MENTAL HEALTH NEWS™

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The Many Faces of Anxiety Disorders

National Institute of Mental Health, NIMH

Anxiety disorders are serious medical illnesses that affect approximately 19 million American adults.1 These disorders fill people's lives with overwhelming anxiety and fear. Unlike the relatively mild, brief anxiety caused by a stressful event such as a business presentation or a first date, anxiety disorders are chronic, relentless, and can grow progressively worse if not treated.

Effective treatments for anxiety disorders are available, and research is yielding new, improved therapies that can help most people with anxiety disorders lead productive, fulfilling lives. Each anxiety disorder has its own distinct features, but they are all bound together by the common theme of excessive, irrational fear and dread.

Panic Disorder

"It started 10 years ago, when I had just graduated from college and started a new job. I was sitting in a business seminar in a hotel and this thing came out of the blue. I felt like I was dying."

"For me, a panic attack is almost a violent experience. I feel disconnected from reality. I feel like I'm losing control in a very extreme way. My heart pounds really hard, I feel like I can't get my breath, and there's an overwhelming feeling that things are crashing in on me."

"In between attacks there is this dread and anxiety that it's going to happen again. I'm afraid to go back to places where I've had an attack. Unless I get help, there soon won't be anyplace where I can go and feel safe from panic."

People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike.

If you are having a panic attack, most likely your heart will pound and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. You may genuinely believe you're having a heart attack or losing your mind, or on the verge of death.

Panic attacks can occur at any time, even during sleep. An attack generally peaks within 10 minutes, but some symptoms may last much longer. Panic disorder affects about 2.4 million adult Americans[1] and is twice as common in

see The Many Faces on page 31

Working with Medications: What's an Anxiolytic?

By Richard H. McCarthy, MD, CM, PhD

Anxiety is a prominent feature of almost every psychiatric disorder. It is so common, that it is hard to think of a disorder where it does not show up. Moreover, almost every psychiatric medication can reduce anxiety. When a medication can dissipate or reduce anxiety it is typically referred to as an anxiolytic agent. Some medications can increase anxiety, and are therefore referred to as anxiogenic drugs. The most common anxiogenic agent that almost everyone is familiar with is caffeine. The anxiolytic agents that most people are familiar with are the benzodiazepines. This would include drugs such as diazepam (Valium®) and drugs that are related to it such as lorazepam (Ativan®), to name one of the most commonly used. Another well known and fairly popular anxiolytic agent is alprazolam (Xanax®). Most of these agents are addictive. Some, but not all, of these medications can also be somewhat sedating and are frequently used as sleeping pills. A non-benzodiazepine, non-addictive, non-sedating agent that has been developed to treat anxiety is buspirone (Buspar®). It does not act quickly, and typically needs to be taken consistently for a few weeks before it is fully effective.

Why are these medications addictive? It is really old fashioned conditioning. If I reward you for something that you do, you will probably do it more and/or do it more often. If I punish you for something you do, you probably will do less of it and/or do it less often. Likewise, if I remove something that is unpleasant when you do something, you are also more likely to do it more and do it more often. Similarly, if I remove a reward when you do something you are likely to do less of it and/or do it less often. I am sorry if this sounds confusing. An example might help. I go to work and I am paid to do so; that is one of the reasons why I work. If they tell me they will pay me more, I am more likely to go again and/or work harder. Similarly, if I were told that I could not get a raise but that I no longer had to do some of the unpleasant aspects of my job, I would still feel like I had been rewarded. However, if I went to work and was told I would be paid less, I might not show up again. Likewise, if I was told that I could no longer do those things that I enjoyed, but had to do everything that I found unpleasant, I would probably quit. Often we do things because "doing it" helps us to either feel better or to feel less bad.

Let's get back to the anxiolytics. The qualities that make these agents helpful are the same qualities that can cause problems. Most of these agents have a very rapid onset and bring about relief of anxiety very soon after they are taken. Unfortunately they can also wear off rather quickly as well. If whatever is causing the anxiety is still present, then the person will experience a return of anxiety as the drug wears off. Typically the person will then take more of the medication, with the resultant decrease in anxiety. It is in this way that the most addictive agents are those anxiolytic agents with a rapid onset, which bring about rapid relief and also wear off rapidly. In a funny way, the better they work and the more effective that they are in the short term, the more likely they are to be taken more often and the more likely the person is to get addicted.

As it happens, we are not limited to benzodiazepines. We have other drugs to treat anxiety. While anxiety is ubiquitous, it is so common in depressive illnesses that when hospitals set up clinics to treat anxiety, they usually do so in "Depression and Anxiety Clinics". Some of my colleagues would go so far as to say that if a person does not have anxiety, then they do not have depression.

see Anxiolytic on page 35

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Table of Contents

- *Please Visit our Websites*
- *Mental Health News: www.mhnews.org*
- *Salud Mental (Bilingual): www.mhnews-latino.org*
- *See Page 43 for Subscription and Advertising Information*
- *See Page 5 for our Upcoming Themes and Deadlines*

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From The Publisher

Mental Health: The Balance Beam We All Walk Every Day

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

Ira H. Minot, LMSW

You don't have to be a doctor or a research scientist to know that many things cause us to feel anxious. Since 9/11 we have come to more frequently think that ours, is a potentially dangerous and stress-filled world. Do we think about it every moment? Certainly not—but most of us would admit that present day uncertainties do lurk in the background shadows of our minds.

This issue of Mental Health News explores "The Many Faces of Anxiety Disorders," a major component in the landscape of psychiatric illness.

While we all feel varying "normal" levels of anxiety from time to time, for some people it becomes persistent, overwhelming and eventually debilitating. When anxiety begins to affect us on a daily basis and interferes with our lives we must classify this as an anxiety disorder.

One of my earliest memories of feeling anxious was in one particular math class I had in high school. I know that's a rather silly example, but to me, at the time, the situation seemed very problematic. Many children have anxieties about school, and in this one advanced math class, if you didn't know the answer to a math problem, the teacher always confronted students in the class which made everyone feel intimidated. But in all cases of anxiety, some people are affected by it—while others are not. I can recall feeling my usual carefree and happy spirit plummeting as I entered this class, and usually sat there with a knot in my stomach dreading that the teacher would call on me. Was this a genetic predisposition? This first brush with anxiety quickly faded and I went on to enjoy and successfully complete the rigors of college and graduate school.

Fifteen years later, however, I would be revisited by a much more frightening encounter with a rather serious anxiety attack. It followed several years of watching my mother loose a gallant battle with cancer—one example on the theme ("Managing Life Transitions") that we will address in in the Winter 2006 issue of Mental Health News.

As an adult, having my first panic attack was a terrifying and disorienting experience. It was (in my case) to be a precursor to a severe depression I developed some months later, and would have to battle this for many years to come. It is a subject I have talked about in many previous columns. Surviving that 10-year battle with depression, was the impetus for starting this publication and Mental Health News Education, Inc.

Asking someone who has had a severe panic attack to describe how it feels, would be as difficult as trying to understand what a blizzard is by examining a snowflake. I used to tell people that it felt like I was going to die.

In today's thinking about the root causes of clinical anxiety, new models have emerged over the last decade. It is now more widely accepted that the old "nature or nurture" models fail to completely explain psychiatric illness. Today's thinking relies more heavily on chemistry rather than upbringing. Genetic and pharmacological research are continually unlocking the mysteries of the brain. We have come to understand that there is a delicate balance of chemical transmitters and receptors in our brains, and that schizophrenia for example, is not the result of bad parenting.

Anxiety disorders are the most common psychiatric illness affecting adults today. Medications, cognitive-behavioral therapy and new innovations employing virtual reality technology are providing hope to people who are gripped by debilitating anxiety, phobias and posttraumatic stress disorder.

In my college days I studied clinical and behavioral psychology, anthropology and sociology. I found them to be fascinating subjects. The hundreds of lectures and textbooks, however, paled in comparison to actually being able to work directly with people who were in the midst of struggling with various forms of psychiatric illness in a psychiatric hospital. It was there, that I encountered everyday people who had just suffered a major breakdown. I saw firsthand the devastating results of their illness—an experience I will never forget.

On the inpatient units of that hospital, were patients of all ages, from all walks of life, and socioeconomic means. Some were admitted in states of frantic anxiety and hopelessness, while others were sullen and catatonic. Some displayed bizarre visual, motor and verbal repertoires. Hardly any were dangerous to others (but perhaps to themselves), while some were in such an unfortunate state of psychosis that they would unpredictably strike out at staff or other patients.

My experience of working at that hospital to help people with mental illness, and then having to survive my own battle with depression later in life, had a profound influence on my own way of thinking.

I realized that we all have the propensity to experience a temporary or a prolonged and severe psychiatric illness. In my own mind, I likened it to an image of a person attempting to walk along a balance beam—a fine line from which we can fall at any time in our life.

I have learned to adjust my life around my vulnerabilities and sensitivities. Perhaps you know what I mean? I now try to evaluate everything in my life for it's benefit or threat to my emotional balance and mental health. It's especially focused on avoiding toxic people and relationships in my life, and being very aware that losses and separations (which I learned were triggers for me) have to be carefully approached and resolved.

Don't ever let family, crises, jobs, relationships, or financial difficulties totally bring you down—your mental

health is too important. Keep your eye on walking that balance beam and surround yourself with good people who believe in you and want to help you reach your goals and dreams in life!!

I want to express my deep appreciation to everyone who helped us bring you this wonderful issue of Mental Health News. One of the primary goals of our organization is to provide ongoing and readily accessible education about the nature of mental illness and the resources available to you in your community. Please continue to write to me at mhnmail@aol.com. Let me know how we're doing and if you have any suggestions.

Have a Great Winter!!

Mental Health News Upcoming Themes & Deadlines

we invite your participation

Spring 2006 Issue
"Managing Mental Health Crises"
Deadline: February 1, 2006

Summer 2006 Issue
"Understanding Autism Spectrum Disorders"
Deadline: May 1, 2006

Fall 2006 Issue
"Psychological Dimensions of Physical Illness"
Deadline: August 1, 2006

Winter 2006 Issue
"Managing Life Transitions"
Deadline: November 1, 2006

Recent Innovations in the Treatment of Anxiety Disorders

Judith Cukor, PhD and JoAnn Difede, PhD, Program for Anxiety and Traumatic Stress Studies, Weill Medical College of Cornell University New York-Presbyterian Hospital

The integration of technology and medicine is creating exciting possibilities for psychiatry and the behavioral sciences. A particularly intriguing one is the marriage of virtual reality technology to established behavioral principles and interventions for the treatment of anxiety disorders. This article will describe the current standard of care as well as discuss these innovations and new pharmacologic studies.

While everyone experiences anxiety to some degree, for some individuals it is persistent, overwhelming and debilitating, affecting their lives on a daily basis. This type of worry is indicative of an anxiety disorder - the most common psychiatric illness affecting adults today. Several standard treatments have been shown to be effective in the treatment of anxiety disorders, including pharmacotherapy and different types of psychotherapy. Classes of anti-anxiety medications include benzodiazepines, beta-blockers and the medication buspirone from the class azipirones. Anti-depressant medications including selective serotonin reuptake inhibitor (SSRIs), tricyclics and monoamine oxidase inhibitors (MAOIs) may also be prescribed. Cognitive-behavioral therapy is commonly used to treat anxiety disorders through the modification of behaviors and unproductive thoughts that perpetuate anxiety. A key element of this treatment is exposure through which the patient confronts his fears.

One type of anxiety disorder is a specific phobia which is an excessive fear of an object which poses little danger. Standard behavioral treatment for phobias centers around exposure which involves approaching the feared stimulus. Ideally this exposure should be done in vivo, or in reality, so an individual with a fear of elevators would ride in one repeatedly. However, in vivo exposure may not always be practical; it would be expensive and time-consuming for an individual with a fear of flying to repeatedly take airplane flights. Furthermore, it would be difficult to employ a graded desensitization approach which entails approaching the feared stimulus in small steps; it is unlikely an individual would be able to board a plane and then get off or practice a take-off with no actual flying. Even when it is feasible to conduct the exposure in reality, a patient may be hesitant to do so because of his anxiety. In these cases, traditional treatment employs the use of imaginal exposure which requires the patient to close his eyes and imagine the feared stimulus. While this often succeeds in inducing an anxiety response, it relies on the imaginative capabilities of the individual.

In recent years, Virtual Reality (VR) technology has provided a tool to enhance treatment. Computer programs simulate different environments which give the patients the illusion that they have gone inside the 3-D virtual world. The set-up

Judith Cukor, PhD

JoAnn Difede, PhD

employs the use of a headset which responds to an individuals' head movements so that when he changes his head orientation the scenery changes. Headphones provide auditory accompaniment and often a platform may provide vibrations to increase the feeling of immersion in the environment. Numerous studies have documented that VR exposure therapy is an effective treatment for phobias including fear of heights, fear of flying, claustrophobia, and spider phobia.

Posttraumatic stress disorder (PTSD) is another type of anxiety disorder consisting of a pattern of symptoms that people may develop in the aftermath of overwhelming events involving threatened death or injury, such as military combat, personal assault, terrorist attack, natural disasters, or motor vehicle accidents. Individuals suffering from the disorder re-experience the traumatic event in a number of ways, remain alert to danger in the world and may attempt to cope using avoidance and numbing. Expert treatment guidelines for PTSD were published for the first time in 1999, recommending that cognitive-behavioral treatment with exposure therapy should be the primary therapy for PTSD.

For the exposure component of the therapy, most treatments employ imaginal exposure, in which the patient either listens to the therapist relating a vivid description of the traumatic event or the patient recounts the trauma memories himself in as detailed manner as possible repeatedly. Studies have demonstrated the effectiveness of exposure in treating Vietnam combat veterans, female victims of sexual assault and mixed trauma populations as well as survivors of terrorism.

Despite the established efficacy of exposure therapy, imaginal exposure presents a predicament for some patients: effective imaginal exposure requires that the patient tell his trauma to his therapist, over and over again; yet avoidance of reminders of the trauma is inherent in PTSD. Hence, most people with PTSD never seek treatment, some who seek treatment refuse to engage in the treatment, and others who express willingness are unable to engage their emotions or senses, retelling an emotionless tale, reflecting their numbness. Such patients often fail to improve. This is consistent with the studies that conclude that failure to engage emotionally predicts a poor treatment outcome.

Recent developments in virtual reality technologies have opened new vistas for the treatment of PTSD by offering patients who are unable to retell their experiences a computer-generated environment in which to encounter and master their trauma. Over the course of the exposure sessions, the patient progresses through a series of computer-generated sequences that gradually increase in intensity and detail at a pace the patient can tolerate. The virtual world is programmed so that the therapist can control what the patient experiences in the virtual world by touching pre-programmed keys on the keyboard. During the exposure segments, the therapist simultaneously views the virtual environments on a computer monitor, as the patient recounts his experience while viewing the virtual world.

VR graded exposure has been successfully applied in treatment of combat-related PTSD. Dr. Barbara Rothbaum and colleagues conducted VR treatment with a man who had served in Vietnam 26 years earlier and suffered from chronic PTSD and Major Depression. Over the course of treatment sessions he viewed a progressively detailed jungle scene and Huey helicopter scene accompanied by sound effects. The patient's clinician-rated level of PTSD dropped by 34% and his self-reported levels of PTSD decreased by 45% and these gains were maintained at six-month follow-up. The success of VR treatment for PTSD was reinforced by a study of 10 Vietnam veterans, who demonstrated a 15% to 67% decrease in PTSD at six-month follow up.

We published the first case report on the use of VR therapy to treat PTSD for individuals who witnessed the World Trade Center (WTC) attacks of September 11, 2001 which was followed by a pilot study conducted on 10 individuals. The WTC virtual environment was developed to allow for a graded hierarchical exposure to the sensory stimuli in the world. Over the course of the exposure sessions, the patient progressed through a series of 11 sequences that gradually increased in intensity from a plane silently flying past the WTC to the entire sequence of events of that day including planes crashing into both buildings and their subsequent collapses accompanied by sounds of explosions and screaming. The civilian patient had witnessed the attack from outside the buildings and had to run as the Towers collapsed. She was diagnosed with PTSD and a co-morbid depression and had been previously unable to engage in imaginal exposure therapy. After six VR sessions the patient showed a large reduction in both PTSD (90% reduction) symptoms and depression (83% reduction).

Further medical advances may enhance the effects of the virtual reality treatment with the administration of D-Cycloserine (DCS; Seromycin). DCS is an antibiotic that has been used in clinical trials over the last decade as a cognitive enhancer. It is a partial agonist at the N-methyl-D-aspartate (NMDA) receptor which is known to play an essential role in learning and memory.

In one recent study, Rothbaum and colleagues assessed the effect of D-Cycloserine (DCS) on outcome for individuals receiving VR treatment for acrophobia. They found that individuals who took a dose of DCS on the days of their VR exposure showed significantly more improvement and the improvement was evident earlier in treatment as compared to patients who did not take DCS, with 2 sessions being sufficient for the DCS group compared to 6 sessions for the controls. In our program at Weill Medical College, we are currently evaluating the effects of DCS on patients undergoing VR treatment for PTSD following the WTC attacks of 9/11/01.

Finally, propanolol, a beta blocker commonly used to treat cardiac problems, is opening up new possibilities in the treatment of PTSD. Both animal and human studies indicate that memory is enhanced by arousal or adrenergic stimulation and that memory for arousing stimuli is impaired if beta-adrenergic receptors are blocked during the time at which the memory is formed, or consolidated. Dr. Margaret Altemus at Weill Medical College of Cornell University in collaboration with Joseph LeDoux's laboratory at New York University is currently studying patients suffering from PTSD for any trauma. By having an individual take propranolol following a traumatic memory, they hope to interfere with the automatic association between the memory of the trauma and the hyperarousal symptoms and also to lessen the frequency of nightmares and flashbacks.

These exciting innovations may provide new possibilities for the estimated 19 million adults who are diagnosed with anxiety disorders. Some may be successful in helping individuals who have not responded to traditional treatments while others may engage patients who have heretofore refused to seek help. Indeed, they are indicative of a dynamic field that is expanding its horizons in the hope of offering relief to those who in need.

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MENTAL HEALTH NEWSDESK

New York's Institute for Community Living Receives National Award And Grants From SAMHSA and United Hospital Fund

Staff Writer
Mental Health News

On the heels of its 20th anniversary, the New York City-based Institute for Community Living (ICL) was presented the Thomas M. Wernert Award for Innovation in Community Behavioral Healthcare. The not-for-profit agency also received notification of two significant grants from United Hospital Fund and the Substance Abuse and Mental Health Services Administration (SAMHSA).

In receiving the Thomas M. Wernert Award For Innovation in Community Behavioral Healthcare, ICL President and CEO Peter C. Campanelli, PsyD stated: "This award is wonderful kudos from our peers—local mental hygiene directors from across the country who know what they value and why they value it. We at ICL are honored that they have selected us to be this year's recipient of the Thomas M. Wernert Award"

The Technical Assistance Collaborative (TAC) and the National Association of County Behavioral Health Directors (NACBHD) presented the $10,000 award to Dr. Campanelli during the NACBHD annual conference in Portland, Oregon, on October 21.

The incidence of mental illness and co-morbidity diseases is alarmingly on the rise. The United Hospital Fund has announced a $75,000 one-year grant to ICL for the agency to work with 90 consumers and 30 staff to research, develop protocols, test their effectiveness and, ultimately, create a self-care and care coordination 'tool kit' for adult clients and providers to combat

Peter C. Campanelli, PsyD

diabetes and co-occurring mental illness. The project will develop three protocols and two workshops, and will teach self-care techniques.

The wide prevalence of post-traumatic stress disorder (PTSD) and substance use disorder (SUD) among homeless, urban women with serious mental illness make engaging this population in services a difficult task. SAMHSA has awarded a five-year grant of $400,000 per year to ICL. This project will enable ICL, in collaboration with the Church Avenue Merchants Block Association (CAMBA), to pilot services to homeless women in CAMBA's 70-bed Park Slope, Brooklyn women's shelter.

The study will combine three promising or proven practices with established shelter and mental health services. These interventions are Critical Time Intervention, a time-limited case management approach that promotes client readiness for and obtaining permanent housing; Seeking Safety, an integrated group intervention for women with histories of trauma and SUD; and Wellness Self Management, a holistic approach to helping people understand, live with and manage their mental illness while living a healthy lifestyle.

ICL is a New York City-based non-profit agency that serves over 5,000 disabled adults, children and families each year through an array of services: residential options for adults and children that offer housing stability, including a unique family reunification program as an alternative to foster care; mental health and healthcare clinics offering evidence-based treatment and best practice approaches; and assertive community outreach and case management services to individuals with mental illness, mental retardation and/or developmental disabilities.

ICL has received national and state recognition, including: Eli Lilly awards for Clinical Medicine (2004) and Psychiatric Community Integration (1999); the American Psychiatric Association's Gold Award (2000) and Significant Achievement Award (1993); and Human Service Agency of the Year (2000) by the NYC Department of Mental Health and Mental Hygiene; and the Center for Mental Health Services' Homeless Program Branch exemplary program award (2003). ICL's mental health services are certified by the international accrediting body the Commission on the Accreditation of Rehabilitation Facilities (CARF).

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 and has served on the faculty of Pace University, Rutgers University and Metropolitan College of New York within their graduate training programs. He 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 President 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. He 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 specialty foci 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.

Mental Health News salutes the Institute for Community Living on its current awards in recognition of its dedication to serving the community and we are equally proud to have Dr. Campanelli serve on our own Board of Directors.

Groups Launch Web Site Dedicated to Medicare's New Prescription Drug Benefit

Important Central Resource for Physicians, Providers and Consumers

NAMI
Arlington, VA

Leading mental health organizations have joined together to create a central resource on Medicare's new prescription drug benefit. The new website, www.mentalhealthpartd.org, contains easy-to-understand, top-line information tailored specifically to psychiatrists and other physicians, providers at community health centers, and consumers and their families.

