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Innovations in Understanding and Treating Anxiety and Depression

Hope, Healing, and Peer Support: A Path Through Depression

By Meghann Simpson, BA, YPA-C, CRPA-P
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Now She Speaks

According to the National Institute of Mental Health (NIMH), an estimated 1 in 5 teenagers experience depression, and 1 in 12 adults have experienced depression in their lifetime.[1] Depression can be a devastating illness. Symptoms of depression may include persistent sadness, hopelessness, loss of enjoyment in life, sleep disturbances, feelings of worthlessness, and in the most severe cases, even death.

With depression being so prevalent in our society, it is essential to have professionals who can address the community's needs. Among these professionals, peer advocates have emerged as a uniquely valuable form of support, bridging the gap between clinical services and lived experience. Peer advocates are individuals who have faced a mental, behavioral, or emotional health challenge, been involved in a system, or experienced recovery from addiction, and who now use their journey of healing to support others along their own paths. Peer advocates have become increasingly sought after, as their support can be profoundly impactful for those actively struggling with these challenges.

Impact, Stigma, and Barriers

Depression has a significant impact on someone's life, both in the short term and long term. In the short term, it can interfere with school, work, and relationships by causing fatigue, loss of concentration, and withdrawal from loved ones. Over the long term, untreated depression can increase the risk of chronic health problems, substance use, and suicidal behavior. [2]

Despite its prevalence, many individuals continue to struggle in silence due to feelings of isolation, stigma, shame, and practical barriers to care. Many individuals experiencing depression may fear being judged, misunderstood, dismissed, or forced into treatment they do not want. Some stigmas include the belief that depression is a sign of personal weakness, the misconception that people should "snap out of it," and the stereotype that depression only affects certain types of people. Some people feel shame for experiencing depression because they feel responsible for the challenges they face due to symptoms. Another contributing factor to shame is someone's immediate culture and how their community views mental illness. Practical barriers, such as limited access to affordable care, long wait times for appointments, or a lack of providers in rural communities, often make it even harder to

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From Childhood Fears to Adult Anxieties: Understanding Anxiety Across the Lifespan

By Debra G. Salzman, PhD
and Hongmarie J. Martinez, PsyD
Behavior Therapy Associates

Anxiety is a universal human emotion that we all experience, both children and adults alike. In fact, it is normal to experience some anxiety and worry at times, as anxiety can be adaptive in nature and serve both as a motivator and as a means of keeping us safe. For example, anxiety can indicate to our brain that there may be something important to address in the future (i.e., studying for an upcoming test or preparing for a job interview), or it may be alerting us to a possible threat that we need to prepare for to maintain our safety (i.e., a flash flood warning).

However, both children and adults can experience excessive anxiety that becomes maladaptive and rises to the level of an anxiety disorder. In fact, the National Institute of Mental Health highlights via the National Comorbidity Survey Adolescent Supplement that the lifetime prevalence rate of anxiety disorders among adolescents in the U.S. aged 13-18 was 31.9% (Merkangas K.R., et al., 2010). Meanwhile, the prevalence data via the National Comorbidity Study Replication indicated that about 31.1% of adults in the U.S. experienced an anxiety disorder in their lifetime (Harvard Medical School, 2007).

It is important to note that there are different anxiety disorders that children and adults can experience and knowing the differences and which one is affecting an individual can help determine the support and treatment needed. Some of the common anxiety disorders and their core features that are listed in the Diagnostic and Statistical Manual of Mental Disorders 5th edition, text revised (DSM-V-TR), include the following (American Psychiatric Association, 2022):

- **Separation Anxiety Disorder:** excessive fear or anxiety about separation from home or from a major attachment figure (i.e., a parental figure)
- **Specific Phobia:** excessive fear or anxiety about certain objects or situations (i.e., heights, dogs, elevators, vomiting, etc.)
- **Social Anxiety Disorder:** excessive fear or anxiety about social situations where an individual is exposed to possible scrutiny or judgment from others (i.e., common social situations may include public speaking, asserting oneself, starting or maintaining conversations, being observed)
- **Panic Disorder:** excessive fear or anxiety about experiencing re-occurring panic attacks
- **Agoraphobia:** excessive fear or anxiety

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David Minot, Executive Director, Mental Health News Education, and Publisher, BehavioralHealthNews.org

The Connection Between Tobacco, Depression, and Anxiety

By Kristen Richardson, RN, CTTS and Danielle O'Brien, MS, CTTS St. Joseph's Health

Despite decades of public health efforts, tobacco use remains a persistent public health issue, especially for individuals experiencing depression and anxiety. These two common mental health conditions are closely linked to tobacco use, both in terms of higher smoking prevalence and the emotional mechanisms that sustain nicotine dependence. Understanding this relationship is essential for effective prevention, treatment, and recovery strategies.

While smoking rates have declined across the general population, they remain disproportionately high among individuals with depression and anxiety. Research shows that people with these conditions account for nearly 40% of all cigarettes consumed in the U.S., despite representing a much smaller share of the population.[1] Population-based studies, including a major Norwegian survey, have found that individuals with symptoms of anxiety and depression are significantly more likely to be current smokers compared to those without these symptoms.[2]

This association is particularly concerning because individuals with depression or anxiety often smoke more heavily and are more likely to become nicotine dependent.[3] Additionally, the co-occurrence of both conditions has been found to strengthen the association with tobacco use, suggesting a compounding effect.[2] The relationship between tobacco use and emotional distress is commonly explained by the self-medication hypothesis. According to this model, individuals with anxiety or depression may start or continue smoking to alleviate symptoms like sadness, tension, or irritability.[4] Nicotine can provide short-term relief by temporarily boosting neurotransmitters such as dopamine and serotonin, which influence mood and reward.[5]

However, this relief is typically fleeting and may represent the alleviation of nicotine withdrawal rather than an improvement in underlying mental health. As nicotine levels drop, symptoms such as restlessness, low mood, and anxiety re-emerge, reinforcing the cycle of dependence.[6] Beyond psychological explanations, nicotine's interaction with the hypothalamic–pituitary–adrenal (HPA) axis, which regulates the stress response, provides a biological basis for its effects on mood. Chronic nicotine use dysregulates this system, increasing stress sensitivity and emotional instability over time.[7]

Additionally, Mendelian randomization studies have found causal evidence that smoking increases the risk of developing depression and even schizophrenia, rather than simply being a consequence of them.[8] This supports the view that smoking may not only sustain but also exacerbate or even initiate mood disorders in vulnerable individuals.

Contrary to the belief that quitting smoking could worsen mental health, evidence shows the opposite. A major meta-analysis of 26 studies found that individuals who quit smoking experienced significant reductions in depression, anxiety, and stress, along with improved overall mood and quality of life.[9] These benefits applied to people with and without diagnosed mental illness. More recent longitudinal research, including a 2023 population-based study, reinforced these findings, showing sustained mental health improvements after quitting—especially among people with a history of psychiatric symptoms.[10]

While many people with anxiety or depression want to quit smoking—and do so for the same reasons as the general population—they may face unique challenges.

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Staff Engagement Improves Patient Wellbeing in Psychiatric Settings

By InvisALERT Solutions

Inpatient psychiatric units are often the first point of stabilization for individuals in crisis, many of whom are experiencing acute anxiety or depression. Standard treatment models include group therapy, individual sessions with psychiatrists and therapists, medication management, psychoeducational groups, and activity-based interventions. While these approaches form the backbone of care, consistent socialization, staff engagement and peer-to-peer connections can be vital to recovery.

Recent studies highlight that intentional staff rounding, structured, scheduled check-ins with patients improves safety, and increased engagement can reduce the length of stay. Similarly, peer support, whether organically occurring or built into group formats, has been shown to enhance coping skills, reduce isolation, and contribute to better mental health outcomes.

The Value of Intentional Rounding

Intentional Rounding (IR) refers to systematic, scheduled visits by staff for each patient, typically at 15-, 30-, or 60- minute intervals. Originating in acute units, IR has demonstrated clear benefits such as increased patient satisfaction, improved safety, and enhanced communication between staff and patients (Brosey & March 2015; Sims et al., 2018).

In psychiatric care, this IR practice takes on additional importance. Patients who are admitted in crisis often require close monitoring to ensure safety. Regular rounding not only confirms wellbeing but also creates opportunities for therapeutic interaction. Staff observing behavioral patterns during these checks can often detect subtle changes, such as withdrawal from activities or changes in mood, well before they escalate into safety concerns. This proactive approach allows for earlier intervention and reduces the likelihood of sentinel and non-sentinel events.

From a nursing perspective, IR is not just a box to be checked. It allows staff to build rapport, demonstrate presence, and show patients that they are consistently supported. Over time, these interactions strengthen trust and improve engagement with formal treatment modalities like group therapy and individual counseling.

Peer Support in Psychiatric Units

Alongside staff engagement, peer-to-peer interaction plays an important role in patient recovery. Research shows that patients in inpatient units naturally support one another through shared experiences, advice, companionship, and empathy (Kogstad, Monness, & Sorensen, 2013). These connections often help patients feel less isolated and more hopeful about recovery.

Formalized peer support, such as structured group therapy, further builds on this foundation. Group settings provide opportunities to develop social skills, learn coping strategies, and recognize commonalities with others. Yalom's therapeutic factors, such as universality, altruism, and the instillation of hope, are well documented benefits of group psychotherapy (Yalom & Leszcz, 2020).

Recent systematic reviews confirm that peer support can improve recovery and psychosocial outcomes, particularly among younger populations experiencing anxiety and depression (Lawn et al., 2008; Brown et al., 2023). While peer interaction does not replace evidence-based treatment, it meaningfully complements it by reinforcing engagement and reducing feelings of loneliness.

Even environmental design reflects this principle: many psychiatric units avoid placing patients in private rooms unless necessary, recognizing that shared spaces reduce isolation and encourage natural peer interaction.

The Role of Education and Monitoring

Staff engagement is most effective when paired with education and awareness. Staff in psychiatric settings often lead educational groups on topics like stress management, nutrition, medication adherence, and coping strategies. These sessions not only deliver practical knowledge but also create opportunities for patients to ask questions and strengthen their sense of agency in recovery.

In addition to structured teaching, routine in person rounding gives staff valuable insight into patient progress. Attendance at group therapy, participation in activities, and engagement with peers are all observable behaviors that can indicate how well a patient is responding to treatment. When staff notice patterns, such as a patient skipping multiple group therapies, they can intervene early, providing additional support or adjusting rounding frequency to ensure safety and wellbeing.

This dual role of educator and observer reinforces the therapeutic alliance. Patients see staff not only as safety monitors, but also as partners in recovery who provide guidance, encouragement, and timely interventions. In turn, staff gain deeper understanding of patient needs, allowing them to tailor care with greater prevision.

Combining Staff and Peer Engagement

When intentional staff rounding and peer socialization are implemented together, they create a comprehensive support system. Staff engagement ensures safety, consistency, and individualized attention, while peer interaction fosters empathy and shared resilience.

For example, a patient who misses group therapy may be identified through staff rounding. Rather than allowing disengagement to go unnoticed, the staff member can provide additional support, encourage participation, or explore barriers to involvement. This blend of oversight and encouragement reinforces accountability while showing compassion.

In this way, staff engagement and peer connection are not separate strategies but complementary forces that promote recovery and wellbeing.

Technology as a Supportive Resource

Although patient care is rooted in human interaction, technology can strengthen the consistency and reliability of engagement practices. A safety platform such as ObservSMART offers proximity-required rounding, structured reminders and alerts, and easy-to-use documentation features that help staff maintain in person timely rounds and easily note behavioral observations in real-time.

By reducing the risk of missed check-ins, supporting staff engagement, and providing data that highlights changes in behavior or therapy attendance, this technology acts as a safety net. Technology does not replace the personal element of staff to patient interaction – it enables staff to sustain consistent, high-quality engagement and patient safety.

Outcomes of Engagement Practices

Research and frontline experience show that staff engagement and peer connection lead to several measurable outcomes in psychiatric care:

- **Shorter lengths of stay**: Patients who are consistently engaged tend to progress more quickly through treatment.
- **Higher patient satisfaction**: Regular, meaningful contact reassures patients and improves their overall experience of care.
- **Improved safety**: Frequent observations allow for early detection of risk behaviors or mood deterioration, enabling timely interventions.
- **Enhanced psychosocial recovery**: Peer connections reduce isolation, foster coping skills, and reinforce treatment gains.

These benefits highlight the importance of viewing engagement not as an optional addition to care, but as a core element of effective psychiatric treatment.

Conclusion

For patients admitted with acute anxiety or depression, the inpatient psychiatric units are more than a place of safety, it's a space where healing is nurtured through connection. Intentional rounding by staff and the promotion of peer interaction contribute significantly to patient wellbeing, complementing formal therapies and medical management.

By blending technology, structured staff rounding and engagement, with opportunities for peer support, psychiatric units create environments where patients feel seen, supported, and empowered in their recovery. Genuine human connection, process, and technology can play a supportive role in sustaining psychiatric care practices.

For additional information regarding ObservSMART, visit our website: https://www.observsmart.com/learn-more/.

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Telehealth Versus Face-to-Face Therapy for Treating Anxiety: Evidence-Based Considerations for Clinicians

By Richard Anemone, MPS, LMHC
Senior Vice President, IDD Division
Institute for Community Living (ICL)

Telehealth has transformed the delivery of psychotherapy, particularly in the treatment of anxiety disorders. This article examines evidence comparing telehealth and face-to-face therapy outcomes for anxiety, explores therapeutic modalities effective in each format, outlines best practices for diagnostic assessment, and provides comprehensive clinical recommendations. Current research demonstrates comparable efficacy across modalities, with cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), exposure therapy, and mindfulness-based interventions adaptable to both telehealth and in-person settings. Additional focus is given to diagnostic strategies, clinician best practice tips, cultural considerations, crisis management (including licensure requirements), hybrid care models, and relapse prevention to optimize anxiety treatment outcomes.

Introduction

Anxiety disorders are among the most prevalent mental health conditions worldwide, impacting functioning, quality of life, and overall well-being (American Psychiatric Association [APA], 2022). Accurate diagnosis and effective intervention are essential, yet modality of care, telehealth versus face-to-face, raises practical, clinical, and ethical considerations for therapists. As telehealth expands rapidly in clinical practice, clinicians must integrate evidence-based strategies to ensure efficacy across both remote and in-person formats.

Best Practices for Diagnosing Anxiety

Telehealth Diagnosis - Telehealth assessments rely on structured interviews, validated self-report scales, and remote observation. Evidence indicates that diagnostic accuracy remains high when standardized tools are used via secure video platforms (Shore et al., 2018).
Recommended tools:

- Mini-International Neuropsychiatric Interview (MINI): Validated for DSM-5 diagnoses, adapted for telehealth.
- Self-report scales: Generalized Anxiety Disorder-7 (GAD-7), Beck Anxiety Inventory (BAI), and Overall Anxiety Severity and Impairment Scale (OASIS) are brief, validated instruments easily administered electronically (Spitzer et al., 2006).
- Child assessments: The Screen for Child Anxiety Related Disorders (SCARED) includes both child and parent reports, suitable for remote use.

Face-to-Face Diagnosis - In-person diagnosis benefits from direct behavioral and physiological observation.

Recommended tools:

- Structured Clinical Interview for DSM-5 (SCID-5): Gold standard clinician-administered tool (First et al., 2015).
- Clinician-rated scales: Hamilton Anxiety Rating Scale (HAM-A) and Liebowitz Social Anxiety Scale (LSAS) provide nuanced, observed ratings.
- Behavioral and physiological assessment: Observation of restlessness, avoidance, and somatic cues; biofeedback (e.g., heart rate variability) can corroborate symptom presentation.

Regardless of modality, multi-method assessment combining structured interviews, standardized scales, and functional assessment maximizes diagnostic validity (García-Carrión et al., 2022).

Evidence Comparing Telehealth and Face-to-Face Treatment

Symptom Reduction and Outcomes - Meta-analyses confirm telehealth's clinical equivalence to face-to-face psychotherapy. Krzyżaniak et al. (2024) conducted a meta-analysis of five randomized controlled trials (RCTs) comparing telehealth and in-person interventions, reporting no significant differences in anxiety reduction, depression symptoms, or functional outcomes. Greenwood et al. (2022) similarly reported equivalent outcomes across anxiety and mood disorders, with high patient satisfaction and adherence.

Therapeutic Alliance and Satisfaction - Shaker et al. (2023) found that therapeutic alliance ratings in telehealth CBT were statistically comparable to those in-person. Despite reduced non-verbal cues, empathy, validation, and collaboration successfully translate across modalities.

Evidence-Based Modalities for Anxiety

Cognitive-Behavioral Therapy (CBT) - CBT remains the first line treatment for anxiety (Hofmann et al., 2012). Telehealth adaptations include screen shared worksheets and secure portals for homework review. Face-to-face CBT allows for in-season behavioral experiments and immediate feedback.

