does not work; they merely fail to show that it does work. The analysis of the 5 studies taken in toto demonstrates overwhelming evidence of the effectiveness of Tiramisu compared to placebo!

Why is this important? Because several state and federal groups are requiring drug companies to have an open registry of negative as well as positive trials of their drugs under development. In every story we have read in the popular media or heard in the popular media that discusses such a registry the conclusion suggested is that negative drug trials demonstrate that a drug really does not work! It should be obvious that such a conclusion is absurd! We applaud the openness of all information regarding a drug's development to the public, but fear its obvious potential for misinterpretation. Should someone read that in the development of Paxil for treating childhood depression there were 2 studies that showed it to be vastly superior to placebo and 3 studies showing no difference from placebo, his conclusion should not be that the evidence is only so-so for it's effectiveness. In fact it is strong evidence that is overwhelmingly positive for treating childhood depression.

We must also keep in mind that, in many ways, clinical trials are quite different than naturalistic treatment. New treatments, which in clinical trials may seem to only have minimal effectiveness as compared to placebo, may be of great benefit when given to real patients not under the constraints of an experimental trial. In naturalistic treatment of actual patients in clinics, hospitals, and doctors' offices, the clinicians are not prohibited from combining that treatment with other treatments (medications or psychotherapy), nor in using only preset dosage levels, nor treating only for a limited and specified time. Therefore, the true effectiveness of any psychotropic agents canot be closely estimated by the results of clinical trials; still needed are data from everyday usage in naturalistic treatment settings.

Clinical drug trials are required to demonstrate two things: efficacy and safety. For the purposes of this article we are focusing only on issues of efficacy. We strongly support open disclosure of all issues regarding their safety, whether they come from negative or positive trials. Some large drug companies have been sued or fined for not disclosing the existence of negative studies in some of their literature given to doctors or patients, even though they have reported these findings to the FDA. A registry for examination of these negative trials will need to be created as an agreement between the pharmaceutical industry and the government to address this issue. Our fear is that more misinformation than information may be gleaned from such registries if interpreted incorrectly. We also know that strong forces exist in society working against psychiatric patients getting the best possible care for their often debilitating conditions. Hospital administrators, owners of managed care and insurance companies may deny the use (or payment for) potentially helpful medications based on their misinterpretation of the negative trial data. Also, some medications may be quite helpful for a subset of patients treated without showing statistically significant effectiveness for the population on the whole. There may be times when standard treatments all fail, when a physician may reasonably choose a treatment even when overall effectiveness for it has not been firmly established. Trial lawyers may try to use such information in scurrilous malpractice suits against doctors, making them reticent to use certain potentially helpful medications. The implications of such a registry are huge.

In conclusion, we believe it is in the interest of psychiatric patients, and those who care about them and for them, to have full disclosure regarding the effectiveness of the medicines they can use to treat their conditions, and which untreated might leave them with distress and disability. It is not in their best interest to have those who treat them, or even those who are their adversaries, to misinterpret the meaning of negative trials, or worse, to use that information against them. "Fiat Lux" *let there be light*.

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