The goal of the Mental Health Part D collaboration is to provide synthesized information that will facilitate informed decision-making for providers and consumers as they choose new Medicare prescription drug plans.

The Medicare prescription drug benefit is especially important for persons with mental illnesses, many of whom are currently without drug coverage or who are receiving prescription drugs through Medicaid. In fact, more than half of people with Medicare under age 65 have mental health problems, almost 40 percent of individuals with both Medicare and Medicaid have a mental or cognitive disorder, and almost 20 percent of all people over age 55 experience specific mental disorders.

This site takes complex information and makes it easy to understand and implement, which will help people with mental illnesses successfully transition to the new benefit.

The Mental Health Part D website will be continually updated to include the latest on enrollment, costs (including low-income subsidies), prescription drug lists, and the appeals process. Notably, it will grow to include comparisons of prescription drug plan formularies to help physicians, providers, and consumers choose a plan to cover all or most of their medications, as well as an interactive tool to provide feedback and assistance on an individual's situation as the new prescription drug benefit begins on January 1, 2006.

Mental Health Part D partners include: the American Association of Community Psychiatrists, the American Psychiatric Association, the National Alliance on Mental Illness, the National Association of State Mental Health Program Directors, the National Council for Community Behavioral Healthcare, the National Mental Health Association, and Treatment Effectiveness Now.

Visit the Mental Health Part D website at www.mentalhealthpartd.org for more information.

MENTAL HEALTH NEWSDESK

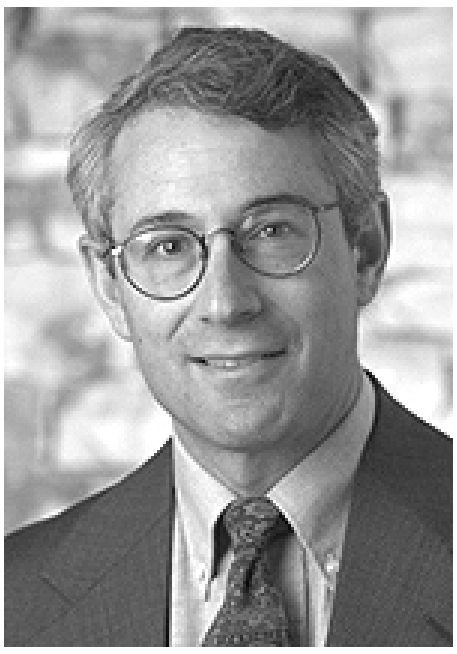
NIMH Study to Guide Treatment Choices for Schizophrenia

The National Institue of Mental Health (NIMH)

A large study funded by NIH's National Institute of Mental Health (NIMH) provides, for the first time, detailed information comparing the effectiveness and side effects of five medications -- both new and older medications -- that are currently used to treat people with schizophrenia.

Overall, the medications were comparably effective but were associated with high rates of discontinuation due to intolerable side effects or failure to adequately control symptoms. One new medication, olanzapine, was slightly better than the other drugs but also was associated with significant weight-gain and metabolic changes. Surprisingly, the older, less expensive medication used in the study generally performed as well as the newer medications. The study, which included more than 1,400 people, supplies important new information that will help doctors and patients choose the most appropriate medication according to the patients' individual needs. The study results are published in the September 22 issue of the "New England Journal of Medicine".

"The study has vital public health implications because it provides doctors and patients with much-needed information comparing medication treatment options," said NIMH Director Thomas R. Insel, M.D. "It is the largest, longest, and most comprehensive independent trial ever done to examine existing therapies for this disease."



Thomas R. Insel, MD

Schizophrenia, which affects 3.2 million Americans, is a chronic, recurrent mental illness, characterized by hallucinations, delusions, and disordered thinking. The medications used to treat the disorder are called antipsychotics. Previous studies have demonstrated that taking antipsychotic medication is far more effective than taking no medicine, and that taking it consistently is essential to the long-term treatment of this severe, disabling disorder. Although the medications alone are not sufficient to cure the disease, they are necessary to manage it.

In the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) trial, researchers directly compared an older medication (perphenazine), available since the 1950s, to four newer medications (olanzapine, quetiapine, risperidone, and ziprasidone), introduced in the 1990s. The purpose of the study was to learn whether there are differences among the newer medications and whether the newer medications hold significant advantages over the older medications; these newer medications known as atypical antipsychotics, cost roughly 10 times as much as the older medications.

The size and scope of the trial, with more than 1,400 participants at 57 sites around the country, its 18-month duration, and its inclusion of a wide range of patients in a variety of treatment settings ensure that the findings are reliable and relevant to the 3.2 million Americans suffering from schizophrenia.

At the beginning of the study, patients were randomly assigned to receive one of the five medications. Almost three quarters of patients switched from their first medication to a different medication. The patients started on olanzapine were less likely to be hospitalized for a psychotic relapse and tended to stay on the medication longer than patients taking other medications. However, patients on olanzapine also experienced substantially more weight gain and metabolic changes associated with an increased risk of diabetes than those study participants taking the other drugs.

Contrary to expectations, movement side effects (rigidity, stiff movements, tremor, and muscle restlessness) primarily associated with the older medications, were not seen more frequently with perphenazine (the drug used to represent the class of older medications) than with the newer drugs. The older medication was as well tolerated as the newer drugs and was equally effective as three of the newer medications. The advantages of olanzapine -- in symptom reduction and duration of treatment -- over the older medication were modest and must be weighed against the increased side effects of olanzapine.

Thus, taken as a whole, the newer medications have no substantial advantage over the older medication used in this study. An important issue still to be considered is individual differences in patient response to these drugs.

Several factors, such as adequacy of symptom relief, tolerability of side effects, and treatment cost influence a person's willingness and ability to stay on medication.

"There is considerable variation in the therapeutic and side effects of antipsychotic medications. Doctors and patients must carefully evaluate the tradeoffs between efficacy and side effects in choosing an appropriate medication. What works for one person may not work for another," said Jeffrey Lieberman, M.D., CATIE's Principal Investigator and Chair of The

see NIMH Study on page 28

Hofstra University to Host Exhibition by Artists With Mental Illness, Mental Retardation and Developmental Disabilities

Staff Writer
Mental Health News

The 17th Annual Art Expressions Exhibition, sponsored by the Nassau County Department of Mental Health, Mental Retardation and Developmental Disabilities, will be held at Hofstra University from February 28 - April 27, 2006. A compelling array of artwork, created by artists with mental illness, mental retardation, and developmental disabilities, who attend various programs in Nassau County, will be displayed.

On Friday March 24, 2006, at 10:30 AM, a special reception will be held, where each artist will be awarded a certificate of recognition from Nassau County.

In conjunction with the art exhibition, a "coffee house" will be held at Hofstra on Friday, April 21, 2006 from 6 - 9 p.m. The event features musicians, poets, and comedians who have disabilities.

Nassau Mental Health Commissioner Arlene Sanchez, pointed out that Art Expressions helps to combat the stigma normally associated with mental disabilities. She said, "Art Expressions has a long-standing tradition focusing on the creative talents of the artists, not their disabilities ."

John Javis, a program director from the Mental Health Association of Nassau County, chairs the Art Expressions 2006 Planning Committee. He commented, "In addition to being beautiful, the artwork also promotes healing from mental illness, mental retardation and developmental disabilities."

Mary Beth Jacovides, Associate Director, Campus Life Projects at Hofstra University indicated, "For two months, Art Expressions transforms the Business Development Center into a professional art gallery. It's an event that our students and faculty look forward to every year."

Arlene González-Sánchez

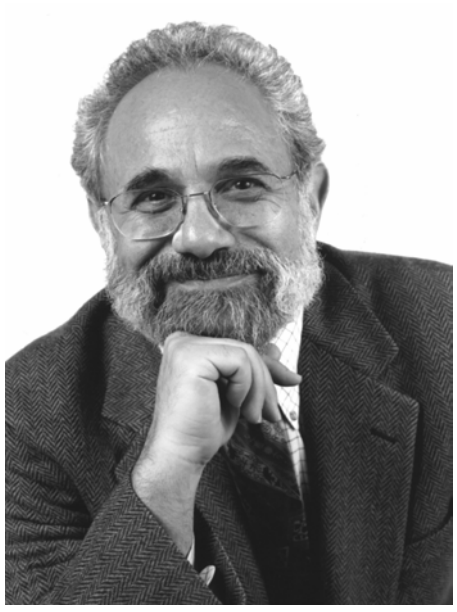
Art Expressions 2006 is open to the public free of charge. The show is housed in the second floor of the Hofstra University Axinn Library in the Scott Skodnek Business Development Center. For more information call John Javis of the MHA of Nassau at (516) 489-1120 Ext. 125 or Mary Beth Jacovides of Hofstra 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.

POINT OF VIEW

Averting Tragedies in The Transition From Medicaid to Medicare Coverage of Prescription Drugs

By Michael B. Friedman, LMSW



Michael B. Friedman

The Medicare Modernization Act, which establishes Medicare coverage of prescription drugs, becomes fully effective on January 1, 2006. Predictable problems with its introduction have begun to make headlines. What these stories rarely make clear is that it is only poor people—people who are eligible for Medicaid as well as Medicare—who are at risk of losing the drug coverage they already have.

For people on Medicare only, glitches could delay getting a new benefit. For people on Medicare and Medicaid—who currently have drug coverage through Medicaid—the glitches in the transition to Medicare coverage could result in tragedy.

This population has come to be called the "dual-eligibles". In New York State alone there are over 600,000 dual-eligibles. Roughly 200,000 of them have cognitive impairments, including long-term psychiatric disabilities. Nearly 100,000 of them are served by New York State's mental health system.

It is only poor people—people who are eligible for Medicaid as well as Medicare—who are at risk of losing the drug coverage they already have.

Here's a possible scenario. John Smith has been diagnosed with schizophrenia for 20 years. After a long period of psychological instability resulting in volatile living circumstances, he found a medication that works for him. For the past 10 years he has avoided acute psychotic episodes and has settled into a life that he finds satisfying. Currently Medicaid pays for his medication. This fall he gets a letter informing him that Medicare will cover his prescription drugs beginning January 1, 2006 and that he can choose a plan from a list he can find by calling Medicare. The letter also tells him that he can do nothing and that he will be auto-enrolled in a plan, which is named in the letter. Information about the plan's network of pharmacies, about the drugs the plan covers (its "formulary"), and about co-payments is provided. The letter tells him that, if he is dissatisfied with the plan to which he has been auto-assigned, he can compare that plan with ten or more other plans with below average costs and choose a different plan. To get information about these plans, the letter says, he can visit a website, call Medicare, call the State Health Insurance Assistance Program, or attend educational events in his community.

Mr. Smith is confused and does nothing. On January 2 he goes to the pharmacy he has been using for years only to be told that the pharmacy is not covered by his plan or that some of the drugs he takes are not covered or that there is a co-pay for each of the drugs he uses ranging from $1 to $3. He is already struggling to manage rent and other basic necessities on the income he gets from Social Security Disability. Co-pays are not in his budget. Obviously Mr. Smith may end up not getting his medication. His mental and/or physical condition might deteriorate. Indeed, he might have a recurrence of acute psychosis, undermining not only his mental state but also his living situation.

There are tens of thousands of John Smiths in New York State, and they are all at serious risk. Some may end up in hospitals and nursing homes; some may end up homeless on the streets; some may end up in jails or prisons; and some may die.

To avert tragedy there are two kinds of action that need to be taken—(1) federal and state policy changes and (2) massive consumer education.

Policy Changes Needed

Perhaps the simplest way to avoid the dreadful consequences glitches can have is to run a dual system for a transitional period. That would mean that for 6 months or a year, dual-eligibles who cannot get the Medicare coverage for which they are eligible would automatically continue to have Medicaid coverage.

Other policy decisions that would help include: Medicaid coverage of drugs not covered by Medicare, a 90-day supply of medications at the end of 2005, Medicaid coverage of co-payments, extension of New York State's EPIC program to people with disabilities, and so forth.

The good news is that both the federal and New York State governments are aware of the risks and have taken some steps to address them. For example, the federal government has ruled that all plans must include in their formularies "all or substantially all" anti-depressant, anti-psychotic, and anti-convulsant medications. It is not clear that all of the medications will actually be in the formularies, but the ruling is certainly a step in the right direction.

In addition, New York State has said that state Medicaid will cover all medically necessary prescription drugs available in New York State's Medicaid program if they are not covered by Medicare. We are not yet clear how complex the process will be or how long it will take for someone needing a medication not covered by Medicare to get it. But this too is certainly a step in the right direction.

Consumer Education

Whatever policy decisions are made, the transitional process is likely to be exceedingly difficult for people becoming eligible for Medicare coverage. Education regarding their choices and about how to actually get coverage is essential.

The Federal government has developed a variety of educational mechanisms including advertising and an interactive website. New York State has also been alert to the issues and has begun training aimed at ultimately helping people who are dually eligible make the choices they have to make and learn how to get coverage. For example, the NYS Office of Mental Health has already provided trainings in its five regions.

In addition, New York State's mental health providers and advocates have stepped up to take responsibility for helping people who use their services. The Coalition of Voluntary Mental Health Agencies in NYC has established a provider help line and published a guide. The Mental Health Association in NYS has organized education and training as has the Council of Community Behavioral Healthcare, the New York State Rehabilitation Association, and others. NAMI-NYS has also published a brief guide.

At the federal level, The National Mental Health Association in collaboration with several other national groups has developed a website for both providers and consumers.

All of these organizations understand that each person who is dually eligible will need to have individualized help to manage their transition from Medicaid to Medicare. And all of these trade associations are preparing their providers to sit down with each of their clients to figure out what is best.

It will not be easy. I have sat through several trainings now and always get confused and have unanswered questions. Mostly, I've come to understand that there will not be one plan that works for everyone because individual circumstances are so different.

For this reason, despite all the efforts by government, providers, and other groups, I remain nervous that a significant number of people will be left without drug coverage for a period of time. It brings back disturbing memories of the early 1970s when there was a transition from locally managed welfare benefits for people with disabilities to the federally managed SSI system. People lost their housing. People came to the program I worked in because they had no other source of food. People came too because they desperately needed advocates on their behalf.

There is a remarkable advocacy effort underway to avert the problems we can anticipate. I hope it will be enough. But I wouldn't bet on it.

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.

The Holidays Can Be A Difficult Time
When You Have A Mental Illness
Never Give Up—Tough Times Don't Last Forever
Your Mental Health Community
Has Many Programs And Support Groups That Can Help

The NARSAD Report

The National Alliance for Research on Schizophrenia and Depression

Anxiety Research: NARSAD Researchers Seek Causes and Improved Treatments

By Constance E. Lieber, President NARSAD

Constance E. Lieber

Anxiety disorders are among one of the most common psychiatric illnesses affecting both children and adults (approximately 19 million American adults). Several disorders fall into this category, including: Panic Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Phobias (including Social Phobia also known as Social Anxiety Disorder), and Generalized Anxiety Disorder. These disorders can result in extensive anxiety and fear for an individual, are chronic and may become worse if not treated. Anxiety can be exhibited by mood disturbances, and/or disturbances of thinking, behavior and physiological activity.

Currently, treatments may include medication and/or psychosocial therapies or some combination of these. Medications used to treat anxiety disorders may include Selective Serotonin Reuptake Inhibitors (SSRIs), tricyclic antidepressants, benzodiazepines, azipirones, beta blockers, and monoamine oxidase inhibitors (MAOIs). Psychosocial therapies may include psychotherapy, cognitive-behavioral therapies or behavioral therapies.

NARSAD researchers are exploring every facet of anxiety disorders in an attempt to unravel their complex nature and develop appropriate interventions. Research is aimed at discovering the origins and improved treatments, and may lead to important breakthroughs for early identification and improved outcomes.

Anxiety--What Happens in the Brain

Robert Sapolsky, Ph.D., (NARSAD 2004 Distinguished Investigator) of Stanford University, notes that the neurobiological aspects of anxiety are now becoming clearer, with attention focused on the effects of stress and trauma upon the amygdala, its role in mediating conditioned fear, and how repeated major stressors can increase amygdaloid activation of the autonomic nervous system. Specifically, this involves stress enhancing synaptic strength in the amygdala and causing amygdala neurons to form new dendritic branches. The stress effects seem to be mediated by glucocorticoids, the adrenal steroid hormones secreted during stress. Dr. Sapolsky is constructing stress-inducible vectors that will be introduced into the amygdala to express genes that will block amygdala hyperexcitation during a stressful event, or to block downstream steps that mediate the stress-induced increase in amygdala activation. He hopes to better understand fear and anxiety, as well as improve gene therapy for trauma and anxiety.

Jack Nitschke, Ph.D., (NARSAD 2005 Young Investigator) of University of Wisconsin, Madison, notes that anticipating aversion, danger, and other unpleasant circumstances helps prepare for and prevent negative outcomes. However, anticipatory overprocessing can be excessive in disorders such as anxiety and results in significant suffering. Dr. Nitschke has already identified several areas involved in anticipating negative events, including the amygdala, insula, prefrontal cortex, and anterior cingulate, which serve functions such as detecting threat and evaluating negative stimuli. He is investigating the neural correlates of the abnormalities in anticipation of negative events in people with social phobia, with results pointing the way to improved treatments for anxiety, while placing greater emphasis on problems with anticipation and the brain substrates involved.

Christopher Wright, M.D., Ph.D., (NARSAD 2004 Young Investigator) of Harvard University, is investigating yet another piece of the amygdala's involvement in anxiety. He is using functional magnetic resonance imaging (fMRI) to look at the effects of D-cycloserine (DCS), a partial activator of the excitatory glutamate receptor and a possibly useful pharmacological agent in the treatment of anxiety and other disorders, on the amygdala in normal subjects. He believes that administering DCS to the subjects while they are viewing fearful faces will result in a heightened decline of amygdala activity. He believes this will provide new insights into the effect of DCS on the human amygdala, as well as assessing specific drug effects on brain structures implicated in anxiety and other disorders.

Animal Models What They Teach Us about Anxiety

Mice are used as one of the favored models in research, as they are biologically and genetically similar to humans and their genetic material can be easily manipulated. Important information about specific disorders, such as anxiety, can be gained by utilizing mouse models.

Stephan Anagnostaras, Ph.D., (NARSAD 2003 Young Investigator) of Emory University, is using a mouse model to study genetic vulnerability in humans with anxiety disorders to understand the relationship among various behavioral measures of unlearned anxiety and conditioned fear at a mathematical level to develop indices for these two constructs that are more robust than current approaches.

Masato Asai, M.D., (NARSAD 2005 Young Investigator) of Children's Hospital, Boston, is using a mouse model to investigate the effects of corticotrophin-releasing hormone (CRH/CRF) in the brain which has been linked to anxiety-related behaviors in animals and humans. In mice genetically altered to have high CRH levels in tissues that normally make CRH, he will determine if CRH is elevated in areas of the brain thought to be associated with anxiety and if this causes the mice to have increased anxiety-like behaviors in non-stressed and stressed conditions. If his hypothesis proves correct, this may help explain different levels of anxiety in humans.

Hagit Cohen, Ph.D., (NARSAD 2003 Young Investigator) of Ben Gurion University, is using a rat model to investigate Post Traumatic Stress Disorder (PTSD), a chronic condition that occurs after life-threatening or horrific traumatic events. By investigating the behavior of animals that have already been exposed to a traumatic event, he hopes to distinguish and analyze the response of those that respond in an exaggerated manner to a similar event. He believes this mimics the posttraumatic stress response in humans, and will provide important information, including marked abnormalities in the endocrine system.

Obsessive Compulsive Disorder Identification, Genetics and Treatment

Obsessive Compulsive Disorder (OCD), classified as an anxiety disorder, usually begins in childhood or adolescence and affects up to 3 percent of people in their lifetime. It is characterized by anxious thoughts and/or rituals that a person feels powerless to control. Many people can identify with some of the symptoms of OCD, such as checking and re-checking to make certain that a door has been locked. However, the actual disorder is more pervasive, and often involves disturbing, repetitive thoughts, and/or rituals the individual may perform over and over again (though these provide only temporary relief of the anxious feelings). The following OCD studies provide an overview for the areas of research being conducted on all of the anxiety disorders. Scientists are exploring early identification techniques, genetic implications and new, advanced treatment options.

Edward Thomas Bullmore, Ph.D., (NARSAD 2004 Distinguished Investigator) of Addenbrookes Hospital, is using neuroimaging techniques on subjects with OCD to examine the cortico-striato-thalamic brain systems, and to develop brain imaging as a method of identifying endophenotypic markers (indicators of a specific disorder which must be measured, but cannot be seen by the naked eye) for improved identification purposes. Early identification and subsequent efficacious treatment are often associated with improved outcomes in many psychiatric disorders. OCD is believed to be genetic, and is associated with an abnormal brain circuit.

Paul Arnold, M.D., (NARSAD 2004 Young Investigator) of University of Toronto, has found genetic associations between certain genetic variants and OCD and is now using neuroimaging techniques to determine if brain circuit abnormalities that cause OCD are the result of inherited variations in genes affecting the action of the neurotransmitter glutamate. Increased knowledge of these circuits may lead to improved treatment strategies and early identification of OCD.

Vladimir Coric, M.D., (NARSAD 2003 Young Investigator) of Yale University, based on the information that current medications, such as serotonin-reuptake inhibitors (SRI's) or dopamine antagonists only provide some, but not full, symptom relief, believes that other neurochemical systems must be involved in OCD. Specific receptors called cannabinoid receptors are thought to directly alter glutamatergic function in individuals with OCD. He plans to use the pharmacological agent dronabinol to evaluate its efficacy in people with OCD who have not experienced amelioration of their symptoms with SRI's, providing valuable information for possible new treatment.