Exposure Therapy (ERP/In-Vivo and Interoceptive) - Exposure therapy is critical for panic disorder, phobias, and social anxiety (Craske et al., 2014). Telehealth supports therapist guided remote exposures (e.g., virtual coaching during feared tasks), while in person sessions permit therapists accompanied in-vivo exposures and controlled interoceptive exercises.

Acceptance and Commitment Therapy (ACT) - ACT emphasizes mindfulness and values-based action (Hayes et al., 2016). Telehealth allows for digital metaphors (e.g., shared-screen exercises), while in-office sessions enhance somatic grounding during acceptance exercises.

Mindfulness-Based Interventions (MBIs) - Mindfulness Based Stress Reduction (MBSR) and Mindfulness Based Cognitive Therapy (MBCT) reduce worry and improve emotion regulation (Khoury et al., 2013). Telehealth can leverage guided audio, while in-person work allows for therapist observation during practice.

Treatment Planning and Case Conceptualization:

- Use structured frameworks (e.g., CBT models) in both modalities.
- In telehealth, share visuals (screen-shared diagrams) to co-create case formulations.
- In-person allows for richer relational and non-verbal data to inform conceptualization.

Measurement-Based Care (MBC) - Routine monitoring using validated tools (e.g., GAD-7, OASIS, SUDS) improves outcomes. Telehealth enables automated scoring and graphing within EHR systems, while face-to-face permits in session review and discussion of trends.

Best Practice Tips for Clinicians

Telehealth-Specific Best Practices:

1. Establish a Secure, Professional Environment: Use HIPAA compliant video platforms and verify client privacy (APA, 2021; Shore et al., 2018).
2. Enhance Therapeutic Presence: Compensate for reduced non-verbal cues with verbal empathy and visible facial expressions (Glueckauf et al., 2018).
3. Structured Session Design: Use consistent session structure with screen-shared worksheets and agenda setting (Backhaus et al., 2012).
4. Promote Engagement: Use interactive tools and shorten sessions if needed to reduce fatigue (Shore et al., 2018).
5. Crisis Planning and Licensure Compliance: Document client location and emergency contacts each session; ensure licensure compliance with the client's state of residence (APA, 2021).
6. Cultural Adaptations: Assess technology literacy and offer accommodations for diverse backgrounds (Shore et al., 2018).

Face-to-Face Best Practices:

- Optimize Therapeutic Space: Create a calming, private setting conducive to anxiety reduction (Norcross & Lambert, 2019).
- Leverage Non-Verbal Cues: Observe posture, fidgeting, and other anxiety signs for assessment (Kazantzis et al., 2018).
- Facilitate In-Vivo Work: Conduct guided exposures and biofeedback supported interventions (Craske et al., 2014; Goessl et al., 2017).
- Deepen Alliance Through Presence: Use warmth, eye contact, and immediate feedback (Norcross & Lambert, 2019).
- Enhance Skill Generalization: Assign real world exposure practice between sessions (Kazantzis et al., 2018).

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ICL's Children and Family Treatment and Support Services

The program offers:

- Community-based therapy
- Rehabilitative services
- Crisis intervention
- Family peer support

Institute for Community Living (ICL)'s Children and Family Treatment and Support Services (CFTSS) offers comprehensive mental health services for children and youth under 21 in East New York.

Located at ICL's East New York Health HUB, our person-centered model of care can help children and youth identify mental health and substance use challenges, provide practical support services to improve well-being, and strengthen family relationships.

The Overlapping Roots of Mental Health Disparities: Poverty, Racism, and Trauma as Social Determinants

By Jordan Baker
Content Marketing Manager
Relias

Mental health cannot be fully understood — or effectively addressed — without considering the powerful forces that shape people's everyday lives. Poverty, racism, and trauma are more than just challenges individuals face; they are deeply embedded social determinants of mental health that influence who receives access to care, who experiences chronic stress, and who is most vulnerable to mental illness.

While the concepts of trauma-informed care and social determinants of health (SDOH) are becoming more widely known among professionals in human services, the intersection of these ideas — particularly as they relate to mental health — requires greater attention.

What Are Social Determinants of Health?

The World Health Organization (WHO) defines social determinants of health as the conditions in which people are born, grow, live, work, and age — conditions shaped by the distribution of power, resources, and opportunity at every level of society. These determinants influence both physical and mental health outcomes across the lifespan.

Social determinants can be thought of as either protective factors or risk factors. Protective factors — such as safe neighborhoods, stable income, and strong social support — help buffer individuals from mental health challenges. Risk factors, on the other hand, increase vulnerability and include experiences like poverty, food insecurity, exposure to violence, and housing instability.

Importantly, these factors are not fixed. A protective factor today, such as stable employment, may become a risk factor tomorrow if that job is lost or becomes unsafe. Understanding this fluidity is essential for building responsive systems of care.

The social determinants of mental health highlight the deep-rooted inequalities in income, education, access to care, physical environments, and social support systems. These factors are often interconnected, compounding their impact on individuals' mental well-being.

Trauma as a Social Determinant of Mental Health

The landmark Adverse Childhood Experiences (ACEs) Study laid the groundwork for understanding how early trauma — such as abuse, neglect, or exposure to domestic violence — correlates with a higher likelihood of mental health conditions later in life. But trauma doesn't only happen in childhood, nor does it exist in a vacuum.

Traumatic experiences, especially when prolonged or repeated, can change brain chemistry and structure, disrupting emotional regulation, memory, and even physical health. These effects often lead to increased risk for depression, anxiety, PTSD, and substance use disorders.

Poverty and Mental Health

Living in poverty can feel like a daily mental health crisis. The constant stress

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A Harm Reduction Approach to Informed and Compassionate Care

By Dani York, LCAT
and Elan Quashie
Recovery & Treatment
Services for the UnderServed (S:US)

Elan Quashie demonstrates how to safely administer Naloxone at a 2024 training session hosted by NYC Health + Hospitals/Woodhull. Photo credit: NYC Health + Hospitals.

Harm Reduction allows us to consider and implement practices that help individuals make safe, viable choices in support of overall wellness. Harm Reduction is also "a movement for social justice built on a belief in, and respect for, the rights of people who use drugs"[1] and is "a key pillar in the U.S. Department of Health and Human Services' Overdose Prevention Strategy."[2] Each definition implicitly places an emphasis on select primary tenets of person-centered, trauma-informed care. These include empowerment and choice, mutuality, respect for the individual's values, preferences and expressed needs, information and education, access to care, and trustworthiness and transparency. Engaging through a harm reduction lens expands its foundation beyond substance use recovery and into varied aspects of recovery and treatment.

Services for the UnderServed (S:US), one of the largest community-based health and human services organizations in New York State working intentionally to right societal imbalances by providing comprehensive and culturally responsive services, utilizes a harm reduction approach to engagement across programs including shelters, respites, clinics, housing, Clubhouse, and transitional residences. Programs at S:US provide direct service delivery with access to resources for individuals living with a range of unmet needs from mental health and substance use challenges to the felt impact of oppression and social determinants of health. Successful (the ability to make contact) and meaningful (the ability to contribute to change through healing relationship) engagement is at the core of our work with participants through the agency's programs.

S:US' Recovery & Treatment Division deploys outreach teams to expand engagement beyond the walls of our program sites. S:US leverages multiple grant streams to expand and sustain harm reduction services. These grant-funded teams connect individuals with lifesaving resources and strategies to mitigate against negative outcomes of high-risk behaviors, symptoms, and circumstances. In practice, this allows for attunement to nuanced needs of the programs' populations by category, i.e. unhoused, dually diagnosed, in substance use recovery, and unique individuals receiving services from the teams. Commitment to advancing health equity and reducing harm among vulnerable populations is demonstrated through comprehensive, evidence-based harm reduction frameworks.

Services are designed to engage individuals with dignity, compassion, and practicality. The Recovery & Treatment Division's Brooklyn outreach teams embody harm reduction through the lens of collaboration. This is accomplished through referring, accompanying, facilitating, and connecting; each team relies consistently on the strengths of others to provide individualized person-centered, trauma-informed, and culturally humble care. Team staffing is intentionally geared towards the diverse levels of support needed during a recovery journey. A key component is the inclusion of Peer Specialists, who bring lived experience, insight, and credibility to their interactions with enrollees; as well as licensed practitioners, Credentialed Alcoholism and Substance Abuse Counselors (CASACs), and case managers.

The Opioid Overdose Prevention Program (OOPP) has trained and enrolled over 60 programs agency-wide in opioid overdose prevention measures, distributes Naloxone to empower immediate overdose intervention, and provides a broad range of supplies in service of safer use practices.

The Medication Assisted Treatment (MAT) Program supports individuals with Opioid Use Disorder through integrated medical and behavioral health services. Beyond linkage to prescribers for medications for Opioid Use Disorders (MOUD), the MAT team takes a compassionate approach to engagement through pacing conversations around recovery that focus on fear and discomfort that may accompany decreased use and consistent follow-up for shifts in perspective and desire via group work, individualized community care, and direct collaboration with S:US' Certified Community Behavioral Health Clinics (CCBHCs).

The Grant for the Benefit of Homeless Individuals (GBHI) provides harm reduction and recovery support to individuals experiencing homelessness and complex life challenges. GBHI understands that contributing factors to being unhoused and/or substance use often derive from trauma and include re-traumatization through racism, daily microaggressions, barriers to care, and the impact of untreated symptoms of mental illness. Additionally, there is a correlation between stressors and symptoms of anxiety and depression. "Stress has direct effects on mood. Early initial symptoms of lowered mood can include irritability, sleep disruption, and cognitive changes, such as impaired concentration. However, the indirect effects of stress are often what causes depression to take hold."[3] Through a keenly developed lens accentuated by way of internal trainings and external partnerships, GBHI refers individuals to S:US' CCBHCs, Care Coordination, and Clubhouse for wrap-around support and structured treatment planning. These referrals cultivate spaces for destigmatization and provide opportunity for processing underlying factors that contribute to mood symptoms therefore reducing the impact of stressors themselves.

The first New York City Public Health Vending Machine (PHVM) offers 24/7 access to harm reduction supplies, including Naloxone, hygiene kits, and safer use materials, reducing barriers to care. PHVMs are an emerging strategy to support low-barrier access to harm reduction and wellness supplies free of charge. To strengthen community-based harm reduction, staff from MAT and GBHI have undergone specialized training in opioid overdose response using Naloxone as well as drug testing with Fentanyl and Xylazine test strips. These essential skills equip outreach teams to respond to the ongoing opioid crisis and provide life-saving education to vulnerable populations. Holistically, MAT and GBHI offer robust support through training sessions and individualized counseling, ensuring that services are accessible and tailored to the needs of each participant. Each team is dedicated to education on suicide safer practices including safety planning, wrap planning, and lethal means reduction for those at risk, fostering connections to community and family supports and challenging internal biases while maintaining awareness of complexities of care.

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Ira Minot, MHNE Founder, Bids Farewell: Looking Forward to New Challenges

Ira Minot receiving the Founder's Legacy Award at the MHNE 2025 Leadership Awards Reception with David Minot (left) and Ashley Brody (right)

By Staff Writer
Behavioral Health News

Mental Health News Education (MHNE) recently held its 2025 Leadership Awards Reception, where Founder and former Executive Director Ira Minot, LMSW, was honored with the Founder's Legacy Award for his more than 25 years of visionary leadership. Presenting the award was Ashley Brody, CEO of Search for Change, alongside Ira's son David Minot, who now serves as MHNE's Executive Director.

In heartfelt farewell remarks, Ira reflected on his personal journey, including the decade he spent battling medication-resistant depression. "When I finally received the treatment that broke the chains of my depression, I set out to unite patients, families, treatment professionals, and service providers in one mental health education publication."

Over the past quarter century, Behavioral Health News has become a trusted platform for collaboration, dialogue, and education throughout the behavioral health community. Ira credits the many dedicated leaders and advocates he met along the way for shaping his path from consumer and survivor to executive-level leadership.

As he prepares to retire at the end of 2025, Ira expressed excitement for what comes next. "I will be looking for my next new and exciting project to unite communities. There are countless untold stories—like mine—of survival in the face of hardship, and I want to help bring them into focus. I want to put what I've learned into helping to organize programs and strengthen organizations for the betterment of the entire community."

He closed with gratitude to MHNE's partners, supporters, and readers for standing alongside him for more than 25 years. "This has been the honor of my life," he said. "Together, we built something that matters—and the work goes on. I am looking forward to being a consultant and mentor to others in need of help."

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Tobacco from page 5

These include more severe nicotine withdrawal symptoms, increased emotional sensitivity, and heightened stress reactivity.[11] [12] These barriers can increase the likelihood of relapse and require targeted support during cessation efforts. Integrated treatment approaches that combine pharmacological aids (such as nicotine replacement therapy, varenicline, or bupropion) with cognitive-behavioral therapy (CBT) have been shown to be particularly effective for individuals with co-occurring mood symptoms.[13]

Furthermore, systematic screening for anxiety and depression in tobacco cessation settings can identify individuals who may benefit from additional psychological support. Studies show that many smokers seeking help with quitting have undiagnosed or untreated mood disorders.[14] Public education must challenge the enduring myth that smoking helps reduce stress or improve mood. These beliefs, often reinforced by tobacco industry messaging, undermine cessation efforts. Instead, communication should emphasize that quitting smoking improves—not worsens—mental health.

Clinically, cessation support should be framed not just as a step toward physical wellness, but also as a powerful tool for improving emotional well-being. In fact, quitting smoking may be one of the most effective lifestyle changes for enhancing mental health among individuals with depression and anxiety.

The connection between tobacco use and depression/anxiety is not only real—it is profound. While individuals may smoke to cope with emotional distress, long-term tobacco use often worsens symptoms and undermines recovery. Fortunately, quitting smoking consistently leads to improvements in mood, anxiety levels, and quality of life. Supporting cessation in people with depression and anxiety is both a public health priority and a compassionate response to emotional suffering.

Systemic, evidence-based screening and treatment of tobacco dependence is integral to improving patient health outcomes. These standards are in alignment with the US Public Health Service's Clinical Practice Guideline – *Treating Tobacco Use and Dependence*: 2008 update, which includes best practice systems strategies for organizations to use with their clientele. Systems Strategy One ensures that a tobacco-user identification system is present in every clinic. That system should include the evidence-based tobacco dependence treatment prompts of the 5A's: Ask, Advise, Assess, Assist and Arrange. Systems Strategy Two ensures that education, resources, and feedback are present to promote provider intervention. The final Systems Strategy is to identify dedicated staff at a given provider's location to dispense tobacco dependence treatment and assess the delivery of this treatment with other staff members in the office.

For more information on how to best address tobacco use, visit the Center for Disease Control website to identify your state's tobacco control program contacts.

Kristen Richardson, RN, CTTS, is Director and Danielle O'Brien, MS, CTTS, is Program Coordinator of the Central New York Regional Center for Tobacco Health Systems at St. Joseph's Health in Syracuse, NY. The program is funded through a grant from the New York State Department of Health Tobacco Control Program. More information can be found at www.nyhealthsystems.org. Kristen Richardson or Danielle O'Brien can be reached directly at Kristen.Richardson@sjhsyr.org and Danielle.L.Obrien@sjhsyr.org.

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How Multidisciplinary Care Improves Outcomes for Anxiety and Depression

By Christopher Ivany, MD
CEO
Family Care Center

Anxiety and depression affect physiology, cognition, behavior, and social functioning. Addressing only one domain - prescribing a medication without psychotherapy or offering therapy without coordinated pharmacologic care - often leaves residual symptoms and increases the risk of relapse.

Whole-person care aligns clinical interventions with each patient's biological, psychological, social, and spiritual needs. In practice, this means recognizing how disrupted sleep, fatigue, pain, and gastrointestinal complaints can obscure the primary diagnosis; how rumination, anhedonia, and impaired concentration drive functional impairment; and how isolation, role conflicts, financial stressors, and stigma slow engagement and recovery. When teams approach these dimensions together, patients move more predictably toward remission.

Beyond Co-Location: What "Multidisciplinary Care" Means

Multidisciplinary care is more than sharing a hallway. It is a coordinated model with shared goals, information, and accountability for outcomes. In a mature program, therapists, psychiatrists, psychiatric PAs/NPs, and care coordinators work from a common record and confer routinely, so treatment plans stay aligned.

Measurement-based care (MBC), which uses patient data to inform treatment goals and progress, is baked into the workflow. PHQ-9, GAD-7, and other patient-reported outcome scores are collected at baseline and regularly throughout treatment, and trajectories—not isolated snapshots—drive timely adjustments. Warm handoffs and rapid access tie the model together, allowing same-week starts and minimizing the friction that otherwise leads to no-shows and dropouts. When indicated, escalation to intensive outpatient programs (IOPs) or transcranial magnetic stimulation (TMS) happens inside the same system, preserving continuity and trust.