Conclusion

Anxiety disorders have been the focus of intense investigation, with the

see NARSAD on page 36

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

Finding Support For Anxiety Disorders: NAMI Cares

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

J. David Seay, JD

As I write this column, we have just completed NAMI-New York State's 23rd Annual Meeting and Educational Conference "Navigating in Rough Seas: Finding the Way to Recovery from Mental Illness." This involved more than 300 people hearing 65 speakers in 30 different sessions over a three day period. And it was capped-off by a Board of Directors and Officers election and a Board meeting! If ever I felt like an expert on anxiety, it is now. However, a diagnosis of anxiety disorder, which often includes panic disorders or panic attacks and phobias, is far more complex than the pressures felt by a NAMI executive director at such times. It is one of the most common, and fortunately, most treatable mental illness diagnoses.

Everyone feels anxious now and then. Anxiety prepares the body to meet challenges, dangers and unfamiliar situations. But there is a big difference between everyday anxiety and having an anxiety disorder. People with anxiety disorders feel overwhelming tension when there is no real danger or need to take extreme action to avoid the source of their anxiety. Anxiety disorders can severely disrupt a person's work, social and family life. But there's help – and hope – for people with anxiety disorders. We at NAMI-NYS are pleased that *Mental Health News* has chosen to highlight this form of mental illness in this issue and salute Ira Minot for shining the spotlight on it. Many people will be helped by the information provided in this issue on anxiety disorders.

I now shamelessly borrow from the national NAMI organization's website – www.nami.org – with the following information which I hope to be helpful to our readers:

What's happening?

- Imagine you've just stepped into an elevator and suddenly your heart races, your chest aches, you break out in a cold sweat and feel as if the elevator is about to crash to the ground. What's happening?

- Imagine you are driving home from the grocery store and suddenly things seem to be out of control. You feel hot flashes, things around you blur, you can't tell where you are, and you feel as if you're dying. What's happening?

What's happening is a panic attack, an uncontrollable panic response to ordinary, nonthreatening situations. Panic attacks are often an indication that a person has panic disorder.

What is panic disorder?

A person who experiences recurrent panic attacks, at least one of which leads to at least a month of increased anxiety or avoidant behavior, is said to have panic disorder. Panic disorder may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack.

Doctors often try to rule out every other possible alternative before diagnosing panic disorder. To be diagnosed as having panic disorder, a person must experience at least four of the following symptoms during a panic attack: sweating; hot or cold flashes; choking or smothering sensations; racing heart; labored breathing; trembling; chest pains; faintness; numbness; nausea; disorientation; or feelings of dying, losing control, or losing one's mind. Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours after experiencing a panic attack.

Panic attacks can occur in anyone. Chemical or hormonal imbalances, drugs or alcohol, stress, or other situational events can cause panic attacks, which are often mistaken for heart attacks, heart disease, or respiratory problems.

What are phobias?

Phobias are irrational, involuntary, and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object about which they feel phobic. A category of symptoms called phobic disorder falls within the broader field of anxiety disorders.

Phobias are divided into three types:

Specific (simple) phobia: an unreasonable fear of specific circumstances or objects, such as traffic jams or snakes.

Social phobia: extreme fear of looking foolish or stupid or unacceptable in public that causes people to avoid public occasions or areas.

Agoraphobia: an intense fear of feeling trapped in a situation, especially in public places, combined with an overwhelming fear of having a panic attack in unfamiliar surroundings. This word means, literally (in Greek), "fear of the marketplace."

Phobias are usually chronic (long-term), distressing disorders that keep people from ordinary activities and places. They can lead to other serious problems, such as depression. In fact, at least half of those who suffer with phobias and panic disorders also have depression. Alcoholism, loss of productivity, secretiveness, and feelings of shame and low self-esteem also occur with this illness. Some people are unable to go anywhere or do anything outside their homes without the help of others they trust.

What does it mean to "fear the fear"?

Many people with phobias or panic disorder "fear the fear," or worry about when the next attack is coming. The fear of more panic attacks can lead to a very limited life. People who have panic attacks often begin to avoid the things they think triggered the panic attack and then stop doing the things they used to do or the places they used to go.

Am I the only one?

It is estimated that 2 percent to 5 percent of Americans have panic disorder, so you are not alone if you, too have these symptoms. Usually panic disorder first strikes people in their early twenties. Severe stress, such as the death of a loved one, can bring on panic attacks.

A 1986 study by the National Institute of Mental Health showed that 5.1 percent to 12.5 percent of people surveyed had experienced phobias in the past six months. The study estimated that 24 million Americans will experience some phobias in their lifetimes.

Phobias are the leading psychiatric disorders among women of all ages. One survey showed that 4.9 percent of women and 1.8 percent of men have panic disorder, agoraphobia, or any other phobias.

What causes panic disorder?

No one really knows what causes panic disorder, but several ideas are being researched. Panic disorder seems to run in families, which suggests that it has at least some genetic basis. Some theories suggest that panic disorder is part of a more generalized anxiety in the people who have panic attacks or that severe separation anxiety can develop into panic disorder or phobias, most often agoraphobia.

Biological theories point to possible physical defects in a person's autonomic (or automatic) nervous system. General hypersensitivity in the nervous system, increased arousal, or a sudden chemical imbalance can trigger panic attacks. Caffeine, alcohol, and several other agents can also trigger these symptoms.

Is panic disorder treatable?

Recovery from panic disorder can be achieved either by taking medication or by cognitive behavioral therapy that is specific for panic disorder. Studies suggest that medication and cognitive behavioral therapy are about equally effective and the decision about which to take depends largely on the preference of the person with the panic disorder. Medication probably works a bit faster, but has more adverse side effects than cognitive behavioral therapy. Also, when successful treatment is finished, people who have had cognitive behavioral therapy tend to remain well longer than people who have taken medication. There is some evidence that the combination of cognitive behavioral therapy and medication may offer some benefits over either one alone.

Cognitive therapy is used to help people think and behave appropriately. Patients learn to make the feared object or situation less threatening as they are exposed to, and slowly get used to, whatever is so frightening to them. Family members and friends help a great deal in this process when they are supportive and encouraging

Medication is most effective when it is used as part of an overall treatment

see NAMI Cares on page 28

THE MENTAL HEALTH LAWYER

A Brief Overview of Legal Capacity

By Carolyn Reinach Wolf, Esq.

Carolyn Reinach Wolf, Esq.

Capacity is broadly used to describe a person's ability to act in a legal environment, as well as the level to which they are accountable or responsible for their actions. The meaning changes depending on the area of law to which it is applied, be it a criminal matter, contracts, elder law, family law, or healthcare law. In the criminal context, due process protects a mentally-ill defendant from being prosecuted if he or she is deemed unfit to stand trial (C.P.L. § 730) or from being held criminally responsible if he or she is deemed to suffer from a mental disease or defect such as he or she did not understand the nature of his or her actions. (C.P.L. § 220.15; § 330.20).

In civil matters, competency and capacity issues arise as to contracts (e.g. is the party capable of entering into, or suing pursuant to a contract), executing advance directives, such as a Healthcare Proxy, Living Will or Power of Attorney, in Guardianship proceedings under Article 81 of New York's Mental Hygiene Law, and in the various hearings for psychiatric patients conducted under Mental Hygiene Law Article 9, including retention and applications for treatment over objection. As such, different statutes will define capacity as it is applicable to that particular area of law.

Definitions to commonly used terms

• *Capacity in General:* Legal qualification by age or mental ability to understand the nature and effects of one's acts.

• *Criminal capacity:* Accountability or the requisite mental state to commit a crime (e.g. child under 7 years lacks criminal capacity);

• *Capacity defense:* Generic term to describe lack of fundamental ability to be accountable for actions, either civil or criminal. As a defense, it tends to negate some essential element of the action required for responsibility.

• *Competency:* In the law of evidence, the presence of those characteristics, or the absence of those disabilities, which render a witness legally fit and qualified to give testimony in a court of justice. A witness may be competent and yet give incredible testimony; he may be incompetent, and yet his evidence, if received, be perfectly credible. Competency is for the court; credibility is for the jury.

• *Competency to stand trial:* A person lacks competency to stand trial if he or she lacks capacity to understand the nature and object of the proceedings, to consult with counsel, and to assist in preparing his or her defense.

Informed Consent

Fundamental to medical care of any kind is the principle of informed consent. The physician is required to discuss with the patient the proposed treatment(s) or procedure(s) and include in his/her discussion the risks, benefits or alternatives to these. The issue of capacity arises in the context of the patient's ability to process and make an "informed" decision to consent. If the patient is deemed to have capacity (the presumption is that they have capacity unless deemed otherwise) then consent or refusal are obtained and the clinician proceeds, as appropriate. However, if it is determined that the patient lacks capacity then the provider must move on to other options, such as obtaining consent from the next of kin, a guardian, health-care proxy, or upon application to a Court for permission to proceed.

Informed consent is defined as follows: *It is a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits.*

The right to informed consent is preserved in the Public Health Law, which states that "every patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions."

Where capacity to consent or refuse medical or psychiatric treatment is in question, the Court must consider the constitutionally-based parameters outlined in Rivers v. Katz, a case heard by the Court of Appeals in 1986. In Rivers, the right of the patient to decide his or her course of treatment was balanced against the patient's best interest, as defined by a medical treatment provider. Success on the part of the treatment provider requires proof by clear and convincing evidence before a Court, thus preserving the due process and equal protection rights of the patient, as well as the community's right to see that a decompensated person is not dangerous to themselves or others.

Treatment Decisions for Psychiatric Patients

The rights of a psychiatric patient to refuse treatment, including but not limited to, psychiatric medication, electroconvulsive therapy, medical medications and/or procedures or treatments are articulated in Mental Hygiene Law Article 33 and by the Court of Appeals in Rivers v. Katz.

The Rivers Court stated that, *Indeed, there is considerable authority within the psychiatric community that from a medical point of view no relationship necessarily exists between the need for commitment and the capacity to make treatment decisions . . . since the presence of mental illness does not ipso facto warrant a finding of incompetency.*

As such, the state has the burden of proving, by clear and convincing evidence, that the patient lacks the capacity to make reasoned, competent treatment decisions, that the benefits of the proposed treatment outweigh the risks, that there are no less restrictive alternatives, and that the treatment is narrowly tailored so as to protect the patient's liberty interest. Id. at 498. The Rivers Court further notes that this

see Legal Capacity on page 35

The NYSPA Report

Dual Eligibles and The New Medicare Prescription Drug Benefit

Everything (And More) You Always Wanted (And Need) To Know

By Seth P. Stein, Esq. and Rachel A. Fernbach, Esq.

In 2003, Congress enacted the Medicare Prescription Drug Improvement and Modernization Act, which added a new prescription drug benefit to the Medicare program that will go into effect January 1, 2006. Previously, the Medicare program did not include a prescription drug benefit to cover the cost of prescription medications for persons enrolled in Medicare.

For most individuals who have Medicare coverage, the new Medicare prescription drug plan, called Medicare Part D, is an optional benefit program that Medicare beneficiaries can choose to enroll in (by paying an additional premium) or can reject (subject to potential financial penalties if they delay enrollment after they are eligible).

Unlike the Medicaid program, the Medicare Part D program will not simply pay pharmacies for prescriptions presented by individuals enrolled in the program. Instead, the actual operation of the plan will be handled by private prescription drug plans that have agreed to participate in the program. In each region of the country (New York State is its own region), there will be many drug plans competing for enrollment of Medicare beneficiaries. Under the new law, these private drug plans are permitted to have limited formularies (a list of the drug covered under the plan) and may impose prior authorization requirements and higher copays for higher cost medications. Drug plans can also offer higher premium plans with better benefits and lower out-of-pocket costs.

Although the program is optional for most Medicare beneficiaries, one group of beneficiaries are required to participate. This group for whom participation is mandatory are the "dual eligibles," those individuals who are covered by both Medicare and Medicaid. Typically, a person becomes a dual eligible because they are disabled and receive SSI or SSDI benefits and are also enrolled in their state Medicaid program. Under federal law, state Medicaid programs are permitted to enroll their Medicaid beneficiaries who are also receiving SSI or SSDI benefits in the federal Medicare program. Thus, these individuals become "dual eligibles," covered first by Medicare and then by Medicaid. Prior to enactment of the new Medicare Part D law, dual eligibles received their prescription drugs through the Medicaid program. However, when Congress enacted the new Medicare Part D law, it included provisions that ended Medicaid drug coverage for all dual eligibles and mandated that dual eligibles be enrolled in the Medicare Part D program in order to receive their prescription drugs.

This article will discuss some of the basics elements of the Part D prescription drug benefit and highlight how the program differs for the average Medicare beneficiary versus the average dual eligible individual.

Basic Benefit

For the typical Medicare beneficiary who becomes eligible when they retire and reach age 65, the standard Part D benefit is structured as follows:

- National average monthly premium: $32.20
- $250 annual deductible
- Medicare will pay for 75% of annual drug costs between $250 and $2,250
- The beneficiary will be responsible for 100% of annual drug costs between $2,250 and $5,100 (called the "coverage gap" or "doughnut hole")
- Medicare will pay for 95% of annual drug costs that exceed $5,100 (called "catastrophic coverage")

In contrast, full benefit dual eligibles ("full benefit dual eligibles" refers to individuals who are receiving SSI or SSDI and are enrolled in Medicare and Medicaid) will have no premiums or out-of-pocket deductibles and are not required to participate in any cost-sharing. Generally, these dual eligibles will be responsible for co-payments of either $1 for generics and $3 for brand-name drugs, but those who live in a nursing home or other long term care facility (in New York, an ICF/MR) will have no co-payment responsibilities at all. Dual eligibles living in a nursing home or an ICF/MR will have no copayment.

Other than these copayments, dual eligibles will have no deductible, cost sharing or coverage gaps. Currently, there is no plan for New York State Medicaid to pick up the cost of these copayments.

Optional Enrollment for Typical Medicare Beneficiaries

For the typical Medicare beneficiary, the Part D initial enrollment period begins November 15, 2005 and ends May 15, 2006. Starting in 2006 and each year thereafter, beneficiaries may only enroll or disenroll in a plan during the annual coordinated election period, which is November 15 - December 31 of each calendar year.

Mandatory Auto-Enrollment for Dual Eligibles

The typical dual eligible will be automatically enrolled by the Medicare administration in a Medicare drug plan in their area, effective January 1, 2006. Individuals who are dual eligibles should receive their notification of auto-enrollment between the end of October and November 15, 2006. In New York, for example, dual eligibles will be auto-enrolled in one of 15 "benchmark plans" that service the New York State region. A "benchmark" plan is defined as a plan whose monthly premium is at or below the average premium for plans in that region.

However, dual eligibles will be permitted to select a new plan if their auto-enrollment plan does not meet their prescription drug needs. Dual eligibles can change their plan once a month, if necessary.

Plan Selection

Medicare will use computers to randomly assign dual eligibles to benchmark drug plans that operate in their service area. As a result, many dual eligibles may be auto-assigned to plans that are not right for them and do not provide access to drugs they need. It is important for dual eligibles, their families, guardians and service providers to pay careful attention to the auto-assignment notification and take the proper steps to re-enroll the beneficiary in a more appropriate plan, if necessary.

Many of the plans offered by Part D will contain tiered formularies, which means that certain higher-tier drugs may be obtained only upon meeting certain conditions. Popular methods of differentiating between tiers are requirements for

see Medicare on page 40

Anxiety: Helping Your Child Overcome a Common Childhood Ailment

By Andrea Siegel, PhD
MHA of Westchester

Have you noticed sleep prob-lems, stomach aches, rest-lessness and concentration difficulties in your child? Does he worry a lot? Is she clingy and afraid of being left alone more so than other children her age? Does he refuse to go to school for no good reason? If any of these problems are excessive and they stop your child from making friends, learning in school, going places, or simply enjoying life as much as other children, take note: your child might be struggling with overwhelm-ing anxiety.

Anxiety can be disabling. In fact, unrecognized and untreated or under treated anxiety is associated with under-achievement, underem-ployment, substance abuse, and depression in adoles-cence and adulthood. Anxiety disorders constitute the most common mental health prob-lem in this country. In fact, 10-20% of youth in the U.S. struggle to overcome exces-sive anxiety. There are eight different types of diagnosable anxiety disorders. The three most common are Separation Anxiety Disorder (SAD), Social Phobia and Generalized Anxiety Disorder (GAD).

Separation Anxiety Disorder entails excessive anxiety over separation or anticipated sep-aration from home or family, with some or all of the follow-ing symptoms:

- Nightmares involving a separation theme
- Fear of being alone
- Refusal to go to school
- Worry about harm to come to self or family
- Stomach or headaches when separation occurs
- Difficulty falling asleep alone

Social Phobia entails nerv-ousness around, and avoid-ance of social or performance situations for fear of embar-rassment or social scrutiny.

Generalized Anxiety Disorder entails excessive worry and anxiety about a great number of things, along with restless-ness, difficulty concentrating, irritability, tension and muscle aches, and sleep problems. In children, the anxiety disor-ders described above often cluster together and they go along with other anxiety dis-orders such as:

- Obsessive Compulsive Disorder: with intrusive, upsetting, scary thoughts and rigid, repetitive behav-iors, such as arranging, washing, or eating things in a special order or a certain number of times before feeling satisfied.

- Post Traumatic Stress Disorder: an anxiety syn-drome that can develop after exposure to a traumatic event.

- Panic Disorder: bouts of sudden, extreme anxiety with hyperventilation, dizziness, and other physical symptoms that is sometimes associated with refusal to leave home for fear of panicking in public.

In the past 20 years, a tremen-dous amount of progress has been made in diagnosing and treating all types of childhood anxiety through a combination of medication and therapy. Medication is

see Child Anxiety on page 41

Perspective on Anxiety

By James R. Dolan, Jr., DSW, LCSW
Assistant to the Commissioner, Nassau County Department of Mental Health, Mental Retardation and Developmental Disabilities

As a young supervisor in the mental health field I was employed to oversee a program that provided mental health supports to the residents of an adult home. During that period, from time to time, we received tickets for our clients to attend cultural events in NYC. This was a positive experience for the clientele as they could experience a Broadway show, a Carnegie Hall performance or a ball game, for free. My staff would accompany the clients on these trips to assure that all went smoothly. On one of these occasions a bus load of clients and staff embarked on their trip and while in route, unfortunately, they got stuck in bumper to bumper traffic, and came to a standstill atop one of the bridges leading into Manhattan.

James R. Dolan, Jr., DSW

As bad luck would have it, at precisely the moment the bus came to a halt, one of the elderly clients had a heart attack. She reported chest pain and was having difficulty breathing and as one could imagine, this became a highly stressful experience for all involved. Fortunately the bus driver had the presence of mind to radio the depot for help and in turn the depot called for an ambulance. Eventually the police and the emergency crew weaved their way through traffic until they reached the bus. The client was still alive and they got her onto a stretcher and on her way to the hospital.

The next day I was approached by one of the staff who was present during the incident and she told me that she was angry with me on a matter related to the prior day's events. She explained that when the woman on the bus had the heart attack, someone handed her the client's pocketbook. The staff person went on to say that she was upset with me because I never informed her what to do if someone hands her a client's pocketbook in that kind of situation.

Initially, I did not know how best to respond to or what to make of the staff person's comments; but it soon became apparent that it revealed the extent to which the staff person had been overwhelmed by the experience. She was in a situation where an attempt to administer CPR would have been appropriate or efforts at managing the commotion in the bus would have been useful. Instead the staff person apparently felt unable to do either of these things; however, she needed to find a place to direct the energies that were fueled by her anxiety. Therefore, the pocketbook, an otherwise neutral stimulus, became the repository for her anxiety.

The staff person did not see herself as capable of intervening relative to the heart attack but she could tolerate the thought of what to do with a pocketbook. However, since her anxiety had been transferred to the pocketbook, her sense of incompetence carried over to the responsibility of keeping tabs on that item.

This story is instructive on various levels. It provides some insight into the psychodynamics of anxiety disorders and it underscores the benefits of skill

see Perspectives on page 41

The Mental Health News

New York City Section

Scrupulosity: Another Face of Obsessive Compulsive Disorder

By Mary Guardino
Founder and Executive Director
Freedom From Fear

It was 1987 when I first heard the term scrupulosity. A Catholic bishop, who was a close friend, asked for help for a parishioner in his parish. He knew of my work helping people with anxiety and depression. When he explained Mrs. Murphy's (fictitious name) story to me, I was amazed and extremely fascinated. Mrs. Murphy would call the bishop at all hours of the day and night asking forgiveness for a multitude of trivial acts. She wanted him to hear her confession and give her absolution for her "sins." The bishop explained that at this point she was calling every day. Her anxiety level was extremely high and he felt that she was severely depressed. She would report that she had sinned because she was not certain that she read all her prayers correctly in her daily prayer book. Each Sunday she would attend all six masses because she feared that if she had missed a word in her missalette as she followed the religious readings, she would commit a mortal sin because her obligation to attend Sunday mass would not be fulfilled. One time she called because she had found a dime in her front yard and felt this was stealing. The most bizarre was that she felt she had stolen the dust that belonged to the church because there was often dust on her coat from her many hours of kneeling in church to recite her prayers.

Mary Guardino

The bishop explained that Mrs. Murphy had "scruples", and asked for me to arrange for her to see a psychiatrist. At the time The New York State Psychiatric Institute was conducting research studies at Freedom From Fear. I called Michael Liebowitz MD who was in charge of the project and explained what I knew about Mrs. Murphy. Dr. Liebowitz was extremely interested in the case and said that he would be glad to personally see her.

Mrs. Murphy came with her son to the evaluation. I will never forget her or that first interview. Mrs. Murphy was a gentile and caring woman who was born in Ireland. She spoke with a brogue in a soft and gentile whisper. Her face showed the signs of extreme fatigue. Her hands were red and raw from the many hours she spent each day washing them. Her main concern was that she continuously feared she had committed a sin. Yet all the examples she gave were benign and meaningless.

Her son told the story of a mother who loved her seven children dearly but was no longer able to function because her life became captured by the fear of "not being forgiven for her sins." Most of her day was taken up by praying. At one point, her confessor in trying to help her, explained that her sins were all forgiven and that she need not come back to confession again. This offered no relief to this tortured soul.

Mrs. Murphy was caught in a world of doubting her fulfillment to the requests of her religion. When questioned about this she understood that it was foolish and God was a loving God, but she could not stop her thoughts of doubting that her sins were not forgiven.

During the evaluation Dr. Liebowitz explained that Mrs. Murphy had OCD, an anxiety disorder. The unwanted thoughts were obsessions that she could not control. Even though she would receive forgiveness from a priest, this would not bring relief because she would doubt that she explained the "sin" appropriately. When she prayed she was plagued by excruciating anxiety that her prayers were not said appropriately or that she had missed a word or became distracted. Some people with OCD, Dr. Leibowitz explained, had uncontrollable rituals like checking, or counting, others had terrible fears of germs and contamination. Mrs. Murphy's illness focused on her religious beliefs and they became repetitive anxiety provoking rituals. It was her OCD that drove her behaviors.

There was a new drug to be released shortly to the public and Dr. Liebowitz explained to Mrs. Murphy and her son that he believed that it would offer help to reduce her symptoms and to treat her severe depression. It was agreed that Mrs. Murphy would try this treatment.

see Scrupulosity on page 41

The Face of Agoraphobia

By Benjamin R. Sher, MA, LMSW
Director of Training and Staff Development
Institute for Community Living

Agoraphobia is an Anxiety Disorder that affects many Americans. According to the National Institute for Mental Health (2004), approximately 3.2 million adults, ages 18 to 54 (or 2.2% of the population), have agoraphobia. The disorder's symptoms can be troubling, as that they can affect an individual's occupational, personal, social, and economic experiences. This article attempts to shed light on this national problem.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ([DSM-IV], 1994), agoraphobia is the avoidance or anxiety related to open spaces or any place outside of one's home or safe zone. According to the DSM-IV, agoraphobia is not diagnosed by itself. There are two disorders in the DSM-IV related to agoraphobia; Panic Disorder with Agoraphobia (300.21) and Agoraphobia Without History of Panic Disorder (300.22). The latter disorder would be characterized by avoidance or anxiety of open spaces or going beyond one's "personal safety zone" and the development of "panic-like" symptoms; whereas, the former diagnosis would include panic attacks as part of the problem. Panic attacks are described as a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms develop abruptly and reach a peak within 10 minutes:

- Palpitations, pounding heart, or ac celerated heart rate,
- Sweating,
- Trembling or shaking,
- Sensations of shortness of breath or smothering,
- Feeling of choking,
- Chest pain or discomfort,
- Nausea or abdominal stress,
- Feeling dizzy, unsteady, light headed, or faint,
- Derealization (feeling unreal) or depersonalization (feeling detached from oneself),
- Fear of losing control or going crazy,
- Fear of dying,
- Paresthesias (numbness or tingling sensations); or,
- Chills or hot flushes.

These panic attacks will follow the anxiety related to the agoraphobia. For example, if the agoraphobic must travel, they may exhibit much distress or anxiety about having a panic attack or panic-like symptoms while traveling. As with all anxiety disorders, an underlying medical condition must be ruled out, as well as evidence that the disturbance is not due to the direct physiological effect of a substance, such as a drug of abuse. If an associated medical condition is present, the fear of developing agoraphobic symptoms is in excess of that usually associated with the condition.

Clearly, agoraphobia can be a crippling problem for the person who experiences the phobia. What many people take for granted, for example, riding in a bus, train, or automobile; being in a crowd; going to work; standing in line; being on a bridge; or being outside of the home alone, would cause sheer terror to an agoraphobic. According to *healthy-space.com* (accessed 10/30/05), the old "doctor's house call" may be required for an agoraphobic, as that the person with the disorder is too fearful to leave their own home for treatment or medical advice.

The causative factors of agoraphobia can be both environmental and biological. With some individuals diagnosed with agoraphobia, their fear of open spaces or going beyond a comfort zone can be linked to a specific triggering event. These events usually have a traumatic element to them, and include such things as loss, death, accidents, rape, fire, torture, or witness to a violent event. Individuals that experience agoraphobia with or without panic disorder may have a genetic or biological predisposition to experience anxiety in an alternate manner, and this coupled with the traumatic stimulus may exacerbate the problem.

All human beings respond to stressful and fearful events in a similar fashion – the "Fight or Flight" response. This biochemical reaction in our bodies prepares us to deal with the stressful or fear-provoking event. For example, our focus becomes sharper, we experience a rush of adrenalin, and our reaction time becomes shorter. We may also have increased speed and strength, as well as the release of a number of hormones that stimulate our fear response system in both a good and bad way. For people with agoraphobia, this "Fight or Flight" system may work into overdrive, or fail to discriminate between truly fearful and stressful-stimulating events, and those that might cause a more "normal" reaction.

Cognition may also play a role in the triggering of agoraphobia. Individuals with agoraphobia may experience a traumatic triggering event that would cause anyone to react in a self-protective function. After the event, it is a natural response to isolate oneself, to feel emotionally "wrung out", and to review the event in one's mind. Through time, support, and personal resiliency, the traumatic event may lose some of its stimulus intensity for a person. For a person predisposed to anxiety disorders or agoraphobia, this may never become the case. The event may never lose its "stimulus-intensity" for the person. This would mean that for any event similar to the trauma, the person would biologically, biochemically, physiologically, and cognitively respond *as if every* event is the triggering event. For example, an agoraphobic who has been raped in a public space may begin to emotionally and biologically react to every public space as if it is the place where the rape took place. Cognitions about the event may become, "I was raped in a public space. Public spaces are bad. Therefore I must avoid public spaces." These cognitions, coupled with an over-stimulated "fight or flight" response may deter the individual from feeling safe enough to leave their home or comfort zone.

Of course, this is a rather simplistic description of the causative factors involved in agoraphobia. The resulting behaviors of fear and anxiety related to open spaces and moving beyond personal safety zones may build up over time. It may not be a rapid change in the person, where one day they are engaging in activities in the community and the next day they are a shut in. The person with agoraphobia may begin to change over time; they may be comfortable taking their everyday route to work, but will no longer deviate from that route and return straight home afterwards.

According to *MedicineNet.com* (retrieved 10/31/05), other biological and genetic factors involved in the causes of agoraphobia include the following. There may be a genetic predisposition for panic disorder, as that twin studies have demonstrated that it is more common in identical rather than fraternal twins. People with agoraphobia are found to have increased activity in the areas of the brain that monitor internal and external stimuli, as well as increased activity in the nervous system that regulate such things as heart rate and body temperature. Here it is unclear whether these increases reflect the anxiety symptoms or if they cause them.

Another group of studies suggest that people with panic disorder or agoraphobia may have abnormalities in their benzodiazepine receptors, which are brain components that react with anxiety-reducing substances. Other things may be stimulus events for people with panic disorder. These include an excessive amount of sodium lactate in the body; excess amounts of caffeine, or hyperventilation leading to unusual amounts of carbon dioxide in the body may trigger panic attacks.

Because these provocations do not trigger panic attacks in people who do not have panic disorder, scientists have made the conclusion that people who have panic disorder are biologically different than those who do not. It is also true that when people with panic attacks are told in advance about the sensations these provocations will cause, they are much less likely to panic. Therefore, this leads scientists to believe that there is a strong psychological and cognitive component to agoraphobia and panic disorder.

Animal studies have led to similar conclusions. For example, the inbreeding of pointer dogs with extreme abnormal fearfulness have been compared to a normal breed of pointer dogs when exposed to high levels of caffeine. The inbred line reacts with greater fear and anxiety, and was found to have more adenosine receptors in their brains. Adenosine is a naturally occurring sedative found in the brain. Macaque monkeys have also been studied. When infused with lactate, some macaques respond with anxiety-like symptoms similar to humans. This study is attempting to break down the differences between the brains of the responsive and non-responsive monkeys. Lastly, research with rats is exploring the effect of various medications on parts of the brain involved in anxiety. The aim is to obtain a clearer picture of which components of the brain are responsive for anxiety, and to learn how the brain's actions can be brought under control.

Because of the strong psychological and cognitive link to agoraphobia, treatment with a cognitive-behavioral focus has proven successful. Initially, the agoraphobic may have to be treated in their home or safe environment. Here, the person may learn some stress reduction and cognitive restructuring activities, such as deep breathing, muscle relaxation, or visualization. The goal of these techniques is to help the individual develop a relaxed state where they can begin to address the fearful or anxiety-provoking stimulus. Other techniques used here include biofeedback or talk therapy.

When the individual feels ready, they may begin to use a cognitive-behavioral technique called systematic desensitization, or exposure therapy, to confront their fears and to leave their home or comfort zone. The goal of exposure therapy is to build on the stress reduction and cognitive restructuring activities that the individual has learned and have them try some "in vivo" (or live) experiences where they feel fearful, anxious, or have a panic attack. For example, the agoraphobic may be fearful of shopping in a crowded supermarket. The aim of exposure therapy may be to help the individual to first relax, and then visualize entering the supermarket in this relaxed state, and then to work on each step of the experience, noticing when the person becomes anxious and fearful, and how to return them to a relaxed state. Exposure therapy may start with the person using imagery in a treatment session to imagine the stimulus event, but always ends with the person actually being exposed to the stimulus event (such as going shopping). Individuals that commit themselves to positive cognitive self-talk, stress reduction activities, and exposure therapy have been found to do very well in reducing their agoraphobia or panic attacks.

Medication may also be used as a partner to cognitive-behavioral therapy in the treatment of agoraphobia. According to *MedicineNet.com* (accessed on 11/01/05), three medications are used; two classes of anti-depressants, and the highly effective anxiety-reducers, the benzodiazepines.

see Agoraphobia on page 40

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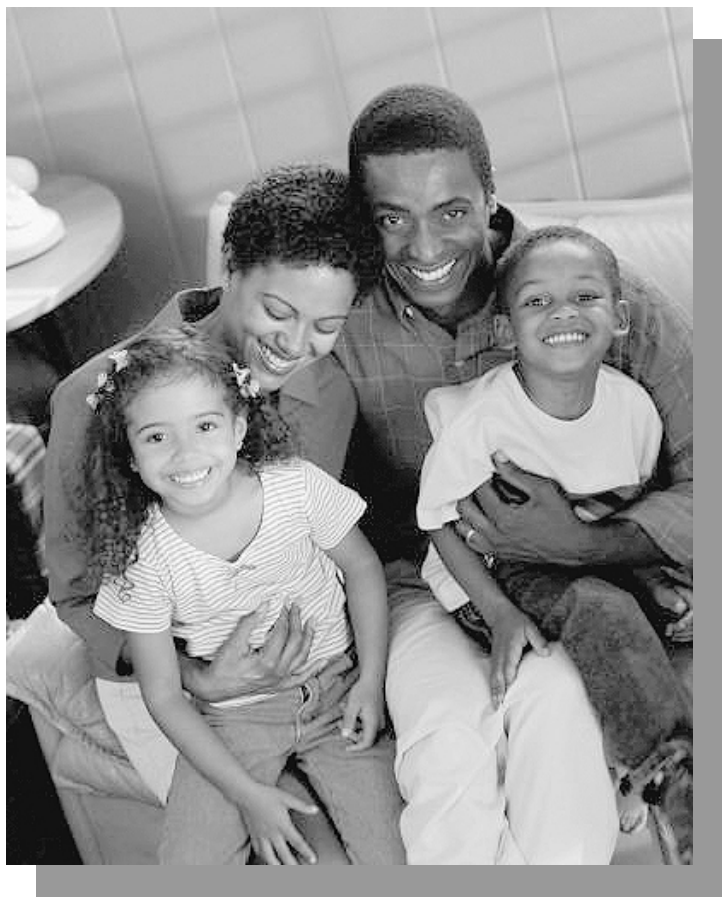

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Traveling Route 66: The Mother Road

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

Giselle Stolper

Some readers may be old enough to remember the adventures of George Maharis and Martin Milner as they traveled the "Mother Road" on the popular sixties TV show, "Route 66." If you did, maybe you shared my fantasy of following the tire tracks burned into the highway by their speeding red and white Corvette. This summer, I had the opportunity to turn my forty-year old dream into reality, driving with my daughter, Nicole, along the historic road from California to her dorm room in Chicago. What's more, I realized a dream that for years I dared not even think about – my daughter going off to college.

It was on Day Two of our road trip that I knew Nicole and I had entered a new chapter of our life together. Prepared with maps and books which directed us to the many historic markers, natural wonders, and "kitchy" landmarks we were about to see, we left early one morning, said good-bye to the Pacific and turned the car eastbound to begin what we both felt would be a once in a lifetime adventure. I also need to introduce our third traveler, Dapper Dan, Nicole's cat who joined us in this bonding experience.

The drive so far had taken us through the Mojave Desert and the aptly named Death Valley, where any sign of life reflected a life from long ago. Abandoned trailers and wrecked cars lay along the road. Grey, dusty ghost towns stood empty and silent as we drove through, all under bright sun and temperatures in triple digits. We followed the occasional faded white Route 66 emblem painted on the roadway, driving hundreds of miles through the barren desert without seeing another car or living soul.

Finally leaving the desert at Needles, California, we crossed into Arizona at dusk, celebrating our arrival with our first taste of homemade beef jerky – a delicacy that's hard to come by at Dean & DeLuca in Soho. Here we were, New Yorkers entering a time and culture warp. As we began to climb the awesome red rock mesas of the Arizona desert to our destination, an old western mining town, we thrilled at the frightening hairpin turns and rocky road conditions with hills so steep we dared not look too closely at the cars that lay wrecked at the bottom as we ascended from the desert to a mountain peak of 3,500 ft.

Life hasn't been easy for Nicole. She has struggled with bipolar disorder and learning disabilities since the age of 12. If you had told me at the time when she was first diagnosed that seven years later I would be driving with Nicole on her trip to college, in her car, visiting the breathtaking natural wonders of the Southwest and odd attractions that mark Route 66, I would have never believed you.

"Life turns on a dime" is an expression we all have heard when someone is confronted with a life-threatening or life-altering illness, whether it be yourself or a loved one. When you are a parent and your young child is diagnosed with an illness, one that will no doubt change the course of her life and alter your dreams, the impact is devastating. Denial, guilt, grief and loss plague every waking moment. The quest to understand and hopefully conquer becomes an obsession. Eventually, realizing that this illness can't be conquered and that life will be different for everyone, you reach a level of acceptance. Yet even with acceptance, hope never dies.

Nicole struggled for years to find her own level of comfort with the disorder, to recognize the symptoms and their cyclical nature, and come to terms with some of the adjustments she had to make in terms of school and friends. My husband and I, and our younger son, Steven, faced our own struggles and challenges. One of the first was in finding a psychiatrist who understood childhood bipolar disorder and was expert in the latest medications and treatment approaches. Not that easy to come by, even in New York City. It often takes years to arrive at the right diagnosis. We were lucky in that in Nicole's case, arriving at the diagnosis wasn't difficult. A family history quickly pointed the way: my own mother suffered from this same illness.

Yet, arriving at the right medications, therapeutic interventions and appropriate school setting, proved to be more difficult than I would have ever anticipated. Here I was, a mental health advocate in this City for years, having such a hard time negotiating the school system and finding the best psychiatric treatment providers for our daughter. How, I wondered, did parents without the knowledge or the resources, deal with these challenges? How were they able to get the best help available for their children? It's a question that I still ponder.

Yes, life changed drastically for all of us over the course of Nicole's illness. Our friends disappeared, as did hers. We recalibrated our dreams and aspirations. Hospitalization, residential treatment replaced high school. Graduation, no longer a given. College, a distant glimmer in the future.

There is no secret for success to bringing a child around to recovery. You already know this story arrives at a happy ending, but I cannot point to a single medication, doctor, type of treatment or school that helped Nicole arrive where she is today – in college, making friends, probably staying up too late, learning to balance her schoolwork and her personal life. I can only say that much of it rests on her own shoulders and resilience, to weather the stormy years. As parents, we can only provide a roadmap to follow, along with undying support – and then strap in for the roller coaster ride which will no doubt follow.

Along Route 66, aptly named the "Mother Road" Nicole, Dapper Dan and I followed our own roadmap begun seven years ago. This time it took us through the natural wonders of the Grand Canyon and Painted Desert, past cowboys on horseback, through the galleries of Santa Fe, the Leaning Water Tower of Texas, across the Continental Divide and into the mouth of the abandoned Blue Whale amusement park in Missouri. We cheered at each of the borders of the eight states we crossed, into, and again as we stood under the Great Arch in St. Louis. The tears we shed were out of happiness this time, and the difficult years are but distant memories.

As we approached Chicago, we left Route 66 and joined the other thousands of cars on the four-lane highway from Springfield. It was back to reality, back to the grind. Once again we were mere commuters, no longer tourists.

If we had taken the interstate, we would have arrived in Chicago in half the time. No hairpin turns, no frightening descents, no bumpy roads, no ghost towns. But Nicole insisted we take Route 66 from beginning to end, with its wild, gorgeous, and occasionally quirky sites we met with delight and surprise. I guess you could say she has been taking Route 66 all along.

When a child or loved one is diagnosed with a mental illness, it is difficult to know where to turn for information or support. When I meet parents now who are facing similar crises to what I experienced seven years ago, I recommend they start by calling 1-800-LIFENET, the Mental Health Association of New York City's 24/7 multi-lingual mental health crisis, information and referral hotline. Our referral specialists, all licensed professionals, can help parents and other individuals get the assistance they need to find the best care possible. LifeNet also operates hotlines in Spanish, 1-877-AYUDESE and in Chinese, Asian LifeNet, 1-877-990-8585.

A Story of Courage and Hope

By Naomi Cutner, LCSW, Senior Social Worker, Harry Blumenfeld Counseling Center, Jewish Board of Family and Children's Services

At the Jewish Board of Family and Children's Services 12 Community Counseling Centers, anxiety and depression represent the two most common presenting problems. With the increasing awareness of anxiety as a real and agonizing condition, there is less stigma associated with getting help for this condition. Cognitive behavioral techniques and certain medications have been found to be very effective in treating anxiety disorders. A current case at the JBFCS Pelham Center sheds light on the challenges and opportunities involved in treating these disorders.

Francesca came to the Jewish Board of Family and Children's Services Pelham Counseling Center for treatment of her frequent panic attacks and depressive symptoms. At the outset, her situation involved family discord, abandonment and dislocation; it would later emerge that she had experienced catastrophic loss and abuse. Her treatment included an extended period of stabilization and strength-building and would later move into the narration of her traumatic experiences. Francesca's case demonstrates the importance of building trust between therapist and patient. This trust gives the patient the ability to eventually recognize and manage her symptoms and to understand those symptoms in the context of family relationships and significant past experiences.

When Francesca first came to the Jewish Board of Family and Children's Services, she was having severe panic attacks almost every day with heart palpitations, difficulty breathing, lightheadedness and tingling in her hands. Many times these panic attacks resulted in a call to 911 and a visit to the emergency room. Overwhelming anxiety caused Francesca to separate from her husband, though they remain close. Francesca was no longer able to take care of herself and was relying on her daughter to shop for her, take her to appointments and respond to her frequent emotional crises. Anxiety had taken control of Francesca's life.

Born in Italy, Francesca came to the United States when she was a child with her parents and siblings. She reported that she had been depressed and anxious much of her life. Francesca's presentation was complicated by her depressive symptoms. She had physical problems, which included knee pain and swelling in her legs. It would later emerge that when most anxious, she feared she had a major illness, though these worries were unfounded. Francesca had been taking Paxil and Xanax for many years, as prescribed by her doctor, but her anxiety symptoms continued to get worse. Her doctor recommended that she see a therapist.

At the beginning of therapy, Francesca told me about her family, her childhood and her health problems. She said that she had never understood her mother's coldness. Francesca adored her father, but he was passive and unable to influence his wife. He even limited his visits with Francesca for fear of his wife's reaction.

As Francesca told her story, it seemed as though there were some missing pieces. Perhaps she was suffering from post-traumatic stress disorder, although she had not reported events of that magnitude. When August approached Francesca would become intensely distressed. She said it was a tragic month, a month of illness and loss, but she remained vague about the memories that the month contained.

While progress was slow, little by little Francesca's self-confidence grew. She learned to focus her breathing and developed her own rituals to relax herself. Our psychiatrist initially screened Francesca and agreed to the medication recommended by her own psychiatrist. Her medication was later switched from Paxil to Zoloft which seemed to suit her better. Francesca continued to make 911 calls at the first signs of anxiety, but now the emergency medical people knew her and their presence was often calming enough that she could remain home. She was driving and shopping by herself, getting her nails and hair done. Her anxiety became less pervasive, and tended to rise only when she had contact with her mother.

One July day, three years into treatment, after a period of months in which she had consistently done things on her own and had even reduced her use of Xanax, she spoke again about her fear of the approaching month. She then told me about the death of a younger brother whom she had never mentioned before. When they were children, she seven and he five, her mother sent them outside to get their father who was working across the street. She held her brother's hand as they stepped toward the street. Spotting their father, her brother let go of her hand to run to him, and was hit by a bus and killed. She wept as she described the terrible scene.

Francesca's mother, unable to bear her own guilt, blamed Francesca, saying she had pushed her brother. Her father did not blame her, but was too crazed with grief and could not attend to his daughter. "I didn't kill him," she said. Only a policeman told her it was not her fault.

I told Francesca that she did not kill her brother, that he had been killed by a bus in a tragic accident and she was not responsible. When I asked Francesca why she had waited so long to tell me this story, she said she was afraid I would think she was guilty. Francesca had so profoundly internalized her mother's claim that she believed she was guilty.

see Courage on page 41

Understanding Anxiety Disorders

By Mindy Liss, Director Communications and Marketing Jewish Board of Family and Children's Services

Among the 185 programs of the Jewish Board of Family and Children's Services (JBFCS) are 12 community counseling centers which offer a wide range of mental health services for adults and children. Each year some 8000 clients are served at these neighborhood-based offices in approximately 180,000 counseling and support sessions.

JBFCS Counseling Center clients present with a wide range of problems, the most common of which are depression and anxiety. Questions were posed to three JBFCS clinicians about the prevalence of and treatment approaches to anxiety disorders. Anne Zweiman, LCSW, is the Roger A.Goldman Director of Community Services. Gretchen Hartman, LCSW, is the division's Administrative Supervisor. Richard Gersh, MD, is the agency's Executive Deputy Chief Psychiatrist.