What Evidence Shows

Across dozens of studies, collaborative and other multidisciplinary models outperform usual care on response and remission for depression and anxiety. Programs that pair team-based care with MBC demonstrate better adherence and fewer delays in treatment adjustments. Economic evaluations consistently show favorable cost-effectiveness and, in some settings, reductions in total cost through fewer emergency department visits and hospitalizations.

Just as importantly, a multidisciplinary approach reduces access barriers by smoothing referrals and creating stepped-care pathways within one coordinated environment. The takeaway for busy clinicians is straightforward: organizing teams, data, and timely escalation.

Why One Location Matters for Patients and Operations

Traditional models ask patients to coordinate therapy, medication, and advanced treatments across different sites and systems. Each handoff introduces delay and risk of attrition.

By contrast, a single multidisciplinary setting lowers logistical barriers, aligns clinical messaging, and allows the team to escalate care promptly when outcome measures and other indicators show insufficient progress. Safety also improves; a shared record and regular team huddles make it easier to monitor suicidality, reconcile medications, and track adverse events without duplication or gaps.

Family Care Center Outcomes

At Family Care Center, multidisciplinary behavioral health care is the standard. Over 80% of patients treated for depression or anxiety report clinically significant improvement within six months, based on PHQ-9 and GAD-7 monitoring. Participants in its IOP and TMS programs show particularly strong gains, with over 90% demonstrating reductions in depressive symptoms and parallel improvements in anxiety and PTSD measures.

Patients who receive coordinated care across modalities—psychotherapy plus medication management with the option to add TMS—improve more than those treated in a single modality. A Family Care Center outcomes analysis of 2,160 adults links the multidisciplinary model to higher engagement, stronger adherence, and meaningful symptom reduction over six months.

A Patient Journey

Consider the difference between two pathways.

1. In the first, a patient begins therapy but must seek medication elsewhere. Appointments are weeks apart, communication between clinicians is piecemeal, and progress plateaus.
2. In the second pathway, the same patient completes a single intake, begins therapy, and meets a prescriber in the same week. The team shares notes, reviews PHQ-9 and GAD-7 trends, and adjusts the plan as needed. When symptoms resist improvement, TMS or IOP are introduced within the same care system. The process is cohesive and supportive, and the patient can focus on healing rather than logistics.

Implementation Essentials or Healthcare Teams

Successful programs are deliberate about cadence and roles. MBC becomes routine when scores are collected at baseline and at a meaningful interval and displayed in the EHR. Access improves when warm handoffs are built into intake, so new therapy starts are paired with a near-term prescribing appointment.

Brief weekly case reviews for patients enrolled in TMS and IOP keep everyone aligned on higher-acuity cases. They also create a predictable forum for problem-solving. Continuity strengthens when after-visit summaries are shared across the team and medication reconciliation is visible in psychotherapy notes.

The New Standard—Built on Teamwork

Multidisciplinary behavioral health aligns clinical best practices with operational sensibility: the right care, at the right time, by the right team. As more systems adopt multi-disciplinary models, patients experience symptoms and durable recovery, and clinicians gain a repeatable framework that improves outcomes, experience, and value.

Christopher Ivany, MD, is a Psychiatrist and the CEO of Family Care Center.

Transcranial Magnetic Stimulation Is Transforming Depression and Anxiety Care

By Dr. TeeJay Tripp
Chief Medical Officer
Serenity Mental Health Centers

Depression affects an estimated 280 million people worldwide. Anxiety disorders impact more than 300 million. These conditions are not just occasional moods. Many live with symptoms such as, and not limited to, persistent sadness, fatigue, loss of interest, and excessive worry that can interfere with daily life.

They go to work. They care for their families. They suffer in silence. And they do it all without realizing that alternative evidence-based treatments exist.

Transcranial Magnetic Stimulation (TMS) is one of the most promising advancements in psychiatric care today, yet too often, it's introduced only after everything else has failed.

That needs to change.

What TMS Is and How It Works

TMS uses targeted magnetic pulses to stimulate regions of the brain tied to mood and anxiety regulation, such as the left dorsolateral prefrontal cortex. These pulses modulate neural activity, promote synaptic plasticity, and help restore functional connectivity in mood-regulating networks. Large-scale studies, such as the STAR*D trial, reinforce TMS's ability to modulate brain networks central to mood and anxiety regulation.

TMS is generally well tolerated, with minimal side effects such as a mild headache. The treatment is administered in an outpatient setting without any downtime, allowing patients to resume daily activities immediately.

The sessions typically last 20–30 minutes, five days per week, over the course of six to eight weeks. Research shows that many patients notice improvements in mood, energy, and concentration around the second or third week of treatment.

The U.S. Food and Drug Administration (FDA) has cleared TMS for the treatment of major depressive disorder and obsessive-compulsive disorder, with growing evidence supporting its use for anxiety disorders.

The treatment is safe, accessible, and covered by most insurance plans for the patients who meet the criteria. It's also covered by most major insurance providers.

Depression and Anxiety Symptom Relief

TMS can help to transform patients' daily lives, enabling them to reclaim the routines and relationships that depression or anxiety has disrupted.

Serenity Mental Health Centers sees results with TMS; 84% of patients experience a positive response to TMS and 78% achieve remission. For most, results last three years or more.

Behind these statistics are real people. Real, everyday people who can sleep through the night again, connect with family and friends again, and return to hobbies or a career they once loved. People who once struggled to get out of bed, or who felt anxious checking out at the grocery store.

TMS directly targets depression and anxiety symptoms that impair daily life. Patients frequently report:

- Improved sleep
- Reduced anxious thoughts and worry
- Increased energy and motivation
- Improved focus and concentration
- Greater emotional presence with family and friends

TMS gives patients the opportunity to actively participate in their recovery, rebuild lost relationships, and live a life no longer debilitated by depression or anxiety.

TMS Pairs Well with Other Therapies

One of the most exciting aspects of TMS is how well it integrates into a broader model of mental health care. It's not a replacement for any single modality; it's an enhancement that can be tailored to fit each patient's needs.

For many, TMS helps other tools, like medication, gratitude, talk therapy, or other wellness practices, take hold more effectively.

Serenity has found that pairing TMS with structured routines, such as gratitude practice and journaling, can reinforce and extend its benefits long after treatment ends. Regularly writing down things you're thankful for can improve emotional regulation and cognitive flexibility, aiding in the processing of emotions and enhancing the benefits of TMS therapy.

This flexibility makes TMS a uniquely valuable tool in mental healthcare. As conversations become more open and informed, patients are increasingly seeking care that is personalized, evidence-based, and empowering. TMS is all three.

TMS is More Than Just a Last Resort

Despite its proven effectiveness, TMS remains underutilized.

If we continue to view TMS only as a last-resort treatment, people will spend unnecessary years suffering when relief could have come sooner.

TMS is one of the most significant advancements in psychiatric treatment in recent decades. With high response and remission rates, minimal side effects, and long-lasting outcomes, it's time to integrate TMS into the earlier stages of clinical decision-making.

When patients complete TMS earlier, clinicians are better able to prevent long-term disability, reduce trial-and-error, and ultimately save lives. For patients, this means reclaiming joy, rebuilding relationships, and rediscovering themselves.

TMS is a personalized, evidence-based treatment that can transform lives. Let's work together to ensure patients have access to TMS.

Dr. TeeJay Tripp is the Chief Medical Officer at Serenity Mental Health Centers. To learn more about Serenity, visit www.serenitymentalhealthcenters.com or call (844) 310-1655.

An Epidemic of Anxiety and Depression Requires a Reevaluation of Conventional Treatment

By Ashley Brody, MPA, CPRP
Chief Executive Officer
Search for Change, Inc.

The field of psychiatry has been governed by a medical model of illness in recent decades. This model posits behavioral health conditions, including anxiety and depression, are manifestations of biological abnormalities that may be corrected through interventions commonly employed in other branches of medicine. This model underpins a pharmaceutical approach to treatment that has dominated the landscape of behavioral healthcare, as evidenced by a proliferation of psychotropic medications and a commensurate increase in expenditures on treatments of questionable value. The global market for psychotropic medications is currently valued at $23 billion, and it is expected to reach $30 billion by 2030 (Mordor Intelligence, 2025). This trend has been driven by a host of factors including an age-related increase in the prevalence of mood disorders, widespread use of antidepressant medications among primary care providers, and initiatives driven by health insurers that incentivize "adherence to" prescription medication regimens, among many others. Nevertheless, behavioral health treatment outcomes remain mediocre at best and belie the purported value of massive investments in the pharmaceutical industry.

Rates of anxiety, depression, and suicidality have reached unprecedented levels in the U.S. despite our increasing reliance on psychotropic medications to alleviate symptoms associated with these potentially debilitating conditions. According to a Commonwealth Fund report, in 2021, the most recent year for which reliable global data were available at the time of its publication, the U.S. had a higher suicide rate than nine other high-income industrialized nations (The Commonwealth Fund, 2024). The declining state of mental health in the U.S. has been attributed to a host of factors, most notably the COVID-19 pandemic and its associated socioeconomic and political effects (National Institute of Mental Health, 2024). An extensive body of research has confirmed the prima facie proposition that severe stress may produce or exacerbate anxiety and depression, so it is unsurprising that the pandemic engendered a national crisis in mental health. What is (or should be) surprising, however, is that the U.S. has fared considerably worse than its peers despite robust investments in both the pharmaceutical industry and healthcare overall. Measures of national healthcare spending on a per capita basis or as a share of Gross Domestic Product (GDP) continually place the U.S. in a "leading" position relative to other wealthy industrialized nations. Such an unmistakably inverse correlation between investments in a biomedical approach to treatment and indicators of mental health warrant extensive scrutiny at the very least, if not a fundamental reevaluation of the premise on which this approach rests.

Deficiencies in the biomedical model have become increasingly apparent to key stakeholders in public health. In 2014, the World Health Organization (WHO) published an assessment that concluded with a searing indictment of the "status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, [that is] is no longer defenseless in the context of improving mental health…" (Leventhal, 2024). This report further characterized biomedical approaches as "reductive" because they neglect socioeconomic factors implicated in individual and societal mental health. The WHO's assessment is consistent with others promulgated by leading researchers who have dedicated their career to uncovering the genetic origins of mental illness but now conclude psychological trauma, *not* genetics or biology, is a primary determinant of mental illness (Leventhal, 2024). Others have heeded this clarion call for a paradigm shift and public policy is now following suit.

The role of socioeconomic factors in mental health, alternatively described as Social Determinants of Health (SDoH) or Health-Related Social Needs (HRSNs), has gained considerable currency in recent years, as evidenced by sweeping initiatives of the New York State (NYS) and federal governments that commit increasing shares of public resources to measures designed to address the HRSNs of vulnerable populations. On January 1, 2025, NYS launched such an initiative pursuant to Section 1115 of the Social Security Act. This Section permits states to utilize Medicaid funding in a manner not customarily authorized under federal guidelines, provided such uses advance the overarching objectives of the Medicaid program and are approved through an extensive review process conducted by the Center for Medicare & Medicaid Services (CMS). NYS implemented this initiative, entitled the "New York Health Equity Reform (NYHER) Waiver," in furtherance of laudable aims that, if achieved, should yield measurable improvements in mental health (and health overall) among our most vulnerable residents. In short, the NYHER aims to facilitate recipients' access to transportation, nutritional assistance, care coordination, and housing-related services not previously available through the Medicaid program. To access these services, recipients must be enrolled in a Medicaid Managed Care program and demonstrate a need for them through an assessment process administered by a representative of a Social Care Network (SCN) serving their region. These SCNs serve as administrative intermediaries between the NYS Department of Health, Managed Care Organizations, local [county] governments, and private Community Based Organizations, among others. The NYHER also aims to address an enduring workforce crisis within the behavioral health and social welfare sectors by establishing professional development and loan forgiveness opportunities on which the success of its core objectives depends. The foregoing developments are surely promising, but their realization requires sustained commitment among a host of entities spanning various sectors of our health and social welfare infrastructure. Furthermore, this initiative "sunsets" in March 2027, and although NYS has pledged to support its most essential elements in perpetuity irrespective of continuing federal financial participation, other actions emanating from Washington, most notably those authorized through the recent budget reconciliation process, are poised to upend the NYS budget and to necessitate a reevaluation of available resources.

The NYHER is one of many ambitious initiatives borne of an emerging recognition that conventional (i.e., biomedical) treatments for anxiety, depression, and related mental health conditions are insufficient to improve the behavioral health of those for whom life's most essential needs

see Reevaluation on page 33

Cultivating a Trauma-Informed Behavioral Health Workforce

By Jill Mastrandrea, LMHC, CASAC
Director of Program Innovation
and Director of OASAS Clinic
New York Psychotherapy and
Counseling Center (NYPCC)

Creating a trauma-informed behavioral health workforce is both a moral imperative and a practical necessity in today's demanding care landscape. Understanding the concept requires recognizing its foundation: a workforce committed to safety, trust, empowerment, collaboration, peer support, and cultural responsiveness. These principles, articulated in the Substance Abuse and Mental Health Services Administration's (SAMHSA) framework guide organizations toward practices that protect and promote healing—not just for clients, but for staff as well.

The significance of this commitment is clear when examined through the lens of current challenges. Trauma is pervasive: approximately 70% of individuals worldwide have experienced at least one potentially traumatic event Global Collaboration. In the U.S., over 60% of adults report having experienced trauma, with an estimated 5% meeting criteria for PTSD annually and 6.8% over their lifetime; women are almost twice as likely as men to be affected. Furthermore, nearly two-thirds of U.S. adults have endured one or more adverse childhood experiences (ACEs), and about 17% report four or more, which dramatically increases their risk for negative health outcomes CDC.

Behavioral health professionals—who often work closely with traumatized individuals—are particularly vulnerable to burnout and secondary traumatic stress (STS). Studies reveal that up to 93% of behavioral health workers report experiencing burnout, with 62% describing it as moderate to severe; nearly half have contemplated leaving their roles according to National Council for Mental Wellbeing. Secondary trauma further compounds this, with prevalence rates among social workers, substance abuse counselors, and juvenile justice workers ranging from 15% to 39%. These troubling figures underscore why a trauma-informed workforce isn't just an ideal, it's essential for workforce sustainability, client care, and broader equity.

At NYPCC, embedding trauma-informed principles means building an organizational culture where staff wellness is a core priority. Our Employee Assistance Program provides confidential counseling and supportive resources that help employees manage personal or professional stress before it escalates. Meanwhile, NYPCC's policy of paid quarterly mental health days off sends a powerful message: self-care is a professional necessity, not a luxury. These types of interventions align with SAMHSA's guidance on mitigating burnout by addressing key drivers such as workload, control, reward, community, fairness, and values according to SAMHSA Library.

Supervision at NYPCC is structured intentionally to support staff emotionally and professionally. Through regular individual and group sessions, clinicians have space to reflect, debrief difficult cases, and process vicarious trauma. Trauma-informed leadership ensures that supervision itself models the approach—balancing empathy with skill development, reducing isolation, and reinforcing connection.

Thoughtful workforce expansion also plays a critical role. By carefully recruiting additional qualified clinicians, especially from diverse backgrounds—NYPCC helps maintain manageable caseloads, supports cultural competency, and strengthens relationships with underserved communities. These practices counteract the much higher turnover typical in behavioral health. Nationwide, the annual turnover rate is about 33% for clinicians and 23% for clinical supervisors, compared to just 7% for primary care providers (Olfson, M. (2016). Building the Mental Health Workforce Capacity Needed to Treat Adults with Serious Mental Illnesses, Health Affairs, 35, 983-990.)

Evolving organizational culture requires feedback—not just from the top down, but from the front lines up. NYPCC's system of anonymous surveys, listening sessions, and open forums empowers staff to voice concerns and suggest improvements. Leadership commits to reviewing input and responding transparently reinforcing empowerment, trust, and mutual accountability.

Sustaining this trauma-informed approach over time depends on continued commitment. NYPCC ensures that leadership keeps allocating resources for training, mental health support, and data measurement. These efforts track staff satisfaction, turnover, and utilization of wellness benefits, signaling what's working and where adjustments are needed. Encouraging peer support networks further builds resilience—creating informal but powerful structures of mutual care.

Ultimately, this holistic approach yields powerful returns. When staff feel valued, supported, and safe, they provide higher-quality client care. A trauma-informed behavioral health workforce, anchored in equity and well-being, sets a new standard for organizational health that resonates with clients and communities alike. NYPCC's multifaceted strategy—combining trauma-sensitive policies, supervision, feedback, and workforce development—demonstrates how systems can evolve to meet behavioral health needs with empathy, strength, and sustainability.

Jill Mastrandrea, LMHC, CASAC, is Director of Program Innovation and Director of the OASAS Clinic at New York Psychotherapy and Counseling Center (NYPCC). For more information, email Jmastrandrea@nypcc.org.

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Burnout among behavioral health workers: up to 93% experience it, with 62% reporting moderate to severe levels National Council for Mental Wellbeing.

Cunningham PJ. Beyond Parity: Primary Care Physicians' Perspectives on Access

see Trauma-Informed on page 34

Enhanced Care for Older Adults with Anxiety and Depression

By Catherine Thurston, LCSW
Chief Executive Officer
Service Program for Older People (SPOP)

Anxiety and depressive disorders are the most common mental health conditions experienced by older adults. The World Health Organization estimates that up to 20% of people aged 60 and older live with anxiety or depression, a number I expect may be a good bit higher given that older adults are routinely under-screened and under-diagnosed.

At Service Program for Older People (SPOP), we recognize the challenges of treating anxiety and depression in older adults who span multiple generations, hold diverse cultural beliefs about mental health, and have varied access to treatment resources. What older adult cohorts have in common, however, is a greater likelihood that their symptoms may be exacerbated by such factors as isolation, unresolved grief, caregiver distress, or chronic pain. We have learned that client outcomes are often improved when we recognize this challenge and provide treatment that includes increased contact, intervention repetition, and acquisition of coping skills.

Located in New York City, SPOP is one of a handful of agencies across the country that focus entirely on community-based mental healthcare for older adults. We work in partnership with hospitals and aging services providers to reach out to the most vulnerable, with a goal to improve the quality of life of older adults by offering age-affirming behavioral healthcare and linkages to aging support services. Our clinical programs serve 1,000 clients each year, over 70% of whom have anxiety or depressive disorders, often occurring comorbidly.

We recently developed an *Enhanced Care* treatment model for those clients who are at elevated risk of decompensation and have a need for repetitive, supportive contact. This model has been especially effective for older adults who live or care-give in isolation or have significant difficulty with self-regulation and coping. For these clients, a panic attack or bout of despair can lead to severe deterioration of activities of daily life, such as bathing, eating and obtaining medical care or, in other cases, to suicidality and violent fantasy.

Enhanced Care offers time-limited services (six to eight weeks) provided in concert with the client's primary therapy, with a goal to stabilize symptoms and improve functioning. In addition to insight-oriented psychotherapy, the client meets with a secondary clinician to build affect regulation and symptoms management skills and is encouraged to participate in a Dialectical Behavior Therapy (DBT) group to practice these skills with their peers. Clients also receive a weekly check-in call from a social work intern to mitigate the impacts of isolation and to assess for any changes in safety or mental health needs. Clients report that *Enhanced Care* not only teaches them how to "live" but how to "live with themselves" using digestible, concrete interventions.

This client story shows how our staff are using *Enhanced Care* interventions to treat anxiety and depression in older adults.

"Donna" is an 81-year-old female client, initially referred to SPOP to treat depression, secondary to caregiving for her husband who was physically declining. She evidenced irritability, tearfulness, and dysphoria, and she admitted to a passive wish that she and her husband would die. She reported that she was unable to take care of either herself or her husband's physical or emotional needs and felt overwhelmed to the point of despair. Donna expressed guilt and horror at the intensity of her rage toward her husband and the irony of wanting to isolate from him while already feeling so alone.

Donna met with a primary clinician who provided psycho education on caregiver distress and helped her identify the underlying factors of depression that had been present but unaddressed for many years. She also with a secondary clinician who taught her regulative breathing techniques, progressive muscle relaxation, and use of sensory changes to ground herself in the present. She joined the DBT skills group and was pleasantly surprised to meet other older adults who struggled with suicidal and violent thoughts towards others. This helped to normalize parts of her experience which had initially made her afraid of herself. She learned through the group how to reduce the power of her thoughts and build stamina for intense emotions.

Donna also appreciated the check-in call with her assigned social work intern. She initially regarded it as a mandatory courtesy call but quickly understood that the call provided valuable reassurance – and was often the only phone call she received over a period of days. This realization underscored the intensity of her isolation and became fodder for her aftercare plans to build social relationships with other caregivers.

After eight weeks of *Enhanced Care* support, Donna reported that she was managing her moods and symptoms with much greater ease. She obtained several hours of home care for her husband and used her new skills to communicate with him more effectively. She reported that she no longer had suicidal ideation or violent fantasies. She also expressed willingness to start taking an anti-depressant, which was a type of assistance she had not previously been open to. She continues to meet with her primary clinician, who helps her further understand her depression, her sense of self, and how to build social support.

In an underfunded healthcare landscape of aging and mental health services, we are always looking for ways to do more with less. How can we help clients who just need "more"? *Enhanced Care* is a strategy that has enabled SPOP to re-resource existing service provision to temporarily target client needs. It creates routine and essential therapeutic redundancy and sets the stage for success long after the interventions have been implemented. Most important, it provides the support, skills, and resources to improve the quality of life of older adults.

Catherine Thurston, LCSW, has served as Chief Executive Officer of Service Program for Older People (SPOP) since 2024, having previously served as Chief Program Officer. She has over 35 years of experience in gerontological social work. She has been a member of the Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Master of Social Work from Hunter College School of Social Work.

Childhood Anxiety Treatment: Should You Choose Pills or Skills?

By Meir Flancbaum, PsyD
and Erica Dashow, PhD, BCBA-D
Center for Cognitive Behavior Therapy

Finding the right treatment for your child's anxiety can feel overwhelming. Parents are often faced with the choice between two options: skills-based therapy or medication (pills). Of course, there's no one-size-fits-all answer as each child's needs are unique. The best plan will be one that combines parent and child input in conjunction with a trusted psychologist or psychiatrist. A good provider will explain the available options, help your family weigh them, and adjust the plan as your child's needs change over time.

With so many possibilities, it can be hard to know where to begin. To make the process less daunting, we'll discuss a few questions to consider as you make your decision. These include: What are my child's needs? How ready is my child (and family) to engage in the treatment? What resources and commitments can we realistically make?

What Exactly Are Your Child's Needs?

The first step is to consider what concerns are bringing you to seek treatment. Is your child facing a temporary challenge, such as a school transition, that may improve with short-term support? Or are they coping with a longer-term, ongoing pattern of anxiety that is disruptive to their daily life? When it comes to anxiety, professional guidelines from the American Academy of Child and Adolescent Psychiatry recommend starting with therapy if symptoms are mild to moderate. More severe anxiety, however, can make it hard for a child to practice and apply therapeutic skills, which may limit the effectiveness of therapy. In these cases, beginning with medication—or pairing it with therapy—may be the most effective path forward.

How Ready Are You and Your Child to Begin Anxiety Treatment?

Whether you are considering medication or behavioral therapy for the treatment of your child's anxiety, your child's willingness is an important factor. They don't need to be enthusiastic, but some openness makes the process more effective. If your child is strongly opposed, therapy is less likely to help, and it may be better to wait until they're more ready. While this would be understandably frustrating as a parent, you still have options. Consider meeting with a psychologist yourself to learn tips or strategies for supporting your child at home or scheduling a consultation with a psychiatrist to understand more about medications. It is also essential that adults in a child's life are aligned about treatment. When parents or caregivers disagree about how to address anxiety, it can create additional stress for everyone involved and slow progress.

Readiness also shapes which treatment path may work best. Therapy requires active participation, including practicing skills between sessions. Without that effort, progress is slower, and treatment may take longer. Medication, on the other hand, doesn't require the same level of "buy-in" as you simply take the pill. However, it can take time to find the right medication and adjust the dosage and side effects may occur. In both cases, commitment is key, though the kind of effort involved looks different depending on the path you take.

What Resources Do You Have Available?

Beyond the clinical questions of whether therapy, medication, or both are the right fit, families also need to weigh practical

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From Research to Recovery: Transforming Anxiety and Depression Care in New York

By Ann M. Sullivan, MD
Commissioner
New York State Office of Mental Health

Our state has a long history as an innovator when it comes to improving the mental well-being of New Yorkers. From establishing the first state-funded psychiatric center to creating the first research institute dedicated to exploring mental health, this spirit of innovation has influenced and driven the important work we do in mental health care, positioning our state as a national leader in the field.

This spirit of innovation continues to push us to find new trauma-informed and family-based treatment approaches to address anxiety and depression – conditions that impact countless individuals across all ages and communities. These cutting-edge treatments and care models provide new strategies to improve outcomes, promote resilience, and positively impact the recovery journeys for New Yorkers impacted by anxiety and depression.

For instance, we are now using Transcranial Magnetic Stimulation (TMS) as an effective method to treat depression. This electroconvulsive therapy uses a magnetic field to generate an electric pulse inside the skull, targeting the left dorsolateral prefrontal cortex. This method is well-tolerated by patients, with mild side effects, including scalp pain, tension-type headaches, dizziness or lightheadedness, fatigue, and insomnia.

High-quality randomized controlled trials and meta-analyses with large numbers of subjects have provided strong evidence for this method, which is especially convenient as it can be used in an office environment without anesthesia. Extensive studies have looked at different factors such as permutations of dose strength, and whether treatments are effective if they are delivered multiple times in a day, with a rest period built in for the patients so they don't need to travel to the office daily.

There is good evidence this technique can be used to treat depression in individuals with Parkinson's Disease, and those who have suffered a stroke. Likewise, TMS is also being used to effectively treat Obsessive-Compulsive Disorder (OCD) and tobacco use disorder.

Innovations are also happening with medications – including Ketamine and Esketamine – to effectively address Treatment-Resistant Depression (TRD) and can rapidly improve conditions for patients with suicidal ideation. A single IV infusion of Ketamine has a rapid-onset anti-suicidal effect, but the duration is still short – less than 72 hours – and repeated infusions are needed to preserve effect.

Esketamine, under the brand name 'Spravato' is an FDA-approved nasal spray that can be administered by a qualified physician or nurse practitioner and has been more effective than a placebo to counter TRD. In longer continuation trials, individuals receiving Esketamine were at significantly lower risk for relapse or recurrence.

We are also studying effective treatments to counter depression in adults 55 and older. Spearheading partnerships between mental health, substance use, and aging services providers in six communities to address complex, cross-service system needs that put older adults at risk of losing community tenure.

The geriatric service demonstrations show that treating mental health and anxiety inherently involves addressing social determinants of health, including food,

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Building Resilience: Early Intervention and Prevention Strategies for Youth at Risk of Anxiety, Depression, and Substance Use

By Temitope Fabayo, BA, MBA-HR
DMC HomeCare

A small seed of concern may take root in the mind of a teenager, planted by social pressures, school demands, or deeper struggles. At first, it may seem manageable. But without support and guidance, that seed can grow unchecked branching into anxiety, deepening into depression, or reaching toward unhealthy coping mechanisms such as substance use.

We have been operating for far too long with a mind to appear when the vines are already in occupation. And what would it be to have met them in the garden a good deal sooner? It is not three-year-old mental health crisis care that is the future of youth mental health, but young people with a better basis. It is yet another step toward becoming proactively resilient, and the strategies are more effective than ever, and more hopeful than ever.

Family as the First Line of Defense

People are great, but the home is the initial and most significant support system a child will ever encounter. Teenagers exist within a complicated environment, and they flourish when they have a support system, a place where they feel loved, where they feel listened to, where they know they have a place. According to a Harvard University study, regular guidance and encouragement by parents and caregivers will lead to developing a healthier brain structure in poised adolescents. This reinforcement enhances the strength of the prefrontal cortex, the part of the brain that cares about emotional control and choice-making behavior, and this forms a natural protective guard against anxiety and sickness. This haven is a strong protection against anxiety, depression and the temptation of substance use.

However, under today's family system, many parents work long hours to provide for their children, a responsibility every caring parent takes on. But in the process, they get carried away and overlook the emotional needs of the children. When parents spend their time fulfilling the material needs of their children, they may unintentionally miss out on a lot of things their little ones need–their love, time, attention, and sense of belongingness. Absence of these can leave a void in children which if left unnoticed can lead them to seek validation elsewhere, often in unhealthy ways. This emotional gap can make them more vulnerable to anxiety, depression, and even substance use, as they look for love and attention outside the home. So, it's important for parents to spend quality time with their children each day, talking to them about school, listening to their thoughts, and indulging in activities they enjoy. These simple acts of connection and presence can make them feel loved and valued, preventing feelings of neglect.

Divorce as a Threat

Divorce is another risk factor that can be extremely disturbing for children. While life is not challenging for every child of a single parent, many go through feelings of anxiety, guilt, insecurity and abandonment. Moreover, divorce can bring environmental changes as well, such as, new living space, financial stress, disrupted routine.

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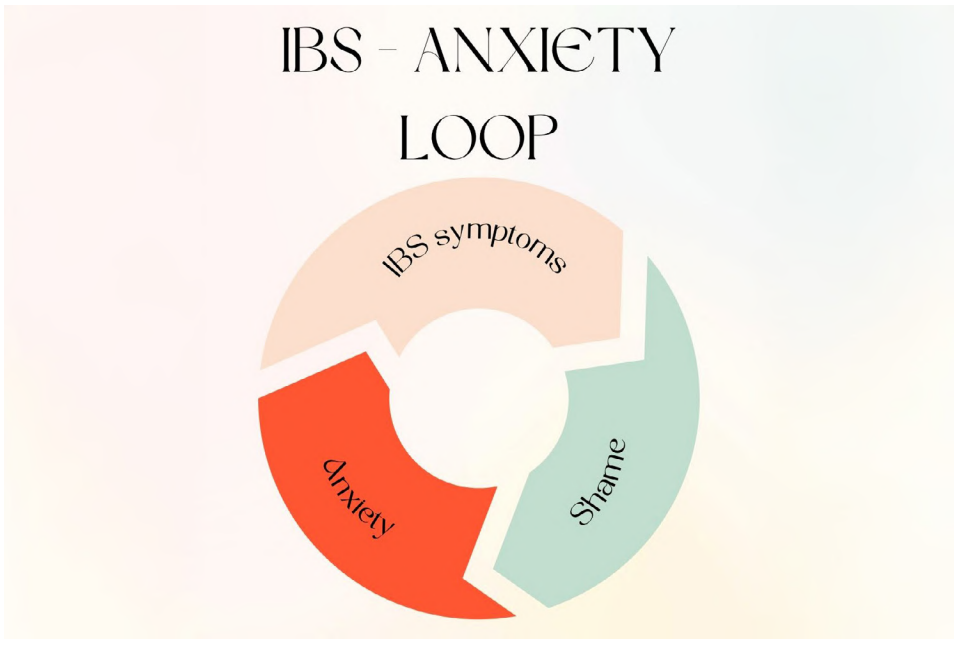
Polyvagal Exercises for IBS Symptom Management

By Skye Dina Ross, LCSW, MPH
Therapist in Private Practice



It is hard to separate gastric distress from psychological distress due to the connection between the brain and the gut. One can lead to the other, and ultimately, while medications can support managing physiological symptoms, psychological interventions may be needed to reduce ongoing symptoms most effectively. The American Psychological Association published an article in April 2025 relating the impacts of the gut microbiome on presentations of anxiety and depression (Abramson, 2025). Abramson notes that there is a growing field of "gastropsychologists" who focus on the connection between the brain and gut to treat the common co-occurrence of mental illness and gastrointestinal symptoms. The prevalence of anxiety and depression among those with gastric distress suggests that cognitive behavioral therapy (CBT) and mindfulness can help moderate symptoms.

Mood and anxiety disorders commonly co-occur among those with gastrointestinal disorders, with women being approximately twice as likely to seek treatment for IBS as men and being more likely to experience co-occurring depression and anxiety (Kim & Kim, 2018; Naliboff, Frese, & Rapgay, 2007; Tarar, Farooq, Zafar, 2023; Staudacher et al., 2023). Symptoms of IBS can feel embarrassing or even shameful, which further contributes to symptoms of depression, anxiety, and detachment from or anger towards one's body (Geller, Levy, & Avitsur, 2024).

Stomach pain, dizziness, nausea, and indigestion are common somatic complaints associated with anxiety (Gelenberg, 2000; Geller, Levy, & Avitsur, 2024; Kolacz & Porges, 2018). While IBS is a disease of the gut, anxiety can exacerbate symptoms due to its induction of somatic symptoms. The somatic symptoms of anxiety can cause a feedback loop of anxiety, IBS symptoms, embarrassment, and worsened IBS symptoms (Geller et al, 2024). The National Institute of Diabetes and Digestive and Kidney Diseases recommends that IBS be managed with medical, mental, and behavioral health interventions.