What is an anxiety disorder?

An anxiety disorder is a condition in which anxiety is the predominant issue, and the individual is having difficulty overcoming or handling anxiety with the usual coping mechanisms. There are general and specific forms of anxiety disorder such as separation anxiety or phobias. Other conditions, such as depression, may also include a component of anxiety.

What are the symptoms of anxiety disorders?

Anxiety can be feel very physical and symptoms are often misdiagnosed as medical problems. In particular, panic attacks can be very frightening, paralyzing, and at times agonizing.

Panic disorders are acute episodes characterized by heart palpations (rapid and/or pounding heart beats), sweating, shaking, difficulty breathing, choking, chest pain, stomach distress, lightheadedness, feeling unreal or detached, feeling out of control, fears of dying, numbness or tingling, and/or chills or hot flushes. Generalized anxiety is frequent periods described as excessive worry or anticipation, with restlessness, fatigue, difficulty concentrating, muscle tension, and/or sleep problems.

How is anxiety disorder usually treated?

Anxiety is generally addressed by developing better coping skills - such as self-soothing relaxation techniques - and by gaining new perspective over the issues causing anxiety. This diagnosis often responds well to cognitive behavioral techniques such as the use of visualization to calm a person and reduce their anxiety when it is triggered.

Psychotherapy may include an explorative approach, practical problem solving, or cognitive behavioral techniques that teach new coping strategies. Identifying and reducing stress can be helpful, and regular exercise is usually effective.

What about the use of medication?

Certain medications can help take the edge off anxiety while a person is in psychotherapeutic treatment such as cognitive behavioral therapy.

Though for some, the side effects of medication can outweigh the benefits, for many, medication can be very helpful. Two general types of medications are commonly used to treat anxiety disorders, along with psychotherapy. Tranquilizers are medications that quickly diminish anxiety, although the effect may last only a few hours, and they may cause sedation. Tranquilizers should be used only in moderation.

Antidepressants have now been recognized as effective in treating some anxiety. These medications must be taken daily, even when the patient is not experiencing anxiety. There can be mild side effects, but anxiety can be prevented or significantly diminished.

We all feel some level of anxiety when is treatment called for?

If anxiety is significantly interfering with day-to-day functioning, an assessment is often called for to better understand what is going on. Anxiety disorders are very treatable and permeate many of our cases.

How are anxiety disorders connected to traumatic experiences?

Recently, particularly since 9/11, we have learned that anxiety is very often connected to trauma. and that this trauma may well go back to early experiences. The anxiety (i.e. panic attacks) often represents the reliving of the trauma.

An underlying issue is a fear of not being in control which sometimes goes back to the traumatic experience. 9/11 increased the prevalence of anxiety disorders.

Trauma can produce an acute physiologic change, related to our instinctive natural functioning around self-preservation. However, in some individuals, this produces an ongoing vulnerability towards psychological stress. Even with relatively minor stress, our bodies react as if we are being seriously threatened. An analogy is a traumatic muscle injury that heals but leaves the arm weaker and more likely to feel pain under minor stress.

We seem to hear so much more about anxiety disorders. Has the incidence of these disorders increased?

Not necessarily. What's made this diagnosis seem more prevalent is that the identification process has become more sophisticated – we are getting

see Understanding on page 30

Mental Health News
The Connecticut Section
Hartford NORWALK Stamford Kent New London

What Are Anxiety Disorders ?

By Lateef Habib LCSW
Outpatient Clinical Coordinator
Norwalk Hospital
Department of Psychiatry

No one can live without experiencing some degree of stress. In fact, any emotion can trigger the body's stress mechanism. The human body is very well equipped to handle life's short term stressors. It activates an automatic alarm system that brings itself back to homeostasis or balance. However, long term, chronic or persistent stress is common in our demanding, intense lifestyle and increasingly takes its toll. According to the National Institute of Mental Health (NIMH), nearly 25 million Americans suffer from some sort of anxiety disorder including panic, phobias, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder and Generalized Anxiety Disorder.

What exactly are anxiety disorders?

Anxiety Disorders are a group of disorders that affect behavior, thoughts, emotions and physical health. Research into its origins continues, but the cause is believed to be a combination of biological factors and individual circumstances, much like other health problems such as heart disease or diabetes. It is common for people to suffer from more than one anxiety disorder and for an anxiety disorder to be accompanied by depression, eating disorder of substance abuse. Anxiety disorders can also coexist with physical disorders, in which case, the physical condition should also be treated.

Some of the signs to look for are:

Panic Disorder is expressed in panic attacks that occur without warning, accompanied by sudden feelings of terror. Physically, an attack may cause chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, and feelings of unreality such as a fear of dying. When a person avoids situations that he or she fears triggering a panic attack, his or her condition is described as panic disorder with agoraphobia.

Phobias are divided into two categories: social phobia, which involves fear of social situations, and specific phobias such as a fear of flying and heights.

People with social phobia feel a paralyzing, irrational self-consciousness about social situations. They have an intense fear of being observed or of doing something horribly wrong in front of the other people. The feelings are so extreme that people with social phobia tend to avoid objects or situations that might stimulate that fear dramatically reducing their ability to lead a normal life.

Lateef Habib LCSW

Specific phobias such as a fear of flying, fear of heights or fear of open spaces are some examples of specific phobias. People with this condition are overwhelmed by unreasonable fears that they are unable to control. Exposure to the feared situations can cause extreme anxiety and panic, even if they recognize that their fears are illogical.

Post Traumatic Stress Disorder (PTSD) is a terrifying experience in which serious physical harm occurred or was threatened causing PTSD. Survivors of rape, child abuse, war or natural disaster may develop PTSD. Symptoms include flashbacks during which the person relives the experience, nightmares, depression and feelings of irritability.

Obsessive-Compulsive Disorder (OCD) is a condition in which people suffer from uncontrollable, and persistent, unwanted thoughts (obsessions) and or rituals (compulsions). Obsessions involve concerns of contamination, doubting such as worrying that the iron has not been turned off and disturbing sexual or religious beliefs. Compulsions include compulsive hand washing, checking, muscle tension or headaches.

Generalized Anxiety Disorder (GAD) is excessive anxiety and worry occurring more days than not for at least 6 months

see Anxiety on page 35

Connecticut Receives More Than $5 Million in Grants From SAMHSA

SAMHSA
Rockville, Maryland

Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator Charles G. Curie, M.A., A.C.S.W., announced over $5 million in new federal grants to Connecticut and presented symbolic "big checks" to Governor M. Jodi Rell during a ceremony in Hartford. The grants will help improve the services provided for adolescents and adults with co-occurring substance use and mental disorders.

"In Connecticut an estimated 8.8 percent of the population suffers from dependence on or abuse of any illicit drug or alcohol and approximately 8.1 percent have serious mental illness. A significant proportion of these people have both substance use and mental disorders. Since people with co-occurring disorders cannot separate their addictions from their mental disorders, they should not have to negotiate separate service delivery systems," Curie said.

Curie continued, "Over the past few decades, the systems of services that promote recovery for substance abuse and mental illness have evolved in exciting ways. As a result, millions of Americans with these disorders have reclaimed their lives. These two new grants will help Connecticut bring together multiple agencies, including mental health, education, health, substance abuse, child welfare, and criminal and juvenile justice services, in order to provide the opportunity for recovery for young people and adults with substance use problems and mental illness."

"The new federal grants will be critical in helping the Departments of Mental Health and Addiction Services DHMAS) and Children and Families (DCF) treat mental health and substance abuse conditions when they occur simultaneously," Governor Rell said. "These problems can overwhelm individuals and their families alike. With these grants, the state will be in a better position to serve people who are hurting and who need help to recover from what is really an extraordinary personal crisis in each case."

The state agencies receiving the grants announced today include:

State of Connecticut Department of Mental Health and Addiction Services: $3.95 million over five years to better serve individuals with co-occurring substance use and mental disorders. The state will standardize screening and assessment to identify individuals with co-occurring disorders and their treatment needs, regardless of where they present for care. Barriers that impeded access to and retention in care will be removed to provide coordinated and integrated serviced for people with co-occurring disorders. Outcome data will be used to continually improve services offered.

State of Connecticut Department of Children and Families: $1.2 million over three years to improve treatment and supports for adolescents with substance abuse and co-occurring mental disorders. In addition to increasing access to treatment services for young people, Connecticut will create a staff position dedicated to ensuring resources available for treatment and support services are being used in the most efficient manner possible.

In addition to the grants to the state, grants were also recently awarded to organizations in New Haven and West Hartford. The grantees are:

Columbus House Inc., New Haven: $2 million over five years to provide peer-based engagement, street- and clinic-based treatment and rehabilitative and social services for adult women who are homeless.

Life Haven, New Haven: $198,400 – to help homeless pregnant women and young women with children overcome social, emotional and educational obstacles by promoting their social competence, problem-solving skills, sense of autonomy, and sense of purpose for future direction.

see Grants on page 30

Hall-Brooke Opens Outpatient Services in new Location

Staff Writer
Mental Health News

Hall-Brooke Behavioral Health Services, 47 Long Lots Road, Westport, has opened ambulatory outpatient services in a new location, 1 Lois Street, Norwalk.

The 10,000 square foot facility is situated directly over the Westport/Norwalk line, just off the Post Road (U.S. 1), behind McDonalds, and across from a major complex housing the Crown Royale Theater and Bed, Bath and Beyond.

The new ambulatory outpatient center includes the following:

- Women's Intensive Outpatient Services
- Mood Disorders Intensive Outpatient Services
- Addiction Psychiatry
- Child and Adolescent Intensive Outpatient Services
- Right Track Extended Day Program (for adolescents)
- Sunrise Outpatient Detox Program

The Westport Planning and Zoning Commission has granted permission for the space being vacated by the Outpatient Services at Hall-Brooke's main campus, to be renovated to accommodate 16 additional beds for adult patients.

"We sought this physical change to meet the growing mental health needs of the Fairfield County Community," said Stephen P. Fahey, Hall-Brooke's President and Chief Executive Officer. "In 2004, we turned

Stephen P. Fahey

away over 800 people seeking admission to Hall-Brooke, approximately 300 were children and adolescents, and 500, adults."

Hall-Brooke is the only mental health facility in Fairfield County which provides inpatient treatment for children.

"There will be no reduction in Hall-Brooke's outpatient services which were formerly located on the main campus," according to Debra Iversen, Director of Outpatient Services. "In fact, our new location will allow future expansion of services, and we are very excited about that."

Approximately 28 Hall-Brooke staff members will be in the new location. Clinicians and individuals interested in more information, should call 203-221-8827.

Hall-Brook Clinical Director Reports On Prevalence of Anxiety Disorder in Women

Staff Writer
Mental Health News

Medical researchers have not determined "why," but statistics indicate that women are more prone to anxiety disorders than men, according to Stewart Levine, M.D., Clinical Director of Hall-Brooke Behavioral Health Services in Westport.

Dr. Levine, who also serves as Vice Chair, Department of Psychiatry at St. Vincent's Health Services of Bridgeport, notes that two to three times more women than men suffer from panic disorder, and the cases among females are more chronic, more severe, and more associated with clinical depression. Typically, the onset of panic disorder is during a person's twenties. Agoraphobia, the fear of being in an open, unsecured place, is also more common in women.

The prevailing opinion, according to Dr. Levine, is that female hormones, estrogen and progesterone, play a role in these anxiety disorders.

In addition to the prevalence of females in this area of mental illness, Dr. Levine also notes that one out of three women will suffer from an anxiety disorder during their lifetime and the incidence of anxiety disorder decreases after a woman reaches 65 years of age. Again, hormones and their diminution seem associated with the statistics.

"Social anxiety disorders are 1.5 times more frequent in women, and the symptoms manifest in very different ways. Women fear talking to authority figures, engaging in public speaking, becoming the center of attention, expressing opinions –particularly disapproval of people – even, giving a party. The male manifestations include fear of such things as urinating in a public rest room or returning goods to a store.

"Obsessive Compulsive Disorder is 1.5 times more frequent in women, after puberty. Before that time, boys and girls are equally afflicted. This fact appears to reinforce the hormonal connection," Dr. Levine notes.

"Of those who suffer generalized anxiety disorder, 85 to 90 percent also have other psychiatric disorders throughout their lives," Dr. Levine reports.

"Post traumatic stress disorder, frequently reported now in the news, is twice as common in women. With females, the disorder often relates to sexual assault, childhood physical and or sexual abuse, while with males, the main cause appears to be a result of being in military combat," according to Dr. Levine.

The good news is that there are effective ways to treat anxiety disorders. Dr. Levine cites exercise, psychotherapy to explore and understand the causative factors, and anti-anxiety and antidepressant medications.

Hall-Brooke is a wholly owned subsidiary of St. Vincent's Health Services of Bridgeport and is affiliated with the Department of Psychiatry of the College of Physicians and Surgeons of Columbia University.

NAMI Cares from page 14

plan that includes supportive therapy. Antidepressants and antianxiety medications are the most successful medications for this disorder. Ask your doctor about these medications or others that may help you.

Healthy living habits may also help people overcome panic disorder. Exercise, a proper and balanced diet, moderate use of caffeine and alcohol, and learning how to reduce stress are all important.

Peer support is a vital part of overcoming panic disorder. Family and friends can play a significant role in the treatment process and should be informed of the treatment plan and of the ways they can be most helpful.

I borrow shamelessly from NAMI for a couple of reasons: I am not a mental health professional, much less a psychiatrist or other clinician, and NAMI is perhaps the best source anywhere on such matters. They have a wealth of information to be shared. Only through support, education and advocacy can people with serious mental illnesses and their families successfully cope with anxiety – or other disorders of the brain. Indeed, that is our mission: support, education and advocacy.

In closing, I wish to alert everyone to NAMI-NYS's Annual Legislative Conference, coming up at the beginning of the next session of the New York State Legislature. The Legislative Conference and Lobby Day will be held on Tuesday, February 7, 2006. It will again be held right in the Legislative Office Building of the Empire State Plaza in Albany. As last year, we will begin with a luncheon and hear prominent speakers from the Legislature, New York State Office of Mental Health and others. The program will be both preceded and followed by visits to Senators and Assemblymen in their offices by NAMI-NYS members from their district around the state, along with members of the NAMI-NYS Board of Directors, Government Affairs Committee and staff. I urge everyone to attend. It gives us a chance to be seen and heard in Albany, and that is a very important part of our overall advocacy strategy. Besides, who can't love the weather in Albany in February? See you there!

NIMH Study from page 9

Department of Psychiatry, Columbia University and Director of the New YorkState Psychiatric Institute.

The CATIE study was led by Lieberman, and co-Principal Investigators Scott Stroup, M.D. (University of North Carolina at Chapel Hill), and Joseph McEvoy, M.D. (Duke University). CATIE was carried out by researchers at 57 sites across the country, including private and public mental health clinics, Veteran's Health Administration Medical Centers, and University Medical Centers, where people with schizophrenia received their usual care.

This "New England Journal of Medicin" article is the first to report outcomes from the CATIE schizophrenia trial, and addresses many of the primary questions from the study. Future reports will address a multitude of topics (e.g., cost-effectiveness of the medications, quality of life, predictors of response) and will provide a more detailed picture of the interaction between patient characteristics, medication, and outcomes. The information from the CATIE study will inform new approaches for improving outcomes in schizophrenia.

CATIE is part of an overall NIMH effort to conduct "practical" clinical trials that address public health issues important to those persons affected by major mental illnesses in real world settings.

The NIMH mission is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior. Additional information about NIMH and schizophrenia can be found at its website, www.nimh.nih.gov.

NIMH is part of the National Institutes of Health (NIH), the Federal Government's primary agency for biomedical and behavioral research. NIH is a component of the U.S. Department of Health and Human Services.

The National Institutes of Health (NIH) -- "The Nation's Medical Research Agency" -- includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary Federal agency for conducting and supporting basic, clinical, and translational medical research, and investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit http://www.nih.gov.

Understanding from page 24

better at identifying this disorder. It often has a ripple effect through all presenting symptoms. And since 9/11 there is an overarching cloud of anxiety. Even people presenting with depression have a piece of anxiety related to not feeling safe. We also have new options for very effective treatment, including psychotherapies and medications. Very importantly, there is less stigma associated with getting help.

There is some epidemiologic evidence that, from generation to generation, there has been an increase in depression and anxiety, over the last several decades. This may be because of increased recognition, but some researchers speculate that younger generations are actually experiencing more depression and anxiety. This may be due to increased stress, less effective community support, increased genetic vulnerability, or other factors.

The most important point to understand is that anxiety disorders, though often agonizing and often paralyzing, are very treatable. Individual and group therapy using cognitive behavioral techniques, often coupled with medication, can be very effective.

To learn more about JBFCS counseling and support services throughout New York City, call (212) 582-9100.

Visit Salud Mental on The Web
Our New Bilingual (Spanish) Quarterly Publication
www.mhnews-latino.org

Grants from page 27

Yale University School of Medicine, New Haven: $496,000 to support the work of the National Center for Children Exposed to Violence as well as increase public and professional awareness of the effects of violence on children.

University of Hartford Wellness and Women's Center, West Hartford: $1.1 million over three years to provide substance abuse intervention to University of Hartford students, with an emphasis on alcohol.

The Many Faces from page 1

women as in men.[2] It most often begins during late adolescence or early adulthood.[2] Risk of developing panic disorder appears to be inherited.[3] Not everyone who experiences panic attacks will develop panic disorder—for example, many people have one attack but never have another. For those who do have panic disorder, though, it's important to seek treatment. Untreated, the disorder can become very disabling.

Many people with panic disorder visit the hospital emergency room repeatedly or see a number of doctors before they obtain a correct diagnosis. Some people with panic disorder may go for years without learning that they have a real, treatable illness.

Panic disorder is often accompanied by other serious conditions such as depression, drug abuse, or alcoholism[4,5] and may lead to a pattern of avoidance of places or situations where panic attacks have occurred. For example, if a panic attack strikes while you're riding in an elevator, you may develop a fear of elevators. If you start avoiding them, that could affect your choice of a job or apartment and greatly restrict other parts of your life.

Some people's lives become so restricted that they avoid normal, everyday activities such as grocery shopping or driving. In some cases they become housebound. Or, they may be able to confront a feared situation only if accompanied by a spouse or other trusted person.

Basically, these people avoid any situation in which they would feel helpless if a panic attack were to occur. When people's lives become so restricted, as happens in about one-third of people with panic disorder,[2] the condition is called *agoraphobia*. Early treatment of panic disorder can often prevent agoraphobia.

Panic disorder is one of the most treatable of the anxiety disorders, responding in most cases to medications or carefully targeted psychotherapy.

You may genuinely believe you're having a heart attack, losing your mind, or are on the verge of death. Attacks can occur at any time, even during sleep.

Depression often accompanies anxiety disorders[4] and, when it does, it needs to be treated as well. Symptoms of depression include feelings of sadness, hopelessness, changes in appetite or sleep, low energy, and difficulty concentrating. Most people with depression can be effectively treated with antidepressant medications, certain types of psychotherapy, or a combination of both.

Obsessive-Compulsive Disorder

"I couldn't do anything without rituals. They invaded every aspect of my life. Counting really bogged me down. I would wash my hair three times as opposed to once because three was a good luck number and one wasn't. It took me longer to read because I'd count the lines in a paragraph. When I set my alarm at night, I had to set it to a number that wouldn't add up to a "bad" number.

"Getting dressed in the morning was tough because I had a routine, and if I didn't follow the routine, I'd get anxious and would have to get dressed again. I always worried that if I didn't do something, my parents were going to die. I'd have these terrible thoughts of harming my parents. That was completely irrational, but the thoughts triggered more anxiety and more senseless behavior. Because of the time I spent on rituals, I was unable to do a lot of things that were important to me.

"I knew the rituals didn't make sense, and I was deeply ashamed of them, but I couldn't seem to overcome them until I had therapy."

Obsessive-compulsive disorder, or OCD, involves anxious thoughts or rituals you feel you can't control. If you have OCD, you may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals.

You may be obsessed with germs or dirt, so you wash your hands over and over. You may be filled with doubt and feel the need to check things repeatedly. You may have frequent thoughts of violence, and fear that you will harm people close to you. You may spend long periods touching things or counting; you may be pre-occupied by order or symmetry; you may have persistent thoughts of performing sexual acts that are repugnant to you; or you may be troubled by thoughts that are against your religious beliefs.

The disturbing thoughts or images are called obsessions, and the rituals that are performed to try to prevent or get rid of them are called compulsions. There is no pleasure in carrying out the rituals you are drawn to, only temporary relief from the anxiety that grows when you don't perform them.

A lot of healthy people can identify with some of the symptoms of OCD, such as checking the stove several times before leaving the house. But for people with OCD, such activities consume at least an hour a day, are very distressing, and interfere with daily life.

Most adults with this condition recognize that what they're doing is senseless, but they can't stop it. Some people, though, particularly children with OCD, may not realize that their behavior is out of the ordinary.

OCD afflicts about 3.3 million adult Americans.[1] It strikes men and women in approximately equal numbers and usually first appears in childhood, adolescence, or early adulthood.[2] One-third of adults with OCD report having experienced their first symptoms as children. The course of the disease is variable—symptoms may come and go, they may ease over time, or they can grow progressively worse. Research evidence suggests that OCD might run in families.[3]

Depression or other anxiety disorders may accompany OCD,[2,4] and some people with OCD also have eating disorders.[6] In addition, people with OCD may avoid situations in which they might have to confront their obsessions, or they may try unsuccessfully to use alcohol or drugs to calm themselves.[4,5] If OCD grows severe enough, it can keep someone from holding down a job or from carrying out normal responsibilities at home.

OCD generally responds well to treatment with medications or carefully targeted psychotherapy.

The disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or get rid of them are called compulsions. There is no pleasure in carrying out the rituals you are drawn to, only temporary relief from the anxiety that grows when you don't perform them.

Post-Traumatic Stress Disorder

"I was raped when I was 25 years old. For a long time, I spoke about the rape as though it was something that happened to someone else. I was very aware that it had happened to me, but there was just no feeling.

"Then I started having flashbacks. They kind of came over me like a splash of water. I would be terrified. Suddenly I was reliving the rape. Every instant was startling. I wasn't aware of anything around me, I was in a bubble, just kind of floating. And it was scary. Having a flashback can wring you out.

"The rape happened the week before Thanksgiving, and I can't believe the anxiety and fear I feel every year around the anniversary date. It's as though I've seen a werewolf. I can't relax, can't sleep, don't want to be with anyone. I wonder whether I'll ever be free of this terrible problem."

Post-traumatic stress disorder (PTSD) is a debilitating condition that can develop following a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include violent attacks such as mugging, rape, or torture; being kidnapped or held captive; child abuse; serious accidents such as car or train wrecks; and natural disasters such as floods or earthquakes. The event that triggers PTSD may be something that threatened the person's life or the life of someone close to him or her. Or it could be something witnessed, such as massive death and destruction after a building is bombed or a plane crashes.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience other sleep problems, feel detached or numb, or be easily startled. They may lose interest in things they used to enjoy and have trouble feeling affectionate. They may feel irritable, more aggressive than before, or even violent. Things that remind them of the trauma may be very distressing, which could lead them to avoid certain places or situations that bring back those memories. Anniversaries of the traumatic event are often very difficult.

PTSD affects about 5.2 million adult Americans.[1] Women are more likely than men to develop PTSD.[7] It can occur at any age, including childhood,[8] and there is some evidence that susceptibility to PTSD may run in families.[9] The disorder is often accompanied by depression, substance abuse, or one or more other anxiety disorders.[4] In severe cases, the person may have trouble working or socializing. In general, the symptoms seem to be worse if the event that triggered them was deliberately initiated by a person—such as a rape or kidnapping. Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. A person having a flashback, which can come in the form of images, sounds, smells, or feelings, may lose touch with reality and believe that the traumatic event is happening all over again.

Not every traumatized person gets full-blown PTSD, or experiences PTSD at all. PTSD is diagnosed only if the symptoms last more than a month. In those who do develop PTSD, symptoms usually begin within 3 months of the trauma, and the course of the illness varies. Some people recover within 6 months, others have symptoms that last much longer. In some cases, the condition may be chronic. Occasionally, the illness doesn't show up until years after the traumatic event.

People with PTSD can be helped by medications and carefully targeted psychotherapy.

Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. Anniversaries of the traumatic event are often very difficult.

Social Phobia
(Social Anxiety Disorder)

"In any social situation, I felt fear. I would be anxious before I even left the house, and it would escalate as I got closer to a college class, a party, or whatever. I would feel sick at my stomach—it almost felt like I had the flu. My heart would pound, my palms would get sweaty, and I would get this feeling of being removed from myself and from everybody else.

"When I would walk into a room full of people, I'd turn red and it would feel like everybody's eyes were on me. I was embarrassed to stand off in a corner by myself, but I couldn't think of anything to say to anybody. It was humiliating. I felt so clumsy, I couldn't wait to get out.

"I couldn't go on dates, and for a while I couldn't even go to class. My sophomore year of college I had to come home for a semester. I felt like such a failure."

Social phobia, also called social anxiety disorder, involves overwhelming anxiety and excessive self-consciousness in everyday social situations. People with social phobia have a persistent, intense, and chronic fear of being watched and judged by others and being embarrassed or humiliated by their own actions. Their fear may be so severe that it interferes with work or school, and other ordinary activities. While many people with social phobia recognize that

see The Many Faces on page 32

The Many Faces from page 31

their fear of being around people may be excessive or unreasonable, they are unable to overcome it. They often worry for days or weeks in advance of a dreaded situation.

Social phobia can be limited to only one type of situation—such as a fear of speaking in formal or informal situations, or eating, drinking, or writing in front of others—or, in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people. Social phobia can be very debilitating—it may even keep people from going to work or school on some days. Many people with this illness have a hard time making and keeping friends.

Physical symptoms often accompany the intense anxiety of social phobia and include blushing, profuse sweating, trembling, nausea, and difficulty talking. If you suffer from social phobia, you may be painfully embarrassed by these symptoms and feel as though all eyes are focused on you. You may be afraid of being with people other than your family.

People with social phobia are aware that their feelings are irrational. Even if they manage to confront what they fear, they usually feel very anxious beforehand and are intensely uncomfortable throughout. Afterward, the unpleasant feelings may linger, as they worry about how they may have been judged or what others may have thought or observed about them.

Social phobia affects about 5.3 million adult Americans.[1] Women and men are equally likely to develop social phobia.[10] The disorder usually begins in childhood or early adolescence,[2] and there is some evidence that genetic factors are involved.[11] Social phobia often co-occurs with other anxiety disorders or depression.[2,4] Substance abuse or dependence may develop in individuals who attempt to "self-medicate" their social phobia by drinking or using drugs.[4,5] Social phobia can be treated successfully with carefully targeted psychotherapy or medications.

Social phobia can severely disrupt normal life, interfering with school, work, or social relationships. The dread of a feared event can begin weeks in advance and be quite debilitating.

Specific Phobias

"I'm scared to death of flying, and I never do it anymore. I used to start dreading a plane trip a month before I was due to leave. It was an awful feeling when that airplane door closed and I felt trapped. My heart would pound and I would sweat bullets. When the airplane would start to ascend, it just reinforced the feeling that I couldn't get out. When I think about flying, I picture myself losing control, freaking out, climbing the walls, but of course I never did that. I'm not afraid of crashing or hitting turbulence. It's just that feeling of being trapped. Whenever I've thought about changing jobs, I've had to think, 'Would I be under pressure to fly?' These days I only go places where I can drive or take a train. My friends always point out that I couldn't get off a train traveling at high speeds either, so why don't trains bother me? I just tell them it isn't a rational fear."

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

Specific phobias affect an estimated 6.3 million adult Americans[1] and are twice as common in women as in men.[10] The causes of specific phobias are not well understood, though there is some evidence that these phobias may run in families.[11] Specific phobias usually first appear during childhood or adolescence and tend to persist into adulthood.[12]

If the object of the fear is easy to avoid, people with specific phobias may not feel the need to seek treatment. Sometimes, though, they may make important career or personal decisions to avoid a phobic situation, and if this avoidance is carried to extreme lengths, it can be disabling. Specific phobias are highly treatable with carefully targeted psychotherapy.

Phobias aren't just extreme fears; they are irrational fears. You may be able to ski the world's tallest mountains with ease but feel panic going above the 5th floor of an office building.

Generalized Anxiety Disorder

"I always thought I was just a worrier. I'd feel keyed up and unable to relax. At times it would come and go, and at times it would be constant. It could go on for days. I'd worry about what I was going to fix for a dinner party, or what would be a great present for somebody. I just couldn't let something go.

"I'd have terrible sleeping problems. There were times I'd wake up wired in the middle of the night. I had trouble concentrating, even reading the newspaper or a novel. Sometimes I'd feel a little lightheaded. My heart would race or pound. And that would make me worry more. I was always imagining things were worse than they really were: when I got a stomachache, I'd think it was an ulcer.

"When my problems were at their worst, I'd miss work and feel just terrible about it. Then I worried that I'd lose my job. My life was miserable until I got treatment."

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day. It's chronic and fills one's day with exaggerated worry and tension, even though there is little or nothing to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of

see The Many Faces on page 33

The Many Faces from 32

the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

People with GAD can't seem to shake their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. Their worries are accompanied by physical symptoms, especially fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, and hot flashes. People with GAD may feel lightheaded or out of breath. They also may feel nauseated or have to go to the bathroom frequently.

Individuals with GAD seem unable to relax, and they may startle more easily than other people. They tend to have difficulty concentrating, too. Often, they have trouble falling or staying asleep.
Unlike people with several other anxiety disorders, people with GAD don't characteristically avoid certain situations as a result of their disorder. When impairment associated with GAD is mild, people with the disorder may be able to function in social settings or on the job. If severe, however, GAD can be very debilitating, making it difficult to carry out even the most ordinary daily activities.

GAD affects about 4 million adult Americans[1] and about twice as many women as men.[2] The disorder comes on gradually and can begin across the life cycle, though the risk is highest between childhood and middle age.[2] It is diagnosed when someone spends at least 6 months worrying excessively about a number of everyday problems. There is evidence that genes play a modest role in GAD.[13]

GAD is commonly treated with medications. GAD rarely occurs alone, however; it is usually accompanied by another anxiety disorder, depression, or substance abuse.[2,4] These other conditions must be treated along with GAD.

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

NIMH supports research into the causes, diagnosis, prevention, and treatment of anxiety disorders and other mental illnesses. Studies examine the genetic and environmental risks for major anxiety disorders, their course—both alone and when they occur along with other diseases such as depression—and their treatment. The ultimate goal is to be able to cure, and perhaps even to prevent, anxiety disorders.

NIMH is harnessing the most sophisticated scientific tools available to determine the causes of anxiety disorders. Like heart disease and diabetes, these brain disorders are complex and probably result from a combination of genetic, behavioral, developmental, and other factors.

Several parts of the brain are key actors in a highly dynamic interplay that gives rise to fear and anxiety.[14] Using brain imaging technologies and neurochemical techniques, scientists are finding that a network of interacting structures is responsible for these emotions. Much research centers on the amygdala, an almond-shaped structure deep within the brain. The amygdala is believed to serve as a communications hub between the parts of the brain that process incoming sensory signals and the parts that interpret them. It can signal that a threat is present, and trigger a fear response or anxiety. It appears that emotional memories stored in the central part of the amygdala may play a role in disorders involving very distinct fears, like phobias, while different parts may be involved in other forms of anxiety.

Other research focuses on the hippocampus, another brain structure that is responsible for processing threatening or traumatic stimuli. The hippocampus plays a key role in the brain by helping to encode information into memories. Studies have shown that the hippocampus appears to be smaller in people who have undergone severe stress because of child abuse or military combat.[15,16] This reduced size could help explain why individuals with PTSD have flashbacks, deficits in explicit memory, and fragmented memory for details of the traumatic event.

Also, research indicates that other brain parts called the basal ganglia and striatum are involved in obsessive-compulsive disorder.[17]

By learning more about brain circuitry involved in fear and anxiety, scientists may be able to devise new and more specific treatments for anxiety disorders. For example, it someday may be possible to increase the influence of the thinking parts of the brain on the amygdala, thus placing the fear and anxiety response under conscious control. In addition, with new findings about neurogenesis (birth of new brain cells) throughout life,[18] perhaps a method will be found to stimulate growth of new neurons in the hippocampus in people with PTSD.

NIMH-supported studies of twins and families suggest that genes play a role in the origin of anxiety disorders. But heredity alone can't explain what goes awry. Experience also plays a part. In PTSD, for example, trauma triggers the anxiety disorder; but genetic factors may explain why only certain individuals exposed to similar traumatic events develop full-blown PTSD. Researchers are attempting to learn how genetics and experience interact in each of the anxiety disorders—information they hope will yield clues to prevention and treatment.

Scientists supported by NIMH are also conducting clinical trials to find the most effective ways of treating anxiety disorders. For example, one trial is examining how well medication and behavioral therapies work together and separately in the treatment of OCD. Another trial is assessing the safety and efficacy of medication treatments for anxiety disorders in children and adolescents with co-occurring attention deficit hyperactivity disorder (ADHD). For more information about these and other clinical trials, visit the NIMH clinical trials web page, www.nimh.nih.gov/studies/index.cfm, or the National Library of Medicine's clinical trials database, www.clinicaltrials.gov.

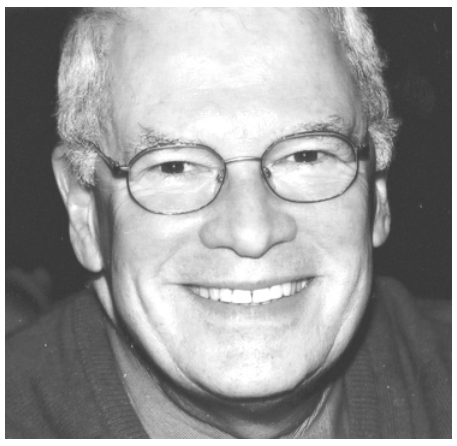
Treatment of Anxiety Disorders

Effective treatments for each of the anxiety disorders have been developed through research.[19] In general, two types

see The Many Faces on page 36

Anxiety: The Rust of Life

By Robert M. Lichtman, PhD, DAPA, CASAC, Behavior Therapist Rockland Psychiatric Center



Robert M. Lichtman, PhD

People who constantly worry or experience anxiety can become emotionally immobilized at times and have great difficulty negotiating their lives. Like rust on an iron pipe, anxiety can erode the quality of our lives. Sigmund Freud called this impediment to growth an "anxiety neurosis."

Anxiety can be described as an autonomic or automatic response that is not under our direct control, occurring when we are exposed to a present or future stressful event. We begin to experience discomfort within our own skin. The physical sensation may be akin to a low-voltage electric current pulsing throughout our bodies. It is usually triggered by a seemingly ever-present issue that remains with us until it is resolved, and sometimes long after.

"Worry" is a label applied to an actual physiological arousal that begins in the thinking part of our brains. We interpret information received by any one of our senses and the resulting response will determine whether we feel safe and calm, or unsafe and anxious. The process of stimulus input, information processing, perception,

Interpretation, and cortical response is completed in milliseconds by our central nervous system, which is composed of our brain and spinal cord. Our spinal cord is bicameral, meaning it is divided into two sections: the sympathetic and the parasympathetic nervous systems. The former is our alarm system, alerting us to take action or do something about our unsafe or anxious state. The latter calms us down when we no longer perceive ourselves as threatened.

When "The Rust" Becomes Corrosive

Anxiety can reach a level where it becomes corrosive, meaning that it can develop into a problem serious enough to warrant a psychological diagnosis. Think about starting your car and putting the engine in neutral while you press on the gas pedal and run the engine as if you were going 80 miles an hour. All the while, though, you are standing still. If you keep the "pedal to the metal," eventually some part of the engine or transmission will break down. As humans, we are the same way. If we keep running our "engines" at high speed, we too will eventually begin to break down psychologically and physically.

Corrosive anxiety is akin to the energy of a gunned engine. It burns a lot of fuel but it gets us nowhere. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR 2000), we qualify for a diagnosis of generalized anxiety disorder (GAD) if we have excessive anxiety and worry about a number of distinctive events or activities that is debilitating, for over a period of at least 6 months. Epidemiologists say that the prevalence rate in our population for generalized anxiety disorder is about 3%. That statistic translates into a large number of people who go through life excessively anxious and worried. Generalized anxiety disorder seems to run in families, and research (twin studies) indicates that heritability estimates are between 30-40%.

Concordance rates for GAD are significantly higher for identical twins (MZ) than for fraternal twins (DZ).

Cognitive or information processing factors also play a role. People who feel less able to control events are more likely to be anxious and develop generalized anxiety disorder.

Stopping the Corrosion

There are two questions to consider before ascertaining what type of intervention is appropriate. First, is the anxiety specific to a current stressful situation or situations? And second, is the anxiety more generalized and diffuse and experienced most of the time, as in generalized anxiety disorder (GAD)? Situation-specific anxiety has a better prognosis than the longer-term generalized anxiety disorder. Therefore, it is very important to accurately diagnose the presenting problem.

Treatment is available in both cases and in three forms – psychotherapeutic, psychopharmacological, or a combination of both. Cognitive behavior therapy is effective when the person is going through a particularly stressful time (such as divorce, the death of a loved one, or job loss) and does not have the requisite cognitive skills to cope with his or her life stressors. In this case, the symptoms are usually of a transient nature and will slowly diminish as life circumstances begin to improve.

Highly skilled cognitive-behavioral therapists have at their command many types of evidence-based treatments and interventions to aid their clients' recovery from the debilitating effects of traumatic events. When people are overwhelmed by their symptoms, it may be difficult for them to concentrate on

see The Rust on page 35

Anxiety from page 27

about a number of events or activities. The patient finds it difficult to control the worry. Anxiety and worry are associated with three or more of the following six symptoms such as restlessness or feeling keyed up or on edge, fatigued, difficulty concentrating or mind going blank, irritability, muscle tension or sleep disturbances (difficulty falling or staying asleep, or restless unsatisfying sleep). A complete clinical evaluation is necessary to establish a diagnosis of GAD.

How can anxiety disorders be treated?

There are three main approaches to treating anxiety disorder: (1) drug therapy (2) Cognitive Behavioral Therapy (CBT). (3) Combination of CBT and drug therapy.

Because most anxiety disorders have at least some biological component, anti-depressants and anti-anxiety drugs are generally prescribed. It is very important to inquire about the possible side effects when taking any sort of medication.

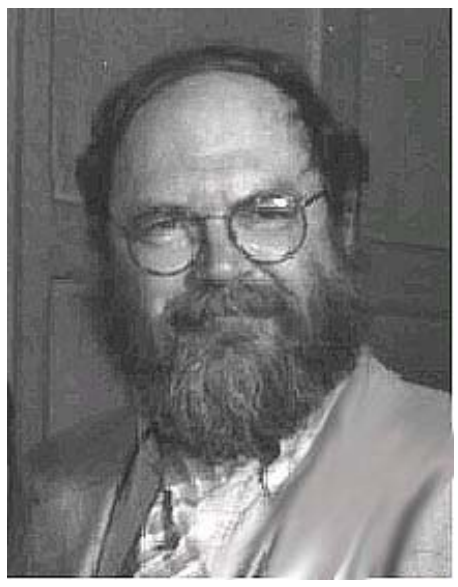
Therapeutic strategies are effective in reducing symptoms in each of the anxiety disorders. Techniques used include cognitive restructuring that helps people turn their anxious thoughts, interpretations and predictions into thoughts that are more rational and less anxiety. People with anxiety disorders may also benefit from systematic desensitization which is exposure to feared objects or situations. People with panic disorder can benefit from deep breathing allowing them to slow their breathing and use meditation when they are feeling anxious. Group therapy can also be included in treatment.

In conclusion, anxiety disorders place a great burden on the individuals affected, their families and friends. Learning all you can about the condition affecting your life can help develop tools for living with anxiety disorder or living with someone who has an anxiety disorder. A proper diagnosis is key to placing a person with anxiety disorder on the right treatment path.

Norwalk Hospital's Behavioral Health Services offers several options for those seeking help for anxiety such as anxiety disorder group, medication management and individual counseling. For more information or to make an appointment, please call 203-852-2988 (24 hours a day/7 days a week).

Anxiolytic from page 1

While good people can disagree about this point, it is rare to find someone who has depression who is also free of anxiety. It should come as no surprise then to find out that some of the best medications to treat anxiety are the so called antidepressants. In particular, the SSRIs (Selective serotonin reuptake inhibitors) are particularly good for this. This group includes drugs such as fluoxetine (Prozac®), sertraline (Zoloft ®), citalopram (Celexa®), paroxetine (Paxil ®) to name but a few. Other drugs from a slightly different class, the SNRIs (Serotonin/Norepinephrine reuptake inhibitors) of which the best known is venlafaxine (Effexor®) are also effective in treating anxiety. These agents do not just treat the anxiety associated with depression but are effective anxiolytics in anxiety related to panic attacks, agoraphobia, social phobia, obsessive compulsive disorders and a host of others. The major advantage to these medications apart form their high level of effectiveness, is that they are not addictive. They have a slow rate of onset. In order for them to be effective, they must be taken every day, for three to four weeks. Moreover, in the early phases of treatment, they can sometimes cause anxiety. As such, when they are being started, many physicians also prescribe the anxiolytics such as the benzodiazepines, to help the patient get through the first few weeks. This is a good idea, but these



Dr. Richard H. McCarthy

medications should not be continued for long periods of time if it is at all possible to avoid it.

The medications discussed in today's column are extremely helpful. However, they are not universally effective for all forms of anxiety. Some anxiety, particularly the kind that occurs in schizophrenia, responds best to the antipsychotic medications. I will discuss this in a future column.

Dr. McCarthy is a member of the Mental Health News Clinical Advisory Board, and frequently pens his popular 'Working with Medications' column.

The Rust from page 34

cognitive-behavioral interventions alone. At that point, referral to a psychiatric colleague for a prescription of an anti-anxiety medication may be indicated. The literature shows that in many cases a combination of psychotherapy and psychopharmacology will yield the best outcomes.

When there are concomitant symptoms of depression, as is often the case, an anti-depressant may be the treatment of choice. A few of the newer anti-depressants are effective in treating the anxiety that may accompany depression. The treating psychiatrist will usually make the decision about which medication to prescribe based upon the client's presenting symptoms.

Generalized Anxiety Disorder (GAD)

A diagnosis of generalized anxiety disorder presents a more complex clinical picture. The client with this diagnosis may report that their anxiety is more diffuse and general, out of proportion to the normal pressures of life. Whereas anxiety at low levels may be adaptive, these clients experience it at a level that is maladaptive and associated with pessimism and negative self-evaluation.

Therapeutic treatment usually consists of relaxation training and cognitive therapy. Clients can learn to recognize the faulty logic behind their worry and rumination. Another treatment approach is to have the patient consider the worst case scenario, which can help them identify their exaggerated worry. This process is known as decatastrophisizing.

Psychopharmacological interventions often rely on SSRIs as the first line of treatment for anxiety disorders, as they have therapeutic benefits similar to anti-anxiety medications, but with fewer side effects. SSRIs are preferred over anti-anxiety medications due to the serious problems with addiction and withdrawal once the client discontinues use of anti-anxiety medications.

Another medication to consider is BuSpar, which affects serotonin transmission and is used in the treatment of generalized anxiety disorder. Responses to this medication vary greatly and remain inconclusive.

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

We are all faced with stressful life events. Many people are able to take direct action by dealing with the event or object that is causing the stressful or anxious reaction. They are able to reduce or tone down the intensity of the anxiety as a matter of course, without any sort of treatment. Yet, due to particular vulnerabilities, others are prone to develop anxiety disorders and become engaged in an ongoing struggle against its corrosive effects.