Vagus Nerve and the Gut

In the 1990s, Stephen Porges, PhD, developed the Polyvagal Theory, which has also contributed to the development of somatic therapy modalities to treat psychological distress. The vagus nerve extends from the brain to the gut, serving as the "mind-gut connection" (Özçağlayan et al., 2020). This nerve plays a role in regulating the autonomic nervous system, also known as subconscious physiological responses, including heartbeat, respiration, stress response, and digestion. The autonomic nervous system is considered to have two primary branches: the parasympathetic nervous system, which maintains a rested state, and the sympathetic nervous system, which is activated during times of stress (Porges, 2011). Polyvagal Theory's biggest strength is its accepted role in mobilizing the parasympathetic nervous system. It is understood that a functioning vagus nerve acts as a "brake" on the body's stress response and returns it to a restful state. Somatic therapists and polyvagal theorists recommend "vagal toning" to improve our responses to stress.

The APA and NIH already recognize the mind-gut link and recommend mental health approaches in addition to medical IBS management for those struggling with both IBS and anxiety or mood disorders (Abramson, 2025; National Institute of Diabetes and Digestive and Kidney Diseases). While overarching research has

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Trauma-Informed Treatment of Anxiety: Empowerment Through Education

By Elaine M. Edelman, PhD, LCSW CASAC-Adv, Professor of Practice Kansas State University

Abuse and neglect are experiences of profound invalidation, of both one's physical and emotional needs. Physical, sexual or emotional abuse or neglect thrusts one into survival mode. There is rarely space for feelings. The body goes into "fight, flight, or freeze" response, there may be overwhelming rage or terror, or there might be numbness in the form of dissociation. All these reactions have biological correlations. The client that comes to us, feeling either nothing, or overwhelming flashbacks, is in the throes of a storm they can't control and often don't understand.

Bessel van der Kolk was right: the body keeps the score. In his groundbreaking work on the biological impact of trauma (van der Kolk, 2015), Dr. van der Kolk brought to the field an understanding that trauma impacts us on a cellular level (Colich, et al, 2020). Those of us who work with trauma are aware that what the body and mind experience often become "hardwired," in the form of startle responses, triggered emotional reactions, flashbacks, and nightmares. As Dr. van der Kolk has pointed out, trauma doesn't embed itself in the brain as words – but rather images and sensations, so why should words be the primary mechanism for healing? As the field of psychotherapy learns more about the pathways to alleviating symptoms (including art, dance, and movement therapies, among other modalities) I would like to reflect on the power of psychoeducation in trauma. To be clear, if education were all it took to facilitate healing – we'd all eat right, exercise, and go to bed early. But as many of us know, insight has limited value when addressing symptoms and suffering as we're trying to find a pathway to health.

Having noted the limits of insight and education, I'd like to reflect, paradoxically, on why it is so essential in trauma treatment, and how it becomes a tool of empowerment.

As clinicians, we are always listening to the information that will help us provide what people need to heal, feel safe, and move towards their goals. As Dr. van der Kolk has said, the goal of therapy is to be comfortable with one's internal experience. As a therapist who has worked with trauma survivors for many years, my "go to" theory for this work is Relational Cultural Therapy, which posits that people grow and heal in the context of healthy connections. When a therapist can offer an authentic and healing connection with a client, they provide a space to integrate what has happened to them as well as to process how the memories and aftereffects of their experiences continue to impact them. As Pearlman and Saakvitne (1995) have pointed out, "The process of building the therapeutic relationship *is* the therapy with trauma survivors. This premise frames the psychotherapy as an evolutionary relational process, rather than a series of either crisis and their solutions, or dramatic mutative interpretations." The relationship is the context for healing. But ultimately, the goal is to take back one's internal experience from the imprint of the past.

An example of psychoeducation as a trauma tool is illustrated below.

Carri was referred to me for therapy in

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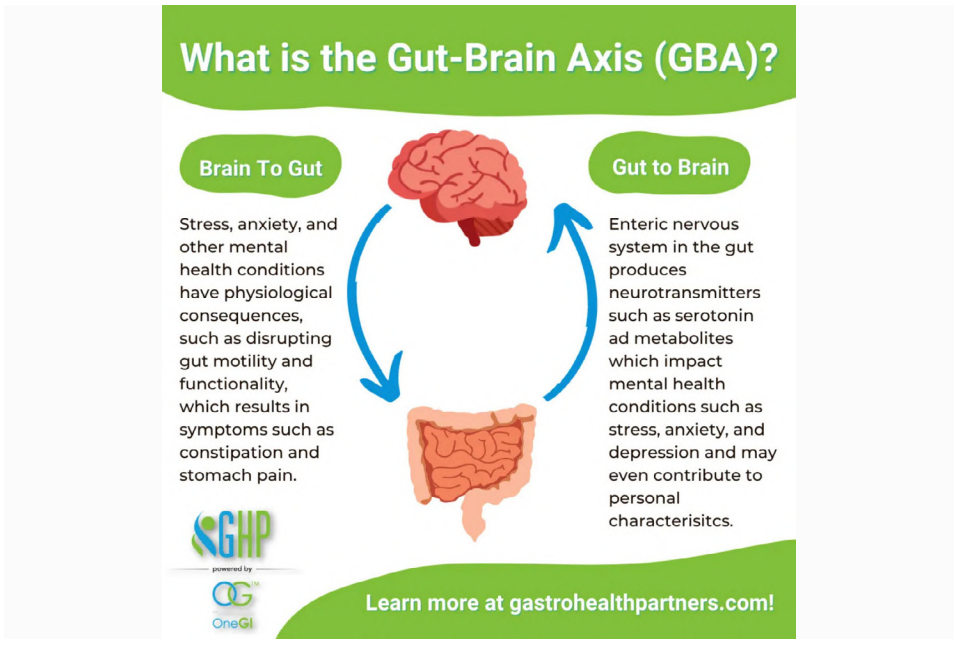
Beyond the Chemical Imbalance: Rethinking Depression and Anxiety

By Dr. Victoria Sanders, LMFT 52610, PhD CEO, VMS Family Counseling Services



For decades, much of the mental health field has operated under the assumption that certain individuals simply do not produce "enough" of a particular neurotransmitter, and that the most effective way to address this imbalance is through medication, supplemented by therapy focused on "coping" skills to help manage symptoms. But what if this view is incomplete? What if depression and anxiety are better understood through the lens of attachment theory and of the brain–body connection, considering how our physiological systems function and interact across the lifespan?

Medication and coping skills have undeniably proven helpful for many people experiencing depression and anxiety, particularly during times of crisis. However, there is often an implicit assumption that these approaches are the only options available. While it is important to recognize and value their role in stabilizing individuals in acute distress, it is equally important to challenge the belief that this is how it must "always be." Such a perspective can be both limiting and, in many cases, inaccurate.

Development

Erik Erikson's theory of psychosocial development offers valuable insight into how individuals come to see themselves and the world around them. According to Erikson, the first developmental task of infancy is to establish trust: trust that caregivers will respond and provide care, trust that the world is safe and predictable, and trust in one's own ability to have needs met. But what happens when this foundational task is left incomplete? When early experiences lead a person to believe that the world is not a trustworthy place, the consequences can echo across the lifespan. Individuals living with anxiety often struggle to accept that others can be trusted that the world is safe, and that they themselves are capable of meeting their own needs.

The remaining developmental tasks of childhood and adolescence also offer opportunities for anxiety and depressive symptoms to emerge, sometimes in ways that may appear "untreatable," particularly when these symptoms are evident early in life. Although these stages focus on the individual's growth, each requires meaningful engagement with a primary caregiver to be successfully navigated. This interdependence underscores the critical role of attachment and early relational experiences in shaping mental health outcomes across the lifespan.

How does this connect back to medication, neurotransmitters, and our understanding of anxiety and depression? Historically, research has linked both conditions to imbalances in specific neurotransmitters, either too little or too much of a given chemical. However, it is short-sighted to assume that the brain and body operate in isolation. The two are in constant communication: what the brain perceives and believes influences the body's chemical production, and what the body produces in turn affects mood, thought patterns, and emotional states.

The gut and brain are in constant communication, working together to help the body "know" and respond to what is happening. For example, the brain signals the gut when to begin digestion and when to stop. You may recall the old saying that constant worry can lead to ulcers, there's truth to that. Chronic stress causes the stomach to release excess acid, and over time, this can overwhelm the gut.

Interestingly, about 80% of the body's serotonin is produced in the gut. Serotonin

see Chemical Imbalance on page 32

Bridging the Tech Gap: How Ambient Monitoring Is Modernizing Mental Health Facilities

By Michael V. Genovese, MD, JD
Chief Medical Officer of Behavioral Health, Access TeleCare

As a psychiatrist, I've witnessed the fragility of patient safety during a psychiatric crisis. As an attorney who's defended doctors in malpractice cases, I've seen the devastation when safety protocols fail. If I've learned one truth from my dual careers, it's that, in behavioral health, safety isn't just important; it's foundational.

Psychiatric units are the "ICU of medicine" – they treat our most acute, vulnerable patients. But while traditional ICUs have evolved with sophisticated monitoring technologies, psychiatric facilities largely rely on the same manual observation protocols they've used for decades, creating a critical gap in care delivery. When a patient's judgment is impaired, it makes safety the fundamental prerequisite for treatment and recovery. While safety in health care has long been guided by the aspiration of zero harm, some question its attainability in behavioral health. However, that debate misses the point. The critical question here isn't if zero harm is the right goal – it's how we get there.

The Safety Paradox

Even after admission, a patient's health remains at risk, requiring vigilant monitoring, typically in the form of 15-minute or even five-minute safety checks. Yet these very protocols, intended to protect, can inadvertently disrupt the healing process. We admit patients to keep them safe, then disrupt their healing by waking them up four times an hour. It's counterproductive, like treating dehydration with small doses of salt water.

The frequency of safety checks doesn't just impact the patient; the field has a high staff burnout rate from the constant monitoring. In 2022, 46 percent of health workers felt burned out, up from 32 percent of workers in 2018. Four or more times an hour, these staff members must check on each patient, sometimes 24 beds per technician, documenting each interaction while juggling countless responsibilities. The math simply doesn't add up. And even with these frequent checks, staff still have no visibility into what's happening once they leave the room.

This relentless, exhausting cycle drives talented healthcare workers from the field, creating staffing shortages that further compromise safety – the very thing these protocols were designed to ensure. While traditional monitoring protocols create a challenging dichotomy, innovative technologies specifically designed for mental health settings offer a promising path forward.

Developing Technology for Mental Health

Compared to other specialties, psychiatric care has historically been slow to adopt technological innovation – not out of reluctance, but because suitable technologies haven't been developed specifically for a mental health setting.

This lag is increasingly problematic as mental health assumes a more central role in a patient's care. Research shows cancer patients with treated psychiatric disorders

see Ambient Monitoring on page 38

Anticipatory Anxiety: Understanding It and How to Manage It

By Madhuri Jha, LCSW, MPH
Clinical Advisor
Psych Hub

Have you ever said to yourself, "I am dreading this event, and I am nervous about what will happen?" What you were likely experiencing was anticipatory anxiety. As outlined by the American Psychological Association, anticipatory anxiety is defined as the development of fear or dread in the face of an anticipated event or situation. More simply, it is a growing worry that something we may experience in the future will be scary, stressful, or result in a distressing outcome. Anticipatory anxiety can impact anyone, and if it is not addressed in real time, can progress to clinical anxiety.

How Is Anticipatory Anxiety Different From Clinical Anxiety?

According to the DSM-5, clinical anxiety is qualified by three or more of the following symptoms persistent for at least six months:

- Feeling restless or on edge
- Becoming easily fatigued
- Having difficulty concentrating or experiencing a blank mind
- Feeling irritable
- Experiencing muscle tension
- Having trouble sleeping, such as difficulty falling or staying asleep, or waking feeling unrested

The symptoms of anticipatory anxiety are more subtle and understated. They can look like lower-grade symptoms of worry, feelings of fear, avoidance, or catastrophic thoughts. The Anxiety and Depression Association of America describes anticipatory anxiety as the "third layer of fear," and provides an accessible framework to think about how anticipatory anxiety shows up in daily life. According to the ADAA, the first layer of fear is the baseline knowledge that we are afraid of something - *"I am afraid of sharks."* The second layer is being afraid of how we will express the fear of that something - *"If I ever encounter a shark in the ocean, I will be so panicked and scared that I will just freeze and be eaten alive."* And the third layer is described to be the fear of the event that will cause the fear response to the thing one is afraid of - *"I am dreading going on this beach vacation because I may see a shark in the ocean and then be so consumed with panic that I won't know how to swim to safety."*

If unrecognized or unaddressed, this third layer of fear can be a breeding ground for catastrophic thoughts, social avoidance, and ultimately a risk factor for progressing to full-blown anxiety.

Anticipatory Anxiety Can Affect All Ages

In my experience as a therapist who works with both kids and adults, I have seen how anticipatory anxiety can impact all ages. For young children and teens, some examples of anticipatory anxiety can be related to an upcoming school year, a major test, or a sports competition. For adults, this may be tied to returning to a toxic work environment after a vacation, an upcoming medical appointment, or the outcome of a political election. As clinicians, the traditional diagnostic tools and behavior definitions we use to diagnose clinical anxiety are not geared to provide focus on early signs of anticipatory anxiety.

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Using Virtual Reality to Address Loneliness and Increase Social Connectedness in a Personalized Recovery-Oriented Services (PROS) Program for Older Adults

By Heidi Billittier, DSW, LMSW
Chief Operating Officer
Envision Wellness WNY

Social isolation refers to the lack of meaningful friendships, connections, and relationships in one's life, whereas loneliness is the perception of the feelings associated with isolation (Wu, 2020). Wu (2020) reported that one-quarter of older people living in-community report feelings of loneliness and lack of social connections. Key consequences of social isolation and loneliness may include a decline in both mental and physical health, an increase in substance use and self-medication, and a rise in destructive behaviors together with a decrease in healthy behaviors. Social isolation limits physical activity, which can worsen chronic illness, heart disease, obesity, and other conditions that require activity to maintain health and prevent decline (Lee & Coughlin, 2014).

A virtual reality (VR) program was developed to explore the use of VR with older participants enrolled in a Personalized Recovery-Oriented Services (PROS) program at a behavioral health agency. PROS supports individuals in setting personal goals, developing life skills, and maintaining community connections through an integrated approach that combines treatment, support, and skill-building in a person-centered environment. This study explored whether use of VR affected feelings of loneliness and social connectedness. Implementation science principles guided the integration of the evidence-based VR program by identifying barriers and facilitators to implementation and by employing strategies to address these challenges (Wensing et al., 2022).

Social isolation and loneliness, often linked to a lack of social connections, pose an ongoing threat to physical and mental health across all age groups. Among older adults, the issue remains prevalent and according to the University of Michigan National Poll on Healthy Aging (Malani et al., 2023), 56% of respondents aged 50–80 reported feeling socially isolated during the COVID-19 pandemic. While this rate has since declined, one in three older adults (34%) continue to experience social isolation and resulting loneliness.

Fakoya and colleagues (2020) identified risk factors contributing to loneliness in older adults, many tied directly to lack of social connectedness and include poor health, cognitive impairment, lower socioeconomic status and neighborhood deprivation. According to Ang (2022), social connectedness refers to having meaningful relationships, engaging socially, and taking part in community life. It serves as a protective factor that can reduce loneliness and strengthen one's sense of belonging. Hughes et al. (2017) researched social isolation and loneliness among older adults, identifying it as a global health issue and a significant risk to overall well-being. The authors proposed that technology could help overcome barriers to socialization, such as physical distance, mobility challenges, and individual crises. Additionally, their research found that older adults generally hold positive attitudes toward virtual reality (VR), suggesting that further exploration of its use is warranted. Virtual reality (VR) has emerged as an innovative and engaging intervention in addressing loneliness and increasing feelings of

see Virtual Reality on page 34

Rewriting Recovery: A Mind-Body Model for OCD and Depression

By Eda Gorbis, PhD, LMFT
Alexander Gorbis, AMFT
Aanya Jajoo, BS
and Neha Mandava
The Westwood Institute for Anxiety Disorders, Los Angeles, CA

Background: Obsessive-Compulsive Disorder (OCD) affects over 3 million adults in the U.S. and is frequently accompanied by depression, anxiety, gastrointestinal issues, and sleep disturbances. Standard treatments, particularly selective serotonin reuptake inhibitors (SSRIs), often fall short—up to 40% of patients do not achieve sufficient relief. Less than 10% receive Exposure and Response Prevention (EXRP), the first-line behavioral therapy. This underscores the need for accessible, integrative, and personalized treatment approaches.

Methods: This study evaluated a multidisciplinary intervention combining EXRP, mindfulness-based therapy, expressive writing, cognitive restructuring, and lifestyle modifications. Forty participants (ages 17–51, mean = 6 weeks of treatment) received care at an intensive outpatient clinic. A collaborative team—including therapists, physicians, and specialists in psychiatry, endocrinology, and gastroenterology—administered treatment. Outcomes were assessed using the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), Hamilton Depression Scale (HAM-D), and the Willoughby Fear Survey. Subgroup analyses explored differences by sex and age.

Results: Participants showed significant mental and physical health improvements. Y-BOCS scores declined by 57.2%, with 82% achieving >50% reduction. Depression symptoms dropped by 53.7%, and fear-based symptoms by 50.97%. Gains were consistent across age and sex groups. Adolescents showed the largest relative improvement. Self-reported sleep, GI distress, and tinnitus also improved.

Conclusion: This study highlights the effectiveness of an integrative, mind-body model for OCD and comorbid conditions. Writing-based therapies, embedded in multidisciplinary care, significantly reduced OCD and depression symptoms while improving overlooked physical symptoms. The findings support broader implementation of holistic, individualized care models in clinical settings.

Introduction

Obsessive-compulsive disorder (OCD) is a chronic and often treatment-resistant mental health condition that significantly impairs daily functioning. Affecting more than three million adults in the United States (NIMH, 2023), OCD is frequently accompanied by comorbid depression and anxiety, both of which exacerbate functional decline and increase the risk of suicide (Fernández de la Cruz et al., 2017). According to the International OCD Foundation (2023), the average delay between symptom onset and treatment is approximately 11 years. During this time, comorbid conditions such as sleep disturbance, gastrointestinal dysfunction, and chronic stress responses often emerge (Cryan & Dinan, 2012; Riemann et al., 2020).

Despite the proven efficacy of Exposure and Response Prevention (EXRP), it remains vastly underutilized, reaching fewer than 10% of those diagnosed (Franklin et al., 2020). Selective serotonin reuptake inhibitors (SSRIs), the most common pharmacological treatment, yield only partial or inconsistent results in up to 40% of patients

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Suicide Risks With Depression, Anxiety, and Co-Occurring Depression/Anxiety

By Thomas Grinley MS, MBA, CMQ/OE, LSSGB, CCISM, Health Services Evaluation Planning and Review Specialist, New Hampshire Department of Health and Human Services

The fact that depression increases the risk of suicide should come as no surprise. Less well known are the suicidal risks of anxiety and the synergistic effect of co-occurring depression and anxiety. Additional life factors can function as triggers and increase those risks even more. We will look at those risks and how they can be mitigated.

Guze and Robins (1970) found that 12% to 19%, or an average of 15%, of those with major depressive disorders would die by suicide. Their studies, however, were based on hospitalized people with depression and Blair-West, et al. (1997) challenged those numbers. Angst, et al. (1999) in their own analysis concurred that the numbers were not representative but concluded: "Little is known about the suicide risk …from general practice or community samples; it seems to be much lower." [p. 61]. However, Orsolini, et al. (2020) were still citing the 15% number fifty years later. The Depression and Bipolar Support Alliance (2025) report a lifetime risk of 20% for untreated depression. Despite challenges to the statistics, for more than 50 years, the consensus seems to be between 15% and 20% of those with depression will die by suicide. Perhaps a better measure is the DBSA claim that depression is the cause of more than two-thirds of reported suicides.

When it comes to anxiety and suicide risk, things become even less clear. According to Kircanski, et al. (2017), approximately half of those diagnosed with depression or anxiety will have both co-occurring. Sareen, et al. (2005) reported the first study to adjust for other factors and look at anxiety alone as a suicide risk. They were able to demonstrate that anxiety on its own is an independent risk factor for suicide. Until their study, there was debate whether anxiety was a risk factor for suicide. Meier, et al. (2016) report that 2.1% of those with anxiety disorders will die by suicide within 10 years, meaning the lifetime prevalence is even higher. The most recent Diagnostic and Statistical Manual of Mental Disorders, the DSM-5-TR (2022), now includes a paragraph for each diagnosis on its association with suicidal thoughts or behaviors. All anxiety disorders have a statement about increased risk of suicidal behaviors.

When you combine depression and anxiety, suicide risks increase even more. We have already stated that half of those with one disorder will also have the other. Sareen, et al. (2005), were the first to study anxiety on its own as a risk factor but also noted: "the data clearly demonstrate that comorbid anxiety disorders amplify the risk of suicide attempts in persons with mood disorders." [p. 1249].

There are other contributing factors we must take into consideration, for example, loneliness. Moon, et al. (2025) reported that individuals with depression that were living alone had a 290% increased risk of suicide. Individuals living alone who had co-occurring depression and anxiety had a 558% increased risk. Fernandez-Rodrigues (2022) highlighted that poor health can also increase the risk of suicide for those with depression, particularly among older adults who already have a higher

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Managing Polypharmacy in Individuals with Anxiety and/or Depression

By Frank Longo, RPh
President
Precision LTC Pharmacy

Many people who take medications to treat anxiety and/or depression also take drugs to manage additional chronic conditions. So-called polypharmacy – which is generally defined as the concurrent use of five or more medications – can lead to a host of problems, including increased risk of adverse drug interactions, confusion, falls and reduced medication adherence, especially in individuals with psychiatric conditions or cognitive decline. For individuals in the long-term care setting, there are unique challenges to managing polypharmacy.

Fortunately, through proactive management and collaboration between pharmacists, prescribers, patients and caregivers, many of the risks associated with polypharmacy can be reduced, thus minimizing the negative impacts on physical and mental health and quality of life.

Depression and Anxiety Medication Usage

Depression and anxiety disorders are the most common mental health conditions, impacting millions of Americans. According to recent data from the Centers for Disease Control and Prevention's National Center for Health Statistics, depression impacts 13.1% of adults and adolescents – an increase of about 60% in the past decade.[1] Meanwhile, about 19.1% of U.S. adults suffer from an anxiety disorder, according to the Anxiety & Depression Association of America.[2]

About 11.4% of adults take prescription medication for depression, and adults with disabilities are nearly three times as likely to take medication for depression as those without disabilities, based on the most recent National Center for Health Statistics data.[3] An earlier study reported that 16.5% of adults took medication for their mental health, including anti-anxiety and anti-depression drugs.[4]

Growing Need to Manage Polypharmacy

Polypharmacy is a rising phenomenon. The overall percentage of U.S. adults with polypharmacy ballooned from 8.2% in 1999-2000 to 17.1% in 2017-2018, according to a study published in the National Library of Medicine.[5] Polypharmacy prevalence is considerably higher among the elderly and adults with diabetes and/or heart disease, according to the study. When appropriate, polypharmacy may effectively treat symptoms, prevent disease complications and increase life expectancy. But, the study cautioned, "The majority of research suggests that polypharmacy is associated with negative clinical consequences, including nonadherence to treatment, adverse drug events (e.g., falls, fractures, renal failure), drug-drug interactions, and hospitalizations. Polypharmacy is also linked to increased risks of disability, cognitive decline and even mortality."[5]

Medications to treat anxiety and depression are an important area of focus for polypharmacy management, given the high incidence of individuals taking these medications and the fact that these medications are known to have adverse interactions with certain other drugs.

For residents of long-term care facilities, managing polypharmacy can be uniquely challenging. Long-term care residents often have multiple chronic conditions and cognitive impairments, adding nuance to medication management. Further, the involvement of various prescribers and care staff can lead to fragmented oversight of a resident's drug regimen and medication interactions.

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Caring for Caregivers: Why They Need to Protect Their Own Mental Health

By Wendy Martinez Farmer and Jantra Coll
Vibrant Emotional Health

Caregiving can be one of life's most meaningful yet demanding responsibilities. Whether you're a parent managing a child's physical or behavioral challenges, an adult caring for an aging parent, or supporting a loved one through illness or disability, the weight of these responsibilities can feel enormous.

Aptly termed "invisible health systems," there is an increasing reliance on the informal and unpaid assistance provided by family, friends, and neighbors. Millions of Americans provide unpaid care to family members and friends, often dedicating 20 or more hours per week to hands-on, hypervigilant assistance. This intense level of caregiving doesn't just demand physical energy; it can take an emotional and psychological toll that can push even the most resilient individuals past their coping limits (Marshall et al., 2023; Rosato et al., 2019).

As we observe Suicide Prevention Month this month and look ahead to World Mental Health Day and National Depression and Mental Health Screening Month in October, it's critical to acknowledge that caregivers can often face significant mental health risks that require further attention and support.

One of the most emotionally challenging aspects of caregiving often begins before the hands-on care starts: watching someone you love transition into needing support. For example, witnessing a parent's memory fade, a child struggling with developmental milestones, or a loved one battling a chronic illness can trigger feelings of grief, helplessness, and loss. The person you've known and loved—or come to deeply care about—may seem different, and you might find yourself mourning the relationship you had while simultaneously trying to provide the best care possible. This emotional complexity adds another layer of stress to an already demanding situation.

These challenges affect not only family members and close friends with personal connections to the care recipient, but also professional caregivers who develop close attachments through their work and may internalize the emotional weight of their responsibilities.

The Hidden Mental Health Crisis Among Caregivers

Research reveals alarming patterns in caregiver mental health that cannot be ignored. Depending on the caregiving context and which studies you consult, suicidal thoughts affect anywhere from 3% to over 70% of caregivers (O'Dwyer et al., 2021).

While the true prevalence of suicide among unpaid caregivers remains difficult to ascertain due to limited research samples, two separate meta-analyses focusing on caregivers of people with cancer and dementia reported suicide rates around 6% (Low et al., 2024; Solimando et al., 2022). These numbers, though based on small samples, point to a growing crisis that demands immediate attention and comprehensive support systems.

Understanding Risk Factors

Several interconnected factors contribute to increased mental health risks among

see Caregivers on page 37

Collaborative Care Improves Outcomes in Depression and Anxiety

By Virna Little, PsyD, LCSW-r, MBA, CCM, SAP and Jian Joyner, LSW
Concert Health

Depression and anxiety are among the most prevalent and disabling mental health conditions in the United States. Millions of people face these challenges every year, often with symptoms that interfere with their daily lives. Yet despite the increasing demand for mental health care, many individuals struggle to access timely, effective treatment, particularly those in underserved or rural areas.

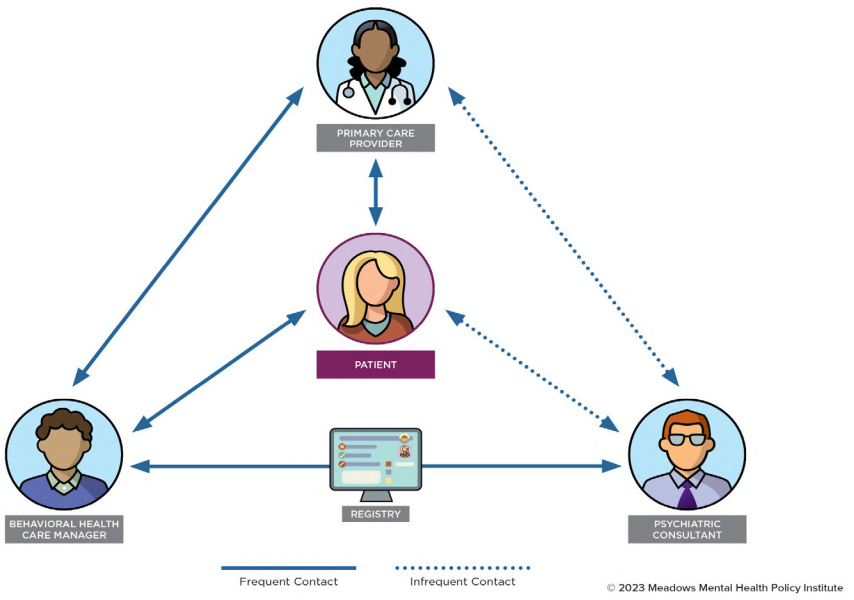
Primary care remains the first point of contact for most individuals seeking help, but many clinics lack the infrastructure or specialized staff to provide sustained behavioral health support. Meanwhile, the nationwide shortage of mental health providers continues to limit access, leading to long wait times, inconsistent follow-up, and missed opportunities for early intervention.

The Collaborative Care Model: A Proven Solution

The Collaborative Care Model (CoCM) directly addresses these challenges by embedding behavioral health services within the primary care setting. Developed and extensively studied by researchers at the University of Washington's AIMS Center, the model is built around a multidisciplinary care team that includes:

- A primary care provider (PCP)
- A behavioral health care manager
- A psychiatric consultant

This team-based approach supports systematic identification and treatment of depression and anxiety using validated tools such as the PHQ-9 for depression and GAD-7 for anxiety. These measures enable measurement-based care, allowing clinicians to track patient symptoms over time and adjust treatment based on real-time clinical outcomes.



The Collaborative Care Model (CoCM)

How It Works: A Coordinated, Patient-Centered Approach

Collaborative Care offers a fundamentally different experience compared to traditional referral models, which often result in disjointed or delayed treatment. Instead, CoCM emphasizes proactive, coordinated engagement between the care team and the patient.

For example, a patient who visits their PCP with symptoms such as fatigue or sleep disturbances may be screened during the visit. If behavioral health concerns are identified, a behavioral health care manager shortly follows up often by phone or video—to provide support, build rapport, and create a personalized care plan. The psychiatric consultant reviews the case regularly, offering clinical guidance to the care team based on symptom scores and progress.

Regular, structured check-ins help maintain treatment momentum, reinforce coping strategies, and allow for timely treatment adjustments. Importantly, the patient remains connected to their primary care team throughout the process, which builds trust and continuity, especially valuable in communities where stigma or logistical barriers can prevent access to traditional mental health services.

What the Research Shows

Numerous studies have validated the effectiveness of the Collaborative Care Model. A landmark Cochrane review found that CoCM leads to significantly better

see Collaborative Care on page 31

The Power of Integration: How Combining Evidence-Based and Holistic Therapies Creates Lasting Mental Health Recovery

By Dr. Sal Raichbach, PsyD, LCSW, CFSW
Chief Clinical Officer
The Recovery Team

Mental health recovery isn't a one-size-fits-all journey. While traditional approaches like medication and psychotherapy have helped millions, a growing body of research shows that combining evidence-based treatments with holistic practices creates the most powerful path to lasting wellness. This integrated approach addresses not just symptoms, but the whole person – mind, body, and spirit.

Understanding Evidence-Based Psychotherapies

Cognitive Behavioral Therapy (CBT) stands as one of the most researched and effective treatments for mental health conditions. This therapy focuses on identifying and changing negative thought patterns that fuel anxiety, depression, and other disorders. CBT teaches practical skills for managing difficult emotions and breaking cycles of destructive thinking.

Dialectical Behavior Therapy (DBT) takes a different, but complementary approach. Originally developed for borderline personality disorder, DBT has proven effective for a wide range of conditions involving emotional dysregulation. While CBT focuses primarily on changing thoughts, DBT emphasizes accepting difficult emotions while learning healthy ways to cope with them.

Research comparing these approaches reveals fascinating insights. A 2022 study found that while CBT was more effective at reducing anxiety and depression symptoms, DBT showed superior results in improving executive function, specifically the brain's ability to plan, focus, and make decisions. This suggests that combining both therapies could address different aspects of mental health recovery.

The Science Behind Holistic Practices

Meditation has moved from an ancient spiritual practice to a scientifically validated treatment. Multiple studies demonstrate that mindfulness meditation programs can significantly reduce anxiety, depression, and psychological stress. The effects are measurable in the brain – meditation changes neural pathways, reducing activity in the amygdala (the brain's alarm center) and strengthening areas responsible for emotional regulation.

Yoga offers another powerful tool for mental health recovery. Research shows that regular yoga practice helps regulate the body's stress response by lowering cortisol levels, the hormone linked to anxiety and depression. A comprehensive review of yoga studies found that 58% of research showed reductions in both anxiety and depression symptoms, with effects lasting months after treatment ended.

What makes these practices particularly valuable is their accessibility. Unlike some treatments that require specialized settings, meditation and yoga can be practiced anywhere, making them practical tools for ongoing self-care.

When Medication Becomes Part of the Picture

For many people, medication plays a crucial role in mental health recovery. Antidepressants, mood stabilizers, and anti-anxiety medications work by correcting chemical imbalances in the brain that con

see Power of Integration on page 38

Harm Reduction from page 11

The Brooklyn grants teams understand that harm reduction is needed to empower individuals to make choices that will lead to personal growth, stability, and joy. This involves an invitation to explore complex contributing factors to diminished wellness and consider options beyond those initially available. Options that promote well-being through authentic engagement are more impactful when delivered through warm handoffs by staff who have developed trust within their working relationships. "…This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care."[4] As teams conduct referrals across programs, participants experience mutuality and a breakdown in the implicit power dynamics inherent in the patient/client dynamic, providing participants with the acknowledgement that the provider is not an expert, while empowering creative solutions that better fit their needs. This pathway increases valued shared decision making in recovery and treatment.