Dr. Lichtman is a Behavior Therapist, Treatment Team Leader at Rockland Psychiatric Center, and an adjunct associate professor in the Forensic Psychology Department at John Jay College of Criminal Justice.

Legal Capacity from page 15

decision is uniquely a judicial not a medical function. Id. at 496.

The decision in Rivers v. Katz articulates standards which may also be applied to informed consent for non-psychiatric treatments offered to those with compromised capacity. This is because Rivers lays out a risk/benefit analysis, which allows for a fluid assessment of the nature of the procedure, its dangers, its necessity, and the relative capacity of the patient.

Guardianship: New York Mental Hygiene Law Article 81

Article 81 is the statutory framework for appointing a Guardian for an Incapacitated Person, specifically tailored to the needs of that person, to govern their personal care, their property and financial affairs, or both. The statute affirmatively recognizes the diverse and complex needs of people deemed incapacitated by the court, providing for the appointment of a person to protect those needs, while also allowing that person to "maintain the greatest amount of self-determination and independence and participation in decisions affecting his or her life." NY M.H.L. § 81.01.

If the person is unable to consent to the appointment of a Guardian, or if they object, the Court must determine that they are incapacitated before appointing a Guardian. The determination involves the following three factors (1) the likelihood the person will suffer harm; (2) the person's inability to provide for the personal needs and/or property management; and (3) the person's inadequate understanding and appreciation of the nature and consequences of such ability.

Analysis of competency and capacity in any legal action involving the mentally ill must take into account a consistent set of factors: the protection or infringement of the patient's liberty interests, including due process and privacy protections, and, a risk-benefit analysis, whether it be risk to the patient, as in treatment over objection, or to society, as in the C.P.L. provisions. The standards will vary depending on the matter pursued, but the analysis through which those standards are articulated remains the same.

The Law Firm of Reinach Wolf, Rothman and Stern, LLP. specializes in legal representation and consultation, in the fields of Mental Health and Elder Law, to families, individuals, hospitals, skilled nursing facilities, out-patient centers, mental health professionals and other attorneys. Our attorneys have extensive experience with the Mental Hygiene Law, Article 81 Guardianship; civil and criminal litigation and negotiation specific to Mental Health issues.

Westchester County NY Receives $2 Million SAMHSA Grant To Help The Homeless

By John Rubin, CSW, Director Open Arms Shelter and Mary DeVivo, CSW, Coordinator Community Education, Westchester County DCMH

Westchester County Department of Community Mental Health (DCMH), Grace Church Community Center, and CHOICE, a peer led homeless outreach service program will be partnering over the next five years to create a new resource for homeless individuals living in Westchester County.

Despite a resource-rich system of outreach and housing services in Westchester, the County has been unable to reach and engage a number of individuals who have rejected services and/or have refused to enter the shelter system. As a result, many of these individuals who have substance abuse disorders, mental illness, and many health problems have been living on the streets, or sleeping at the drop-in-shelter located on the grounds of the Westchester County Airport .

Many experienced homeless outreach workers have indicated that a more flexible approach is needed that would be less threatening, less confrontational and more culturally appropriate to hopefully engage this group into treatment, with an ultimate goal of providing transitional and/or permanent housing.

Project Trust, a daytime drop-in-center will open its doors on November 14, 2005 at 7:00 a.m. as an attempt to provide one solution. The drop-in-center will be located initially at 86 East Post Road in the Open Arms Shelter in White Plains and operate until 7 p.m.

County Executive Andrew J. Spano stated, "I am looking forward to having the new drop in center here in White Plains because it is so important to give people a place to go during the day."

Eventually, a new space a few doors down will become available as the number of those attending the program increases. Homeless individuals are encouraged to come to the drop in for breakfast, lunch and or dinner, take a shower, do some laundry, get clean clothes and talk to a staff members if they choose. The center will be open twelve hours a day seven days a week, and eventually once we move to the new space sixteen hours a day seven days a week.

Andrew J. Spano

The new Project Trust staff will include Team Leader, Henry Wilson, Emilio Acosta, CASAC, and Joyce Doyle, Nurse Practitioner. The Team will assist homeless individuals with an array their current needs, and also be available to assist professionals in the community who may know homeless individuals that could benefit from using the drop in services during the day. For some it will start out as a place and a space. Hopefully after attending Project Trust people will feel more secure and will enter into discussions focused around future goals.

The Department of Community Mental Health, Grace Church/ Open Arms, the DCMH Homeless Outreach Team, and CHOICE are all excited about being able to offer this new program just as the winter is arriving. Columbia University will assist Project Trust in data collection and analysis to enable the project to assess which services people are accessing and what services are still needed.

For further information about Project Trust please call Mary DeVivo, CSW at the Westchester County Department of Community Mental Heath, in White Plains, New York at (914) 995-4534.

NARSAD from page 12

hope that research will yield answers and provide steps for creating improved identification strategies, better treatments and eventual cures. NARSAD researchers are conducting work in all areas of anxiety disorders, and the above-mentioned studies provide just a sampling of the many current outstanding research projects in anxiety. Results from these studies, and others like them, are critical in bringing much-needed relief to those who experience the often disabling symptoms of anxiety.

NARSAD, The Mental Health Research Association, 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 $180.3 million in research grants to 2,090 scientists at 335 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 of this research has accelerated resulting in greater knowledge of brain functioning, neurochemistry, new and improved treatments and genetic origins. Constance E. Lieber serves as President of NARSAD.

The Many Faces from 33

of treatment are available for an anxiety disorder—medication and specific types of psychotherapy (sometimes called "talk therapy"). Both approaches can be effective for most disorders. The choice of one or the other, or both, depends on the patient's and the doctor's preference, and also on the particular anxiety disorder. For example, only psychotherapy has been found effective for specific phobias. When choosing a therapist, you should find out whether medications will be available if needed.

Before treatment can begin, the doctor must conduct a careful diagnostic evaluation to determine whether your symptoms are due to an anxiety disorder, which anxiety disorder(s) you may have, and what coexisting conditions may be present. Anxiety disorders are not all treated the same, and it is important to determine the specific problem before embarking on a course of treatment. Sometimes alcoholism or some other coexisting condition will have such an impact that it is necessary to treat it at the same time or before treating the anxiety disorder.

If you have been treated previously for an anxiety disorder, be prepared to tell the doctor what treatment you tried. If it was a medication, what was the dosage, was it gradually increased, and how long did you take it? If you had psychotherapy, what kind was it, and how often did you attend sessions? It often happens that people believe they have "failed" at treatment, or that the treatment has failed them, when in fact it was never given an adequate trial.

When you undergo treatment for an anxiety disorder, you and your doctor or therapist will be working together as a team. Together, you will attempt to find the approach that is best for you. If one treatment doesn't work, the odds are good that another one will. And new treatments are continually being developed through research. So don't give up hope.

Medications

Psychiatrists or other physicians can prescribe medications for anxiety disorders. These doctors often work closely with psychologists, social workers, or counselors who provide psychotherapy. Although medications won't cure an anxiety disorder, they can keep the symptoms under control and enable you to lead a normal, fulfilling life.

The major classes of medications used for various anxiety disorders are described below.

Antidepressants

A number of medications that were originally approved for treatment of depression have been found to be effective for anxiety disorders. If your doctor prescribes an antidepressant, you will need to take it for several weeks before symptoms start to fade. So it is important not to get discouraged and stop taking these medications before they've had a chance to work.

Some of the newest antidepressants are called **selective serotonin reuptake inhibitors**, or **SSRIs**. These medications act in the brain on a chemical messenger called serotonin. SSRIs tend to have fewer side effects than older antidepressants. People do sometimes report feeling slightly nauseated or jittery when they first start taking SSRIs, but that usually disappears with time. Some people also experience sexual dysfunction when taking some of these medications. An adjustment in dosage or a switch to another SSRI will usually correct bothersome problems. It is important to discuss side effects with your doctor so that he or she will know when there is a need for a change in medication.

Fluoxetine, sertraline, fluvoxamine, paroxetine, and citalopram are among the SSRIs commonly prescribed for panic disorder, OCD, PTSD, and social phobia. SSRIs are often used to treat people who have panic disorder in combination with OCD, social phobia, or depression. Venlafaxine, a drug closely related to the SSRIs, is useful for treating GAD. Other newer antidepressants are under study in anxiety disorders, although one, bupropion, does not appear effective for these conditions. These medications are started at a low dose and gradually increased until they reach a therapeutic level.

Similarly, antidepressant medications called **tricyclics** are started at low doses and gradually increased. Tricyclics have been around longer than SSRIs and have been more widely studied for treating anxiety disorders. For anxiety disorders other than OCD, they are as effective as the SSRIs, but many physicians and patients prefer the newer drugs because the tricyclics sometimes cause dizziness, drowsiness, dry mouth, and weight gain. When these problems persist or are bothersome, a change in dosage or a switch in medications may be needed.

Tricyclics are useful in treating people with co-occurring anxiety disorders and depression. Clomipramine, the only antidepressant in its class prescribed for OCD, and imipramine, prescribed for panic disorder and GAD, are examples of tricyclics.

Monoamine oxidase inhibitors, or **MAOIs**, are the oldest class of antidepressant medications. The most commonly prescribed MAOI is phenelzine, which is helpful for people with panic disorder and social phobia. Tranylcypromine and isoprocarboxazid are also used to treat anxiety disorders. People who take MAOIs are put on a restrictive diet because these medications can interact with some foods and beverages, including cheese and red wine, which contain a chemical called tyramine. MAOIs also interact with some other medications, including SSRIs. Interactions between MAOIs and other substances can cause dangerous elevations in blood pressure or other potentially life-threatening reactions.

Anti-Anxiety Medications

High-potency **benzodiazepines** relieve symptoms quickly and have few side effects, although drowsiness can be a problem. Because people can develop a tolerance to them—and would have to continue increasing the dosage to get the

see The Many Faces on page 37

The Many Faces from 36

same effect—benzodiazepines are generally prescribed for short periods of time. One exception is panic disorder, for which they may be used for 6 months to a year. People who have had problems with drug or alcohol abuse are not usually good candidates for these medications because they may become dependent on them.

Some people experience withdrawal symptoms when they stop taking benzodiazepines, although reducing the dosage gradually can diminish those symptoms. In certain instances, the symptoms of anxiety can rebound after these medications are stopped. Potential problems with benzodiazepines have led some physicians to shy away from using them, or to use them in inadequate doses, even when they are of potential benefit to the patient.

Benzodiazepines include clonazepam, which is used for social phobia and GAD; alprazolam, which is helpful for panic disorder and GAD; and lorazepam, which is also useful for panic disorder.

Buspirone, a member of a class of drugs called azipirones, is a newer anti-anxiety medication that is used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike the benzodiazepines, buspirone must be taken consistently for at least two weeks to achieve an anti-anxiety effect.

Other Medications

Beta-blockers, such as propanolol, are often used to treat heart conditions but have also been found to be helpful in certain anxiety disorders, particularly in social phobia. When a feared situation, such as giving an oral presentation, can be predicted in advance, your doctor may prescribe a beta-blocker that can be taken to keep your heart from pounding, your hands from shaking, and other physical symptoms from developing.

Taking Medications

Before taking medication for an anxiety disorder:

- Ask your doctor to tell you about the effects and side effects of the drug he or she is prescribing.
- Tell your doctor about any alternative therapies or over-the-counter medications you are using.
- Ask your doctor when and how the medication will be stopped. Some drugs can't safely be stopped abruptly; they have to be tapered slowly under a physician's supervision.
- Be aware that some medications are effective in anxiety disorders only as long as they are taken regularly, and symptoms may occur again when the medications are discontinued.
- Work together with your doctor to determine the right dosage of the right medication to treat your anxiety disorder.

Psychotherapy

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, psychologist, social worker, or counselor to learn how to deal with problems like anxiety disorders.

Cognitive-Behavioral and Behavioral Therapy

Research has shown that a form of psychotherapy that is effective for several anxiety disorders, particularly panic disorder and social phobia, is **cognitive-behavioral therapy (CBT)**. It has two components. The **cognitive** component helps people change thinking patterns that keep them from overcoming their fears. For example, a person with panic disorder might be helped to see that his or her panic attacks are not really heart attacks as previously feared; the tendency to put the worst possible interpretation on physical symptoms can be overcome. Similarly, a person with social phobia might be helped to overcome the belief that others are continually watching and harshly judging him or her.

The **behavioral** component of CBT seeks to change people's reactions to anxiety-provoking situations. A key element of this component is **exposure**, in which people confront the things they fear. An example would be a treatment approach called **exposure and response prevention** for people with OCD. If the person has a fear of dirt and germs, the therapist may encourage them to dirty their hands, then go a certain period of time without washing. The therapist helps the patient to cope with the resultant anxiety. Eventually, after this exercise has been repeated a number of times, anxiety will diminish. In another sort of exposure exercise, a person with social phobia may be encouraged to spend time in feared social situations without giving in to the temptation to flee. In some cases the individual with social phobia will be asked to deliberately make what appear to be slight social blunders and observe other people's reactions; if they are not as harsh as expected, the person's social anxiety may begin to fade. For a person with PTSD, exposure might consist of recalling the traumatic event in detail, as if in slow motion, and in effect re-experiencing it in a safe situation. If this is done carefully, with support from the therapist, it may be possible to defuse the anxiety associated with the memories. Another behavioral technique is to teach the patient deep breathing as an aid to relaxation and anxiety management.

Behavioral therapy alone, without a strong cognitive component, has long been used effectively to treat specific phobias. Here also, therapy involves exposure. The person is gradually exposed to the object or situation that is feared. At first, the exposure may be only through pictures or audiotapes. Later, if possible, the person actually confronts the feared object or situation. Often the therapist will accompany him or her to provide support and guidance.

If you undergo CBT or behavioral therapy, exposure will be carried out only when you are ready; it will be done gradually and only with your permission. You will work with the therapist to determine how much you can handle and at what pace you can proceed.

see The Many Faces on page 38

WJCS Offers Adult Day Center for Disabled Seniors at Mt. Vernon Synagogue

Staff Writer
Mental Health News

Seniors from Mt. Vernon and surrounding communities who have various disabilities that prevent them from participating in a traditional Senior Center can find a welcome at the social model Adult Day Program sponsored by Westchester Jewish Community Services at Sinai Free Synagogue, 550 N Columbus Ave, Mount Vernon. At the handicapped-accessible facility, these adults have their own activity area and dedicated staff. Each day attendees can take part in five hours of enjoyable programming. A hot lunch is served and transportation is provided for most participants. There is a modest fee for this program and scholarships are available. For more information, contact Karen McCabe at (914) 668-4350 or kmccabe@wjcs.com.

Founded in 1943, Westchester Jewish Community Services (WJCS) provides comprehensive mental health, developmental disabilities, social services and home health care on a non-sectarian basis. State-licensed, JCAHO-accredited and not-for-profit, WJCS serves all people who live or work in Westchester County. WJCS is funded by government grants, UJA-Federation, United Way, foundations, corporations and private individuals. Each year, more than 13,000 people find assistance through our sites located county-wide. For more information, visit our website at www.wjcs.com.

The Many Faces from 37

A major aim of CBT and behavioral therapy is to reduce anxiety by eliminating beliefs or behaviors that help to maintain the anxiety disorder. For example, avoidance of a feared object or situation prevents a person from learning that it is harmless. Similarly, performance of compulsive rituals in OCD gives some relief from anxiety and prevents the person from testing rational thoughts about danger, contamination, etc.

To be effective, CBT or behavioral therapy must be directed at the person's specific anxieties. An approach that is effective for a person with a specific phobia about dogs is not going to help a person with OCD who has intrusive thoughts of harming loved ones. Even for a single disorder, such as OCD, it is necessary to tailor the therapy to the person's particular concerns. CBT and behavioral therapy have no adverse side effects other than the temporary discomfort of increased anxiety, but the therapist must be well trained in the techniques of the treatment in order for it to work as desired. During treatment, the therapist probably will assign "homework"—specific problems that the patient will need to work on between sessions.

CBT or behavioral therapy generally lasts about 12 weeks. It may be conducted in a group, provided the people in the group have sufficiently similar problems. Group therapy is particularly effective for people with social phobia. There is some evidence that, after treatment is terminated, the beneficial effects of CBT last longer than those of medications for people with panic disorder; the same may be true for OCD, PTSD, and social phobia.

Medication may be combined with psychotherapy, and for many people this is the best approach to treatment. As stated earlier, it is important to give any treatment a fair trial. And if one approach doesn't work, the odds are that another one will, so don't give up.

If you have recovered from an anxiety disorder, and at a later date it recurs, don't consider yourself a "treatment failure." Recurrences can be treated effectively, just like an initial episode. In fact, the skills you learned in dealing with the initial episode can be helpful in coping with a setback.

Coexisting Conditions

It is common for an anxiety disorder to be accompanied by another anxiety disorder or another illness.[4,5,6] Often people who have panic disorder or social phobia, for example, also experience the intense sadness and hopelessness associated with depression. Other conditions that a person can have along with an anxiety disorder include an eating disorder or alcohol or drug abuse. Any of these problems will need to be treated as well, ideally at the same time as the anxiety disorder.

How to Get Help for Anxiety Disorders

If you, or someone you know, has symptoms of anxiety, a visit to the family physician is usually the best place to start. A physician can help determine whether the symptoms are due to an anxiety disorder, some other medical condition, or both. Frequently, the next step in getting treatment for an anxiety disorder is referral to a mental health professional.

Among the professionals who can help are psychiatrists, psychologists, social workers, and counselors. However, it's best to look for a professional who has *specialized training* in cognitive-behavioral therapy and/or behavioral therapy, as appropriate, and who is open to the use of medications, should they be needed.

As stated earlier, psychologists, social workers, and counselors sometimes work closely with a psychiatrist or other physician, who will prescribe medications when they are required. For some people, group therapy is a helpful part of treatment.

It's important that you feel comfortable with the therapy that the mental health professional suggests. If this is not the case, seek help elsewhere. However, if you've been taking medication, it's important not to discontinue it abruptly, as stated before. Certain drugs have to be tapered off under the supervision of your physician.

Remember, though, that when you find a health care professional that you're satisfied with, the two of you are working together as a team. Together you will be able to develop a plan to treat your anxiety disorder that may involve medications, cognitive-behavioral or other talk therapy, or both, as appropriate.

You may be concerned about paying for treatment for an anxiety disorder. If you belong to a Health Maintenance Organization (HMO) or have some other kind of health insurance, the costs of your treatment may be fully or partially covered. There are also public mental health centers that charge people according to how much they are able to pay. If you are on public assistance, you may be able to get care through your state Medicaid plan.

Strategies To Make Treatment More Effective

Many people with anxiety disorders benefit from joining a self-help group and sharing their problems and achievements with others. Talking with trusted friends or a trusted member of the clergy can also be very helpful, although not a substitute for mental health care. Participating in an Internet chat room may also be of value in sharing concerns and decreasing a sense of isolation, but any advice received should be viewed with caution.

The family is of great importance in the recovery of a person with an anxiety disorder. Ideally, the family should be supportive without helping to perpetuate the person's symptoms. If the family tends to trivialize the disorder or demand improvement without treatment, the affected person will suffer. You may wish to show this booklet to your family and enlist their help as educated allies in your fight against your anxiety disorder.

Stress management techniques and meditation may help you to calm yourself and enhance the effects of therapy, although there is as yet no scientific evidence to support the value of these "wellness" approaches to recovery from anxiety disorders. There is preliminary evidence that aerobic exercise may be of value, and it is known that caffeine, illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of an anxiety disorder. Check with your physician or pharmacist before taking any additional medicines.

For More Information

Anxiety Disorders Information and Organizations from NLM's MedlinePlus (en Espanol)

For Information About Clinical Trials

NIMH Clinical Trials Web Page www.nimh.nih.gov/studies/index.cfm

National Library of Medicine Clinical Trials Database www.clinicaltrials.gov

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This brochure is a revision by Mary Lynn Hendrix of an earlier version written by Marilyn Dickey.

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When Change Comes: Dealing With Grief and Loss

By Dr. Brenda Shoshanna

Dr. Brenda Shoshanna

We all want to live in a world that feels stable and secure, and do all we can to make it that way. For those suffering from mental illness creating a sense of safety and stability can be a challenge on a daily basis. Then, when the world as they know it is suddenly torn apart by either natural or personal catastrophes, not only is there deep shock and sorrow, but there is an added burden in feeling balanced and safe

At a time of sudden change or loss, along with a sense of abandonment and sorrow, anger often arises as well. Most have little understanding of what they are going through or what to expect in the future. Facing the unknown can produce additional fear.

Yet, when the process of grief is handled properly, suffering can be diminished for all. It is even possible for the individual to grow a great deal during this time and benefit from the experience.

The Dynamics of Loss And Change

The more we understand what we are going through, the less out of control we will feel. At a time like this we need context, meaning and direction. We need to know what to expect and how to handle the many changes that are happening.

The Dynamics of Loss and Grief

Each person reacts differently to loss and that is fine. Some feel abandoned, others feel betrayed and afraid. Some reach out for love and comfort, while others withdraw, wanting time alone. Some go into denial and seem not to register the loss that has happened. These individuals are often unconsciously processing what has happened, not ready to face reality yet. They may fear they will be overwhelmed if they allow themselves to register what has gone on at this time. It is best not to pressure a person to react differently. When the individual is accepted for who they are at the moment, it is easier for them to let go, and move on. This entire process takes time.

It helps greatly to realize that the pain we go through during grief is normal. It does not mean there is something wrong with us. We need not feel ashamed of or afraid of our feelings. And, in order to best handle these feelings, there is a fundamental assumption that must be questioned. It is the idea that pain is terrible and must be avoided at all costs.

Most people do all they can to avoid experiencing their feelings directly. Many fear that if they face their suffering, it will make them feel small and helpless. Actually, the opposite is true. By allowing ourselves to enter the truth of the moment and experience it, we actually become stronger, and once feelings are fully experienced, they can simply let go.