Harm Reduction is a foundational framework for care throughout S:US. The outreach teams bridge gaps in community healthcare through tailored community engagement and connections to the most appropriate service types. Over the last three years, hundreds of individuals across underserved communities have connected with the Brooklyn outreach teams to receive services and support. Ongoing communication with program leadership and direct service providers systematizes treatment for participants identified as most at risk based on screenings and assessments, individual narratives, and disclosures and documentation. The Recovery & Treatment Division has seen success through teams' co-facilitation of harm reduction workshops, preparing staff and participants to respond to high-risk behaviors. Success lies in individuals accepting invitations for psychotherapy, processing traumatic experiences, developing safer support systems, and invigorating internal strength-based strategies. Beyond Substance Use Disorder (SUD) support, harm reduction is harnessed through evidence-based practices, purposeful engagement, and treatment interventions delivered by CCBHCs. Each program shares a singular goal— to support people in making informed decisions to save their lives and co-create pathways to meaningful futures.

In partnership with NYC Department of Health and Mental Hygiene, S:US launched the city's first public health vending machine in 2023.

Dani York, LCAT, is Director of Clinical Support & Enhancement, and Elan Quashie, is Director of the Opioid Overdose Prevention Program, Recovery & Treatment at Services for the UnderServed (S:US).

Footnotes

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Bipolar Disorder in Older Adults: Symptoms, Cognitive Impact, and Supportive Activities

By Jill Hanika Stout, BA
Mental Health Professional
and Self-Advocate

Bipolar disorder in older adults is often underdiagnosed or misdiagnosed as dementia, early Alzheimer's disease, or even normal age-related cognitive decline (Brown et al., 2011). It is important to distinguish older age bipolar disorder from these diagnoses because treatments and medications are different for each of these illnesses of aging.

If you think you have older age bipolar disorder, this article will describe your symptoms, the cognitive impact of your illness, the differences between apathy and mild cognitive impairment (MCI), and supportive interventions and activities that can mitigate the influence of the disorder.

Types of Bipolar Disorder

Older age bipolar disorder has two main categories: Bipolar I is episodes of major depression and of mania that can be severe enough to require hospitalization. Severe depression and hypomania characterize bipolar II (DSM–5-TR; American Psychiatric Association, 2022). Hypomania isn't as intense as full mania.

Symptoms in Older Adults

If you've already been diagnosed with bipolar disorder, you know symptoms of depression include apathy, lethargy, hopelessness, withdrawal from normal activities, changes in appetite, and sleeping too much. Mania includes poor judgment, reduced need for sleep, agitation, and, in older adults, irritability rather than the euphoria experienced by younger adults with bipolar disorder (Dols et al., 2023).

Challenges in Diagnosing Older Age Bipolar Disorder

Dementia or side effects from medications for chronic conditions of aging such as cardiovascular disease, diabetes, chronic kidney disease, and chronic obstructive pulmonary disease (COPD) can complicate a diagnosis of older age bipolar disorder by obscuring symptoms of bipolar disease or by requiring medications that may cause depression or dementia side effects themselves (Goldstein et al., 2009; Charles et al., 2016; Katz et al., 2017).

You may be underreporting bipolar symptoms due to memory issues or the stigma surrounding mental illness. You need to mention recurring symptoms to your doctor: Don't be ashamed if you are experiencing emotional issues. Ask relatives or caregivers to help you write down questions for your medical appointments.

Diagnostic Differences: Apathy

If you have apathy, you are uninterested in hobbies and activities and are probably not socializing with friends or family members (Ishii et al., 2009). Some studies in the last ten years have shown that apathy in older adults who are showing no signs of dementia may be associated with decreased brain volume, as shown on MRI studies (Anderson-Hanley et al., 2018; Grool et al., 2014).

The decreased brain volume of gray matter—the brain's and spinal cord's information processing tissue—is present in some older adults. White matter is also reduced; it is the part of the central nervous system that connects and communicates with the areas of gray matter. Researchers have been unable to find a causal relationship

see Bipolar Disorder on page 39

Peer Support from page 1

receive treatment.

Given these emotional and practical obstacles, peer advocates can play a critical role in helping individuals navigate these challenges, providing understanding, and fostering hope where clinical services alone may not suffice.

Benefits of Peer Advocates

There are numerous benefits to having a peer advocate. Different types of peer advocates serve different populations:

- Youth Peer Advocates (YPA) work specifically with young people,
- Family Peer Advocates (FPA) support parents and guardians,
- Certified Recovery Peer Advocates (CRPA) assist individuals who have experienced addiction,
- Adult Peer Specialists (APS) focus on adults, and
- Other peer certifications address diverse needs across communities.

All peer advocates are trained to provide non-clinical, professional support while maintaining clear boundaries, ethical standards, and a defined scope of practice.

Although each peer certification has its own unique scope and role dynamics, there are common themes across all peer positions. These include empowering the individuals they support, advocating for their needs as they navigate complex systems, fostering mutual collaboration between the individual and the peer advocate, and facilitating connections to community resources. Together, these shared practices help peer advocates create meaningful support networks that enhance recovery, resilience, and overall well-being.

Meghann Simpson, BA, YPA-C, CRPA-P

The impact of peer advocates is profound. First and foremost, a peer advocate models recovery and healing through life challenges. Someone actively experiencing depression may feel as though they will never be happy or successful again. This is where a peer advocate can make a meaningful difference. The peer advocate demonstrates what recovery and healing look like, provides guidance and support for navigating and overcoming depression, and inspires the individual to understand that healing is truly possible.

Peer advocates are also able to offer validation and understanding because they have experienced depression and can relate to the challenges the individuals they support are going through. This lived experience allows peer advocates to suggest coping strategies that may be effective or assist the individual in developing personalized coping skills. Some people may be hesitant or avoid clinical services for a variety of reasons. In these cases, a peer advocate provides an excellent alternative because they do not rely on clinical approaches that might feel intimidating, instead offering a relatable, collaborative, and equal-power dynamic.

Conclusion

The benefits of a peer advocate are vast, far exceeding what can be fully captured in this article. They extend beyond individual recovery to strengthen individuals, families, communities, and the broader support system for mental health and well-being. By bridging gaps between formal services and lived experience, peer advocates help reduce stigma, foster hope, and create lasting change in how mental health is understood and supported within society. Peer advocates bring connection, empowerment, and a sense of possibility to those living with depression. Organizations are urged to support and expand peer advocacy programs, while individuals experiencing mental health challenges are encouraged to seek assistance, knowing that recovery, hope, and healing are within reach.

Meghann Simpson, BA, YPA-C, CRPA-P, is an ambitious leader who leverages her lived experience, education, and professional expertise to develop trauma-informed support services for youth and adults. Having navigated trauma, mental illness, and addiction herself, she is deeply committed to supporting others along their healing and recovery journeys. Meghann earned a B.A. in Interdisciplinary Social Science with a Minor in African American Studies from the University at Buffalo. She co-founded Now She Speaks, a peer-led nonprofit supporting victims and survivors of domestic and interpersonal violence and human trafficking. Meghann strives to inspire others to know, with certainty, that they can and will live a happy and successful life, regardless of trauma or mental illness. For more information, visit www.meghann-simpson.net.

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Understanding Anxiety from page 1

about being in a setting where escape or accessing help might be difficult (i.e., settings may include public transportation, enclosed places such as stores or open spaces such as bridges)

- **Generalized Anxiety Disorder:** excessive anxiety or worry about a variety of events (i.e., responsibilities at work or school, one's health, finances, being on time, etc.)

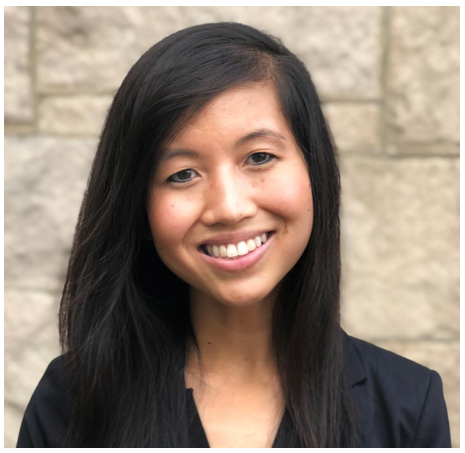
Ways Anxiety Can Manifest Across the Lifespan

While the primary concern varies across the different anxiety disorders, a common theme is *excessive fear or anxiety.* You may be thinking, "What is considered excessive anxiety?" Individuals affected by anxiety disorders are frequently *overestimating* the likelihood of feared outcomes occurring and how bad it would be if they did occur or face them AND often *underestimating* their ability to cope with the perceived threat. In other words, their worries about the feared object/situation are usually persistent and often unlikely to occur or be as catastrophic in nature as one assumes. In turn, the persistent and unhelpful worries usually result in significant distress and often times lead to avoidance of the feared situation, (i.e., avoidance of social situations, dealing with responsibilities, going to places where one may be concerned about being separated from a parental figure such as school, avoidance of an object such as dogs or a place where one believes they may experience a panic attack, etc.). When these maladaptive patterns of thinking and coping repeat for both children and adults, one can find themselves in the *anxiety cycle*, and the anxiety can begin to interfere with daily life, such as in school, at work, in social life/relationships, or in managing responsibilities.

In addition to persistent worries and avoidance of feared situations being common signs of anxiety in both children and adults, additional cognitive, emotional, physical, and behavioral signs of anxiety can include the following:

- Difficulties controlling one's racing thoughts/worries and thus concentrating
- Various somatic complaints, such as muscle tension, upset stomach, headaches, difficulties breathing, racing heart, fatigue, restlessness/fidgety behavior
- Changes in sleep (i.e., trouble falling asleep, staying asleep, tired upon waking up, nightmares, sometimes difficulties sleeping alone for children)
- Changes in appetite (i.e., minimal appetite or excessive appetite)
- Irritability

Debra G. Salzman, PhD



Hongmarie J. Martinez, PsyD

- Excessive crying or clinginess in children
- Sometimes school refusal for children
- Disruptive behavior in children, such as outbursts or tantrums

While children and adults can experience any of the aforementioned symptoms of anxiety, it's important to realize that children may have a more difficult time expressing their fears and worries to others compared to adults given their developmental stage, thus, it's often helpful for adults to pay close attention to changes in a child's emotional, physical, and behavioral functioning that are persistent and interfering in their daily life.

Undoubtedly, anxiety disorders can be overwhelming for both children and adults to experience. Fortunately, there are effective, evidence-based treatments that can be pursued regardless of age that can help individuals manage their anxiety and lessen the impact on one's day-to-day life.

Treatment of Anxiety and Worry Across the Lifespan

Cognitive Behavioral Therapy (CBT) offers a structured and evidenced based approach to help individuals more effectively manage anxiety and worry. While treatment across the lifespan shares many core components, treatment is tailored to each person's age, cognitive ability, and developmental stage.

One of the initial steps in treatment is building trust and assessing motivation. Because anxiety is uncomfortable and often frightening, people naturally want to avoid situations that trigger it. Therapy helps individuals identify what matters most to them. Identifying goals and values they can pursue even when anxiety is present. Treatment is not something done *to* a person but rather a collaborative process, working together to reach agreed upon goals that the individual is committed to. Instead of allowing fear to dictate behavior, therapy encourages individuals to focus on how they want to live their lives and let their values guide them.

Psychoeducation is another early and essential step. Many people enter therapy hoping their anxiety will simply "disappear," but this expectation can lead to disappointment and treatment dropout. As highlighted, anxiety is a natural and necessary emotion that helps protect us from danger and achieve success. Reflecting on a time when anxiety helped achieve a goal can shift one's perspective on the body's fight or flight response. Recognizing that innocuous events can trigger this response can help us identify the "false alarms" that signal danger. Giving a presentation, taking public transportation, going on a school bus, attending social events, driving a car, being near someone vomiting, hearing thunder, going to school, and feeling a racing heart may indicate danger to someone with an anxiety disorder. This in turn can lead to further physical symptoms and an assessment of heightened risk. Treatment can help individuals identify "false alarms" and reframe their reactions.

A common pattern in anxiety disorders is the feedback loop between anxious thoughts and physical symptoms. For instance, someone may feel their heart race before a presentation and believe their mind will go blank or they may faint and embarrass themselves which then spirals into further anxiety. CBT teaches strategies to interrupt this cycle and better manage symptoms.

Treatment plans in CBT vary based on diagnosis, age, and cognitive level but often include:

- **Psychoeducation** about anxiety
- **Relaxation and breathing retraining** to manage physical symptoms
- **Cognitive restructuring**, which involves challenging anxious thoughts
- **Gradual exposure** to feared situations, sensations, or thoughts
- **Values clarification**, helping individuals focus on what matters most

As part of CBT, individuals are taught to notice their thoughts and recognize when they are catastrophizing or overestimating risks. Individuals learn to face their fears with support and gradually learn that the feared outcomes either do not happen or can be managed. This process builds confidence in handling these situations and builds resilience.

Adults refer themselves to therapy, indicating potential readiness and motivation for change. Still, it can be daunting to learn that reducing the intensity of anxiety involves first feeling anxious while facing feared thoughts and situations. Once individuals understand the nature of anxiety and learn coping tools, through a collaborative process with the therapist, a hierarchy of feared situations is developed. Therapy starts with less distressing fears and gradually moves up the ladder, allowing individuals to build confidence. These exposure exercises are often practiced during sessions, with the therapist encouraging, supporting, and guiding throughout.

Motivating children and teens can be more challenging, as they are often brought to therapy by adults. Young clients may be less inclined to face fears, especially if parents or caregivers have enabled avoidance. For instance, if a child is allowed to skip school on test or presentation days, is driven to school instead of riding the bus, does not go to friends' houses or avoids going to the doctor, they may lack motivation to confront their fears. If the child/teen must engage in activities that induce anxiety, motivation to participate in therapy may increase. Additionally, if the child/teen understands that therapy involves facing anxiety in a structured, collaborative way and they have power as to the pace and order of therapy, motivation tends to improve.

Caregivers and teachers play a crucial role in the treatment process. They must be aware of how they may be unintentionally reinforcing avoidance. For example, giving attention to fear rather than acts of bravery can maintain anxiety. Shifting this attention toward encouraging bravery while approaching feared situations helps reinforce positive change.

The key message is that the goal of treatment is not to eliminate anxiety, but to learn how to live without being controlled by it. Therapy empowers individuals to make choices based on their values rather than their fears. With motivation, effort, effective strategies, and support, individuals and families can learn to manage anxiety and lead fulfilling lives.

Debra Salzman, PhD, and Hongmarie Martinez, PsyD, are licensed psychologists in New Jersey and New York and work at Behavior Therapy Associates in Somerset, New Jersey. Dr. Salzman and Dr. Martinez also have the authority to practice interjurisdictional telepsychology (APIT) from the PSYPACT commission, allowing them to provide telepsychology to clients in many states. To learn more, please visit behaviortherapyassociates.com or call (732) 873-1212. Email inquiries can be sent to dsalzman@behaviortherapyassociates.com and hmartinez@BehaviorTherapyAssociates.com.

Telehealth from page 8

Crisis Planning and Safety Protocols:

- Telehealth: Confirm client's location every session, document emergency contacts, maintain crisis intervention steps, and verify licensure jurisdiction (APA, 2021).
- Face-to-Face: Prepare de-escalation plans, access to medical support, and panic response strategies for acute anxiety.

Cultural and Diversity Considerations:

- Address privacy barriers in shared households for telehealth.
- Use culturally validated measures and integrate client's coping traditions into mindfulness or relaxation practices.

Relapse Prevention and Maintenance:

- Develop relapse prevention plans with triggers and coping strategies.
- Use booster sessions (telehealth or in-person) to reinforce skills.

Hybrid/Stepped Care Models:

Hybrid approaches combine telehealth CBT for accessibility with periodic in-person sessions for intensive exposure or biofeedback. This flexibility tailors care for severity and logistics.

Conclusion

Anxiety treatment delivered via telehealth is evidence based and comparable to in-person care when clinicians utilize structured diagnostic methods, validated assessment tools, and evidence-based modalities. Telehealth excels in accessibility, while face-to-face treatment remains vital for severe anxiety, somatic work, and intensive exposure. By integrating measurement-based care, cultural adaptations,

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licensure compliance, crisis protocols, and hybrid models, clinicians can deliver effective, client-centered anxiety treatment across both modalities.

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of unstable housing, food insecurity, and limited access to healthcare or transportation exerts a mental and emotional toll that many professionals now recognize as a form of chronic, toxic stress.

Research consistently links poverty with higher rates of depression and anxiety. But the relationship is bidirectional: mental illness can also make it more difficult to secure and maintain employment, leading to a cycle of economic instability and worsening mental health. Breaking this cycle requires upstream interventions that go beyond clinical care.

Racism and Racial Trauma

For many communities of color, racism is not an isolated incident — it is a persistent, systemic force. From discriminatory housing practices to biased policing and healthcare inequities, racism contributes to chronic stress and race-based traumatic stress, often known as racial trauma.