In order to do this, it's best not to control or resist the feelings. When different emotions arise be gentle with yourself and patient. When these feelings are not resisted, they simply come to awareness and then fade away. The next time they return they are milder. This happens for awhile. This is a process of letting go.

Feelings that are repressed indefinitely come out later in different ways, including various physical symptoms, phobias and unwanted behaviors. If we do not address our feelings in one mode, they will appear in another - physically, mentally, emotionally, spiritually. It takes courage and strength to face our situation directly and grieve fully. Not only that, but when we learn to accept and listen to our feelings, we find that the pain itself has a meaning. It's there to be listened to.

Exercise

- Turn to a feeling you are having and enter a dialogue with it. Ask, "What are you saying to me?" Listen for an answer. Ask, "What can I learn from this difficult situation? How can I grow strong?" Become silent and listen. As you do this more and more, insight and inspiration will come your way.

- Think of three times in your life when you felt particularly sad or upset. Notice how you handled it. Did you express the feeling? Did you take action on it? Did you pretend it wasn't there? What happened to you physically? Take a moment to write all this down. Look at the connections between your feelings, actions and reactions. Become aware.

Be Patient

Grief cannot be rushed or willed away. It takes us on a journey and it takes time. Grief is a process that should be honored. The loss we've suffered has

see Change on page 42

Medicare from page 16

prior approvals or authorizations and charging higher co-pays to receive higher-tier drugs. Keep in mind that plans with tiered co-pays will be far preferable to dual eligibles than plans with prior approval tiers because dual eligibles are never required to pay more than $1/$3 copays or, in some cases, no copay at all. That way, dually eligible beneficiaries can have easy access to higher tiered drugs without having to comply with requirements for prior approval or other special condiditions.

Drugs Covered

All Medicare drug plans will offer both brand name and generic drugs by prescription only. However, drug plans are not required to cover all drugs or all dosages or methods of administration (e.g., time release). The basic rule is that a drug plan must offer at least two drugs in each class of drugs. However, the Medicare program has mandated that for 2006, drug plans must cover all or substantially all of the drugs in the following six classes: antidepressants, antipsychotics, anticonvulsants, antiretrovivals, antineoplastics and immunosuppressants. However, even in this special group of six classes, drug plans will not have to cover all dosages or formulations.

Certain types of drugs are specifically excluded by statute from the Part D program, for example, drugs for anorexia, fertility drugs, drugs for hair growth and drugs to relieve cough and cold symptoms. Also specifically excluded from the program are barbiturates and benzodiazepines, which is of particular interest to the mental health community, because some of these excluded drugs may be used to treat certain mental illnesses.

The Medicare website located at **www.medicare.gov** will have a special drug finder program that will enable anyone to determine what plans in their region cover a specific medication. For those without internet access, Medicare has opened a 1-800-MEDICARE toll-free number that will provide individual assistance in finding the best drug plan. Individuals can also change plans over the internet or by calling the Medicare 800 number.

Exceptions and Appeals

Even after a diligent review of the drugs covered under the benchmark plan, it is still very possible that a dual eligible may enroll in a plan that does not cover a specific medication that the patient's doctor has prescribed. An enrollee can submit a request for an exception and, if the request is made by the enrollee's physician and the physician requests expedited review, the plan must respond to the request within 24 hours. If the plan denies the request for an exception, there are multiple levels of appeal that may be pursued.

Pharmacies

Unfortunately, not every pharmacy will be able to fill every Medicare Part D prescription. Each drug plan in a region will have its own network of pharmacies. All Medicare Part D enrollees (including dual eligibles) will only be able to fill their prescriptions at a pharmacy that is enrolled as a participating pharmacy with their drug plan. While it is anticipated that most large pharmacy chains will participate in most drug plans, all Medicare Part D enrollees including dual eligibles will have to check whether the pharmacies participating in their drug plans are located in their community or neighborhood.

New York State Medicaid Wrap Around Program for Dual Eligibles

Because New York State covers benzodiazepines and barbiturates under its Medicaid program, the federal government has mandated that these drugs must continue to be covered through the New York State Medicaid Program for all dual eligibles.

In addition, New York State Medicaid has announced that it will provide a special "wrap-around" benefit to provide coverage through the Medicaid program when a dual eligible cannot secure coverage for a prescription through a Medicare Part D plan because plan does not include the drug or has refused to cover the drug because of special coverage rules.

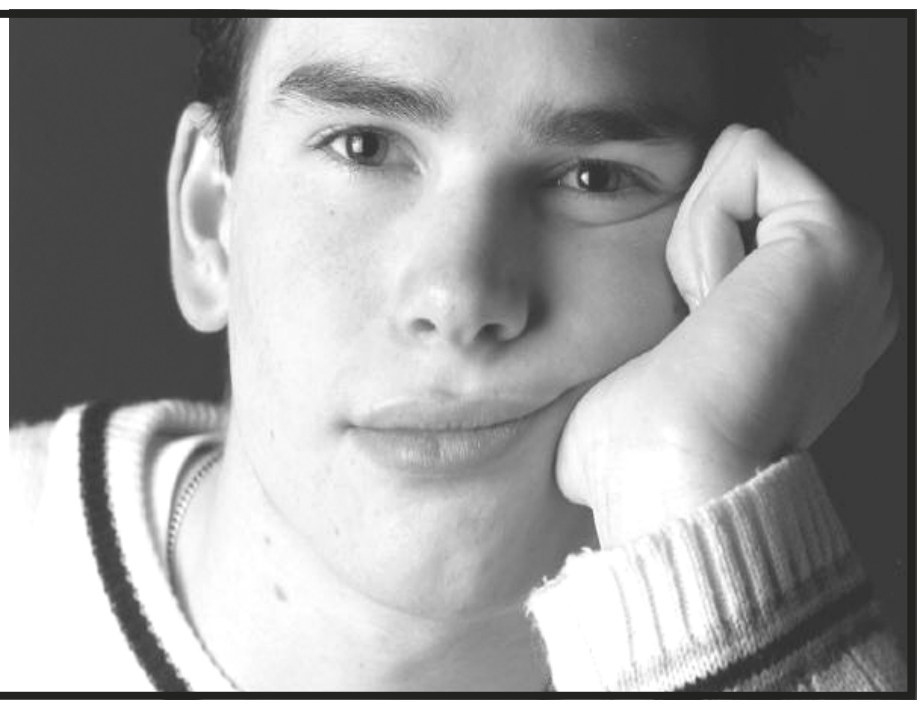
In such cases, the enrollee will only be required to request an exception from the plan and, if denied, the New York State Medicaid Program will cover the drug provided it is covered under the New York State Medicaid program. This wrap-around program is entirely optional and many states will not provide dual eligibles with wrap-around coverage for drugs not covered under Medicare Part D. The enrollee's physician will be required to contact New York State Medicaid and secure an authorization number covering the wrap-around prescription and provide this number to the pharmacy. Only New York and New Jersey have agreed to provide "wrap-around" benefits through their state Medicaid programs for drugs not available from the Medicare Part D plan.

A Final Word

Medicare has not yet finalized all aspects of the program and its operation, even now less than two months from its start date on January 1, 2006. The information in this article reflects the best information available as of November 2, 2005.

All dual eligible individuals who face auto-enrollment in Medicare Part D and loss of Medicaid coverage for their medications at the end of this year should make sure that they secure renewals of their current medications at the end of December so that they have an adequate supply of medication on hand in January. No one wants to be the first person who goes to a pharmacy on January 1, 2006 to fill a prescription under the Medicare Part D program. Dual eligibles who have a month's supply of their medications on hand will be able to wait until the inevitable program glitches and computer software problems are resolved.

Seth P. Stein is the Executive Director and General Counsel of the New York State Psychiatric Association. Mr. Stein is also senior partner in the law firm of Stein & Schonfeld LLP. Rachel A. Fernbach is an associate attorney in the firm.



Agoraphobia from page 20

The latter can be habit-forming in individuals predisposed to alcohol or substance disorders, so must be carefully monitored for abuse. The former have been used for the treatment of depression, and have been found effective in reducing some symptoms of anxiety. Benzodiazepines generally are used for alleviation of the short-term florid symptoms of anxiety, and there are safer alternatives, such as beta-blockers, which have been found effective with people who fear public speaking. Of course with all medications, consultation with a treating physician is required, and knowledge about the side effects and careful monitoring of them is important.

Self-help and family and community support are also important components in the treatment of agoraphobia. Preliminary studies by NIMH (2005) have shown that when spouses or loved ones participate in the cognitive-behavioral treatment of agoraphobia, better outcomes and self-efficacy are achieved. There are numerous support groups based on the 12-Step model for those suffering from agoraphobia, as well as on-line chat rooms and support networks. Of course with the latter, care should be taken not to use the Internet as the sole source of treatment, as that this very activity can be done from the home or personal safety zone that the agoraphobic has created.

As can be seen from this article, the prevalence of agoraphobia as an anxiety disorder is a very real problem in America. The underlying causes of the disorder are varied and complex, and scientists are just beginning to unlock the secrets of how the brain and nervous system impact and are impacted by agoraphobia. Treatment for the problem is available, and outcomes, as with any anxiety disorder, are quite positive when we remember the strength, determination, and sheer willpower of those in treatment who want freedom from this crippling problem.

Scrupulosity from page 19

Dr. Liebowitz arranged to receive the drug on a humanitarian protocol. The drug was Prozac.

During the following months I watched in amazement as a miracle unfolded before my eyes. First came the remission of Mrs. Murphy's severe major depression. Then she began to wash her hands less and less. The major breakthrough came when I received a call from my bishop friend. He could not believe it. Mrs. Murphy had stopped calling him to seek absolution for her "sins." She was still very visible at the prayer meetings and church attendance, but her whole demeanor had changed. He reported that she was a new person. "Whatever you are doing please continue it," said the bishop.

Mrs. Murphy was my first experience with scrupulosity. Since 1987 I have seen many people with this illness. I make it a point when talking with someone who has OCD to also inquire about traits of scrupulosity. I have seen many orthodox Jews who keep very strict kosher homes. They suffer from behaviors similar to those of Mrs. Murphy, but with a slight variation. They obsess that they are not following the mandates of keeping their home "kosher." They take great pains to constantly check that everything is done correctly.

Eric Peselow MD, Research Professor of Psychiatry at New York University Medical School and Consultant to Freedom From Fear related a case to the author of a man who would call his rabbi saying he was a bad orthodox Jew because he thought that he had eaten five minutes after sundown on Yom Kippur eve, a strict day of fasting and a very holy Jewish holiday. For years he obsessed about following the mandates of Jewish law. His rabbi did not realize that this was a symptom of OCD. The rabbi believed that the man was trying hard to be an observant Jew. Fortunately, the man confided his over concern regarding the requirements of his religious mandates to a friend. The friend was very familiar with these behaviors and understood that they were way beyond appropriate and were rooted in uncontrollable anxiety. He convinced the man to see Dr. Peselow for a consultation.

Like Mrs. Murphy, this man was diagnosed with scrupulosity. He was successfully treated with medication and therapy. Dr. Peselow also solicited the help and support of the man's rabbi. What was particularly rewarding was not only the relief and improved quality of life for this man, but his rabbi became educated about anxiety disorders and was able to use this knowledge in counseling the members of his religious community.

OCD is quite common. About 2.3% of the population suffers from it. It has not been estimated what percentage of these people suffer with scrupulosity, since they probably fall into the numbers for OCD. Traditional treatments for OCD, like medication and cognitive behavioral therapy can be very effective for people suffering with scrupulosity. However, it is often very helpful for a mental health professional to work with a rabbi, priest, minister, etc. They are familiar with the religious component of the individual's belief system. Also, they offer a trust network.

An interesting point about this illness is that it has affected even the most saintly of individuals. Saint Ignatius of Loyola, the founder of the Jesuit Order and Saint Theresa, the Little Flower, both suffered from scrupulosity. Appropriately, Professor J.W. Ciarrocchi of the Institute of Pastoral Studies of Loyola University has called the illness The Doubting Disease. Today research has provided a much clearer understanding of scrupulosity. It is recognized as an anxiety disorder and a form of OCD. This has resulted in help for those who suffer with scrupulosity.

To learn more about anxiety disorders call 718-351-1717 or visit our Web site www.freedomfromfear.org.

Child Anxiety from page 18

not always needed but can be very help-ful in the initial phases of treatment with moderate to severe symptoms and/or where the child's growth is stunted in social, educational, or family situations. A special type of therapy called Cognitive Behavior Therapy (CBT) is usually very effective in treating high anxiety. In CBT, children and parents learn where high anxiety comes from and what to do about it. They learn how to calm themselves when anxiety is too high and how to change unhelpful thoughts and behav-iors including *avoidance* behaviors that only serve to strengthen anxiety. Although anxiety is an emotion that cannot and should not be eliminated in life (anxiety does have a protective value when real danger is present), with appropriate coaching and careful guidance by a trained professional, children and their parents can learn how to take control of this emotion before it takes control of the child ... and her family!

The moral of the story ... don't be afraid of anxiety, but don't ignore it either. You can help your child nip it in the bud. When it comes to anxiety, an ounce of prevention is truly worth a pound of cure.

Perspectives from page 18

building as a tool for managing anxiety. It also helps us to recognize that usually people will, in response to unresolved problems, seek to correct the situation or bring it to closure. However, if the nature of the problem is too disturbing, the problem solving process may unfold on an unconscious level. This unconscious process, which propels the person into action, is manifested as emotional discomfort or anxiety.

During this period the person may engage in symbolic "problem solving" activities designed to reduce anxiety; however, since these measures only-provide momentary relief, the anxious state will tend to resurface. We know that certain medications can alleviate this condition but it has also been found that individuals are likely to benefit from a cognitive behavioral intervention. This treatment approach helps the person understand why their prior attempts to reduce anxiety have been unsuccessful and encourages the client to adopt new attitudes and behaviors that target the underlying cause of the anxiety.

The staff person described above was symbolically addressing the matter of the client's heart attack, by obsessing on the question of what to do with the pocketbook. She was distressed by the incident and could not face the fact that the client could have died and she could not help. This disturbing thought was repressed; but the anxiety continued. Thus, the person sought a symbolic problem solving thought, that being, that all would have been alright if she knew how to properly dispose of the pocketbook.

There are innumerable examples of people displacing anxiety or anger. This often occurs because people feel ill equipped to face the disturbing thought and lack the skills needed to effectively address the presenting issue. Cognitive Behavioral therapy can assist with this condition by helping the client to replace the sense of incompetence with more positive and rational thoughts. In addition, the client would be provided with instruction on how to develop behaviors that would enhance their self esteem, sense of control and state of well-being.

Courage from page 24

Francesca's painful disclosure freed her to then tell me that several years after this traumatic experience she was sexually assaulted. She had never told anyone–not her husband or her children–any of this. Finally she had named the driving forces of her anxiety.

It took many more months for Francesca to believe that she was not her brother's killer. She admitted to hateful and murderous feelings toward her mother, and began to appreciate the intersection of these feelings, the traumatic events that had given rise to them and her decades-long emotional and even physical pain. Eventually–on her birthday–she told her children her story. Though it saddened her deeply, she also felt tremendous relief.

Since her disclosure two years ago, Francesca has remained largely in control of her anxiety. She has an occasional panic attack, but can barely remember the last time she called 911. This year she has been sorely tested, as her father was diagnosed with cancer in the spring and is near death. Faced with this loss, Francesca has handled herself with considerable grace and determination. She recently reported that she could see that her mother was also suffering. She has been at her father's side constantly and has made good use of her self-soothing capacities. She worries about being able to cope but seems to know, in a new way, that she can.

Correction:

In the Summer 2005 issue of Mental Health News, Vol. 7, No. 3, pp. 36-37, the article entitled, " Mental Health Issues for Grandparents Raising Grandchildren, " by Deborah Langosch, PhD, LCSW, her title is Project Director at the Center for Trauma Program Innovation at JBFCS, not Program Director.

Social Security Announces 4.1 Percent Benefit Increase for 2006

Social Security Administration

Monthly Social Security and Supplemental Security Income benefits for more than 52 million Americans will increase 4.1 percent in 2006, the Social Security Administration announced today.

Social Security and Supplemental Security Income benefits increase automatically each year based on the rise in the Bureau of Labor Statistics' Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), from the third quarter of the prior year to the corresponding period of the current year. This year's increase in the CPI-W was 4.1 percent.

The 4.1 percent Cost-of-Living Adjustment (COLA) will begin with benefits that more than 48 million Social Security beneficiaries receive in January 2006. Increased payments to 7 million Supplemental Security Income beneficiaries will begin on December 30.

Some other changes that take effect in January of each year are based on the increase in average wages. Based on that increase, the maximum amount of earnings subject to the Social Security tax (taxable maximum) will increase to $94,200 from $90,000. Of the estimated 161 million workers who will pay Social Security taxes in 2006, about 11.3 million will pay higher taxes as a result of the increase in the taxable maximum in 2006.

Social Security Disability (SSD) thresholds for substantial gainful activity (SGA) will increase from $830 a month in 2005 to $860 a month in 2006 for non-blind recipients. The trial work period (TWP) will increase from $590 a month in 2005 to $620 a month in 2006

It is important to note that no one's Social Security benefit will decrease as a result of the 2006 Medicare Part B premium increase, announced last month. By law, the Part B premium increase cannot be larger than a beneficiary's COLA increase. More information about Medicare can be found at www.cms.hhs.gov.

Change from page 39

functioned as an earthquake in our lives, disrupting our equilibrium. During the journey of grief a new balance is being re-established. Like the nine months it takes for a baby to grow, we must be patient as we integrate events and as life knits us together again.

The Work Of Grief

When we are grieving, interest in the outside world subsides, we slow down, sleep more, our social activities seem less meaningful. This is not necessarily bad. An individual may need more time alone. In this process the grieving individual is actually contemplating the very nature of their lives and relationships, that which was done and that which may have been left unsaid or undone.

The more significant the losses the longer the process can take. Grief takes us deep into to the heart of ourselves. Often at the end of the journey we emerge stronger, wiser, more aware, and with our values re-aligned.

Grief is usually most difficult when the individual has had troubled or incomplete relationship. When there have been unsolved conflicts left behind, this makes it harder to be at peace. Many spend time blaming themselves for what they did or didn't do. Others blame doctors, helpers or family members. Casting blame is a way of removing the guilt and sorrow we feel. The sooner they are able to let go of blame and accusations, the sooner they start on the road of healing.

Let Go Of Blame

Blame, self hate and other forms of anger, are common during grief. Although it is important not to repress anger and disappointment, it is best to feel it and then let it go. Some individuals hold onto anger as a way of keeping connected to the person or situation they have lost. The truth is that anger always keeps us out of balance. It is a poison to the one who holds onto it.

Normal and Pathological Grief

Though the process of grief itself is normal, (and even beneficial) it can become pathological. This happens when an individual becomes unable to pass through a phase and let go, or when they realize that there are secondary benefits to gain from grieving. Some use their loss and grief to manipulate others and to control.

Some decide to blame God and hate life itself, to see themselves as the victim of an unjust fate. These individuals can become martyrs and manipulators. Sensitive or weak family members often become vulnerable to this kind of person. But by understanding that this is not the normal course of grief, but a distortion of it, the family member can begin to prevent themselves from affected by it and try to get the person professional help.

Other pathological aspects of the grief process include guilt about surviving or about having love and pleasure in one's life. An individual feels that now that their loved one is gone, they should "die" as well. They live diminished lives out of respect for the one who is gone. Some idealize the lost relationship and feel no one else in the world can ever be as wonderful. This becomes a reason not to socialize, contribute or share love again.

Others blame themselves bitterly for what happened, and engage in self-punishment for what happened. All of these are forms of pathological guilt, and require help.

Coming To Terms Steps You Can Take

Ultimately one must reconcile oneself to what happened. Through acceptance of reality, of oneself and the other, one develops the power the affirm life, and to grow. One can then give to others, and become a source of inspiration, and live a life that is meaningful. The discovery and experience of value and meaning in one's life and one's losses is the most potent healing of all.

Hopefully, we come to a point where forgiveness can take place, (forgiveness of the person we've lost, forgiveness of ourselves, the universe, or whatever it is we feel anger with). In order to do this, it is deeply helpful to realize that all of life is temporary. People possessions, situations are given to us for a short time. As we acknowledge the transitory nature of life, we can then begin to look deeper and see what it is that we never lose.

Below are a couple of exercises that are helpful in coming to terms with the relationship you have lost, and with the meaning of loss itself.

Exercise – Giving Gifts

Make a list of the gifts you received from the person, the ways they taught and inspired you. Now find ways to give those gifts to others. As you do so, not only will you be acknowledging what you received from that person, but honoring their memory and keeping their spirit alive.

Exercise – It Suffices

Whenever you think of the person and the way they fell short, what they didn't give you, say to yourself, "It Suffices." This is in recognition that they gave all they could, being who they were, and that you can feel satisfied with what you received. (This is an ancient Buddhist practice)

Prayer, Silence And Meditation

Of course the deepest sense of healing, peace and security can come from our connection to God, A Higher Power or our Higher Selves, (different people call it by different names). During the process of grieving it is very helpful to be able to connect with that which is ultimately meaningful to you. Either through prayer, silence, contemplation or meditation, know that you are looked after and protected and that there is a larger purpose in all that happens, though you may not be totally aware of it. Our true security, in all kinds of circumstances, comes from this kind of understanding.

Dr Brenda Shoshanna, psychologist, speaker, relationship expert has offered over 500 workshops on all aspects of relationships and personal development, including dealing with illness, change and loss. She is the author of many books including The Anger Diet, (30 days to Stress Free Living), McMeel, www.theangerdiet.com, and Journey Through Illness and Beyond, www.journeythroughillness.com Zen Miracles (Finding Peace In An Insane World), Wiley. You can contact her at: topspeaker@yahoo.com or at www.brendashoshanna.com (212) 288-0028.

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	Width	Height
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