This form of trauma can lead to PTSD, especially when paired with socioeconomic disadvantages. Black and Latino Americans, for example, have higher rates of life-

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time PTSD compared to white Americans.

What Can Human Services and Behavioral Health Organizations Do?

To effectively support individuals living at the intersection of poverty, racism, and trauma, behavioral health organizations must take a holistic, trauma-informed, and equity-centered approach. Here's how:

Advocate for Economic Stability: Support policies that provide income support, housing assistance, and food security. Economic relief is mental health care.

Build Community Resilience: Foster safe, connected environments by investing in youth mentorship, after-school programs, and trauma-informed community initiatives.

Practice Cultural Humility: Move beyond cultural competence to embrace cultural humility — actively acknowledging and addressing power imbalances, systemic bias, and ongoing learning in service delivery.

Collaborate Across Systems: Partner with healthcare providers, schools, and justice systems to address the root causes of trauma and connect individuals to comprehensive support networks.

Strengthen Protective Factors: Empower individuals by highlighting resilience and providing opportunities to build coping skills, self-efficacy, and social support.

Final Thoughts

Mental health disparities will persist unless we address the factors that shape mental well-being. Poverty, racism, and trauma are not separate issues — they are interconnected realities that demand integrated, systemic responses. By aligning trauma-informed care with a deep understanding of social determinants, we can move closer to mental health equity for all.

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housing, transportation, etc., along with loneliness and social isolation, and holistic mind-body needs. Through them, we have discovered three very promising strategies to reduce depression and anxiety if they are provided in tandem with traditional mental health therapy.

Intensive case management links older adults to benefits and other resources to address social determinants of health. In Manhattan, Service Program for Older People is incorporating intensive case management into its intake process to meet the client's needs before focusing on behavioral health therapy.

We are using peers to share lived experience and promote social connectivity, which has helped outreach to the stigmatized populations hardest hit by the COVID-19 pandemic. Certified mental health peer specialists, certified recovery peer advocates, and older adults with lived experience helping connect with these individuals and are now a required component of all geriatric service demonstrations.

Group wellness classes have also been effective at helping older adults. At Jamaica Hospital in Queens, a group class offering manualized curriculum focusing on mental wellbeing is combined with a Fitbit

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tracker to help address mild to moderate depression and anxiety in older adults.

Across the geriatric service demonstrations using these strategies, older adults with moderate or above depression who are at risk dropped from 46.4 percent at admission to 34 percent at their most recent follow-up. Additionally, this downward trajectory is seen in older adults with moderate or above anxiety who are at risk, dropping from 43.9 percent at admission to 29.1 percent at follow-up.

We are also using the New York State Trauma-Informed Network and Resource Center to support and implement strategies to reduce anxiety and depression and support wellness in the workplace. The center is partnering with the Breath-Body-Mind Foundation to host free virtual sessions offering a set of gentle exercises to help with stress and improve well-being that can be used at home, work or in public settings.

The center is also close to releasing the Frontline Worker Wellness Toolkit, an all-inclusive guide detailing the impact of stress on the body. Expected to be released this fall, the toolkit includes resources to promote well-being for individuals and specific training and informational resources to help employers create work environments that are trauma-informed and support wellness.

This month, the center is launching its Resilient Leadership pilot to provide a learning experience grounded in wellness, reflective practice, and trauma-responsive values. The goal is to bring together leaders from diverse fields – including behavioral health, healthcare, human services, education, and community-based organizations – to deepen understanding, build community, and sustain wellness-driven leadership practices.

Finally, we are learning that the Collaborative Care model can be used to significantly decrease suicide risk. This model allows patients to be treated in a familiar setting and have access to behavioral health services right away to prevent the lapses in care that sometimes occur with external referrals. One study showed that 76 percent of patients improved their suicide risk when enrolled in a Collaborative Care model for six months or more, and that this approach may be helpful in treating a broader range of diagnoses like Post-Traumatic Stress, Bipolar and substance use disorders.

These unique approaches help to identify new, more effective methods, treatments, and therapies for addressing anxiety and depression, and the impact and complex challenges these conditions present for individuals, their families, and our system of care. By continuing to innovate, we can develop cutting-edge treatments to improve outcomes, promote resilience, and support the recovery journey while New York State remains a leader and establishes best practices in the mental health care field.

Ann M. Sullivan, MD, is Commissioner of the New York State Office of Mental Health.

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considerations. As parents, we often say that we will do anything for our children—and sometimes we can. But sometimes time, transportation, and finances place limits on what is possible. Recognizing these factors early on can help you set realistic expectations and avoid unnecessary stress.

Time and Effort - Getting started with any treatment requires some time and energy. It can take several hours to research providers, consider in-network and out-of-network options, and try to find someone who you feel comfortable working with. These logistics can feel daunting, but support from a pediatrician, school counselor, or trusted friend can help streamline the search. Once you get going, therapy and medication management also require availability for meetings at the recommended frequency.

Transportation - It can be hard to find a provider who "checks all the boxes," and sometimes that means your best match isn't around the corner. Some families work to accommodate the necessary travel. For families already stretched thin, long commutes may not be realistic. Finding virtual therapy or hybrid options can ease the burden, but these are not always appropriate for every child or every type of therapy. You can discuss the option with the providers you are considering seeing what they recommend.

Finances - Treatment is also a financial commitment. Weekly therapy sessions add up quickly depending on how your insurance covers or reimburses. Medication may seem less expensive at first, but prescriptions, follow-up visits, and monitoring can also carry expenses. High-quality care often comes with higher costs, so it's important to understand

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your insurance coverage and budget before committing to a plan.

How Much of a Commitment Can You Make?

Therapy and medication are both effective treatments for anxiety, but each entail a different type of commitment. Therapy takes weeks of consistent sessions and skill building before children can apply techniques effectively in daily life. Even though this is a longer-term time investment, the goal is to provide your child with a toolbox of skills that can be applied long after treatment has concluded, perhaps with a few booster sessions as needed.

If you are pursuing medication, there is often a less substantial investment of time. Medication management for anxiety doesn't typically involve weekly meetings the way therapy does. And for some children, relief comes within several weeks. For others, finding the right prescription and dosage may involve trial and error, and side effects, both physical and emotional, may also need to be managed. While the daily effort of taking a pill may be simple, the overall process still demands commitment, patience, and ongoing communication.

Is Anxiety Therapy or Medication the Best Treatment for My Child?

Every situation is different, and what works for one child may not work for another. The most effective approach is one that is developed in collaboration with a trusted provider who can guide your family through options and adjust the plan over time. It also has to fit the practical realities of your family's life – your time, resources, and level of commitment.

As a parent, a large part of your role is to stay engaged in the process by asking questions and continue to support and encourage your child. Remember, therapy is not a sign of weakness, and medication is not simply "the easy way out." Unfortunately, many children who need help for anxiety never receive treatment, and among those who do, the chosen approach is not always the best fit. By staying present in the process through reading articles – like this and others – you are already beginning to help your child to manage their anxiety and build the skills necessary to lead a brave and productive life.

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Note: This article is intended for informational purposes only. It should not be taken as medical advice. All medical and mental health decisions should be made in consultation with a qualified professional.

Resilience from page 20

And if the parental conflict continues, a child may internalize the stress, leading to emotional or behavioral difficulties. In some cases, they may turn to coping mechanisms including substance use. Protective factors, however, matter. A strong bond with one of the parents, peer support, and healthy coping mechanisms used as early intervention tools can bring about a positive change and lower the chances of long-term harm. Even if the conflict arises between the parents after separation, it remains their responsibility to ensure their child's emotional needs are never overlooked. No matter how bad the relationship may be, children's need for love, stability and support must always come first.

School as a Savior

Our best early detection tool is the school environment in which children spend most of the day. The most important and initial step will be training the front-line observers- teachers, coaches and staff to be attentive in spotting the red flags. That is, monitoring any significant behavior changes.

Effective, simple, non-identifying screening questions provided in a non-judgmental environment have the potential to indicate children in need of assistance that can be provided even before a crisis. At the same time, programs like Social-emotional learning (SEL) programs and Cognitive Behavioral Therapy (CBT) teach all students to understand and manage emotions, reduce stigma, and make it easier to identify those needing extra support.

These efforts can go a long way and prove to be effective in a caring atmo-

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sphere with strong teacher-student relationships and measures that prevent bullying, reduce stress, and promote security. Equally important is access. Having a counsellor or mental health worker in school also means that help is readily available and there is no stigma. Frameworks, such as the one known as Attachment, Self-Regulation, and Competency (ARC), further show how adult relationships can help students with regulating emotions and coping with challenges inside and outside the classroom.

Positive Peer and Community Connections

A feeling of belonging acts as a strong defense mechanism for the mental health of a young person. Healthy avenues such as sports teams, arts groups, voluntary work or mentorship programs are positive sources of connection and a place where a teen can be among like-minded people without fear of judgment. These relationships ease the sense of isolation and build resiliency because they enhance the sense of self-worth and community support. Research strongly proves the effectiveness of the approach given. According to a study published in the American Psychological Association (APA), adolescents who have a strong relationship with society and fellow students are less likely to experience depression and anxiety. In addition, systematic programs on mentoring (which have been found to raise self-esteem and academic activity) are helpful.

Building Skills for Life

Prevention is a combination of empowering young people by teaching them to be self-reliant and developing lifelong skills. Learning stress-management techniques such as mindfulness, deep breathing, and journaling gives them the power to overcome emotional situations. Combined with advancing a healthy lifestyle, including daily physical activity, a balanced diet, and sleep, these methods construct resilience at the foundational level. Role-playing refusal techniques equips adolescents with skills to say no to substances such as alcohol, drugs, or vaping when their friends do so, without any fear of doing so.

Making Help Easy to Access

Early intervention is the key to addressing an aspect or a manageable struggle before it becomes a crisis. With ready access to counseling or therapy, young people can learn to cope healthily before unhealthier patterns become a part of their lives. The access to telehealth has changed this in that it has reversed major obstacles existing in access to professionals in rural areas and individuals with tight schedules who previously did not have access to professionals, by connecting them to professionals in any location. This is best achieved when systems work cooperatively, when the care settings are coordinated, and solidarity is used to streamline a young person's needs, so that the journey to support is met without stigma and with ease.

Conclusion

Efforts to prevent risks among young people should focus on instilling safeguards early in their development, rather than waiting for a crisis to occur. Resilience and minimal risks will be achieved because of the accessibility of counseling, excellent community policy, and early education activities. Prevention is not just an initiative, but the promise to young people that no matter what, their health and welfare will always be their paramount concern.

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Collaborative Care from page 25

outcomes for both depression and anxiety compared to usual care, across diverse patient populations and healthcare settings.

More recent real-world data further reinforce the model's impact. For instance, large-scale implementations have shown that:

- Nearly 50% of patients experience a 50% or greater reduction in symptoms
- Many patients complete treatment in under four months
- Results are consistent across age groups, socioeconomic backgrounds, and care delivery methods, including telehealth

The model has proven especially effective in settings with limited access to specialty care, such as rural clinics, community health centers, and pediatric primary care. Whether delivered in-person or virtually, CoCM has demonstrated its flexibility, scalability, and reliability in supporting mental health recovery.

Looking Ahead: Scalable, Sustainable Mental Health Integration

As health systems search for scalable solutions to the mental health crisis, Collaborative Care stands out as both evidence-based and operationally feasible. It leverages existing primary care infrastruc-

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ture, strengthens care coordination, and delivers results that matter to patients and providers alike.

By embedding behavioral health into the everyday delivery of care, CoCM offers a path forward—one that meets patients where they are, supports them through recovery, and ultimately changes the way mental health is treated across the healthcare system.

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plays two key roles: supporting digestion and regulating mood. Because the body prioritizes survival, serotonin is first directed toward digestion. This is why people who experience ongoing gut issues often also report symptoms of depression, the same chemical system that supports healthy digestion is closely tied to our sense of well-being.

Healing Old Wounds

There is encouraging news when it comes to healing old wounds. While emotional wounds are often the most difficult to address, they are also the ones that most deeply shape our beliefs about ourselves, others, and the world. Even though we cannot see these wounds, it is possible to heal them, often through the power of new, healthy relationships. Beyond the importance of our connections with others, our relationship with ourselves plays an equally vital role in this healing process.

Healing begins when we allow ourselves to be open to new experiences that challenge the narratives our wounds have created. Safe, nurturing relationships can offer corrective emotional experiences that help rewrite the messages of unworthiness, fear,

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or mistrust that may have taken root long ago. These new interactions, whether with friends, partners, mentors, or therapists, can provide evidence that our old beliefs no longer define us.

Equally essential is the internal work of developing self-compassion and self-trust (Greater Good Science Center). Our inner dialogue can either perpetuate old pain or pave the way toward renewal. By consciously choosing to speak to ourselves with kindness, set healthy boundaries, and honor our needs, we begin to restore the parts of ourselves that were once hurt. In doing so, we cultivate a relationship with ourselves that becomes a steady, supportive foundation, one that not only helps heal the past but also strengthens our ability to face the future with hope and resilience.

Practical Steps to Address Depression and Anxiety Using Attachment Theory

Here are a few actionable steps that you can take to address experiences of depression and anxiety:

1. **Identify healthy support people already in your life.** If part of the reason that you are experiencing some of these symptoms is because of disrupted relationships in the past, it is helpful to notice and leverage the support people already in your life. (APA)

2. Change your internal monologue. **We believe what we hear, even if it is in our own head.** If your internal monologue is consistently negative, we will believe those thoughts are "truth." However, thoughts like "I am a complete and utter failure" or "I cannot do anything right" are not rational and they are not truth. Challenging and replacing thoughts is an important step in addressing difficulties.

3. **Notice your body and care for it.** Taking good care of your body requires healthy food, enough water, enough rest, a reduction in stress, and exercise or movement. Our body impacts our mood, and our mood impacts our body! (Harvard)

Conclusion

Too often, we assume that how things are *right now* is how they have always been—and how they will always be. But that simply isn't true. The body is a system, and when one-part changes, the others inevitably adapt. When we view our body, mind, and spirit as a unified whole rather than separate parts, we open the door to new and creative ways of managing life's challenges. In that integration lies the possibility of renewal, and the restoration of hope where it may have long been lost.

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the middle of the pandemic. She was in her 70's, a domestic violence survivor, a lung cancer survivor, and the child of parents who, in her memory, saw her as the "least" of their several children, despite her having had a successful career. She never felt loved by her family or appreciated for who she was. And while she felt loved in her brief marriage, she was also physically abused by her husband. She was currently single, riddled with anxiety, claustrophobia and depression, and dependent on a home health aide – who, as per Carri's report, would endlessly discuss her own happy life and political views which were abhorrent to Carri. She felt trapped by her situation. Her presenting problems were bouts of panic that she would die alone, claustrophobia (she was having trouble getting into her own shower), and loneliness. Her recent history of breathing problems exacerbated her anxiety. We began her treatment by discussing her psychosocial history. Towards the end of the first session, we set aside some time to discuss the biology of anxiety. I explained the sympathetic and parasympathetic nervous system, how deep breathing is "a way for your lungs to tell your brain that you are safe," that while anxiety affects the body by releasing adrenaline and cortisol, as well as inducing shallow breathing, the body can also tell the brain that it is safe by slowing down breathing and using movement to "burn off" the adrenaline. When I was done explaining this, she looked at me and said, "why hasn't any therapist ever told me this before?" Apparently, no one had ever shared with her that you can be proactive in your biological responses.

As we continued our work together, I was able to provide a supportive relationship, I encouraged her to attend her local senior center (which she did when she was physically well enough to go), and we continued to work on how she could be intentional in teaching her body to communicate to her

Elaine M. Edelman, PhD, LCSW

brain that she was safe. During our sessions she would reference experiences during the week in which she dealt with anxiety by doing deep breathing and distraction techniques. She would do this prior to getting into the shower and by combining deep breathing and reading, which she loved, before bed, which was a difficult time for her.

While the psychoeducation piece of therapy is something I do regularly, what makes it especially important for trauma survivors is the introduction of the idea that they can do more than just experience involuntary physical reactions (or triggers) from their brain (these are called "top down" messages). They can begin to direct the message that their body gives their brain (known as "bottom up" messages). As noted above, trauma is an experience that wrests control of our body, our thoughts, and our feelings. We begin to feel our own internal experience as something *happening to us*. Understanding what is happening in our bodies begins the process of taking back that control.

Some suggestions on what may be helpful for your clients to know:

- Therapists should understand the basics of the sympathetic (fight, flight or freeze) as well as the parasympathetic ("you're safe") nervous system. Deep rhythmic breathing activates the parasympathetic nervous system, which tells our body that we are safe. It curtails the fight or flight response.

- Therapists should understand that adrenaline and cortisol are released during times of stress and panic. These hormones are the biological correlations of fight or flight. This release of hormones will resolve without intervention within a short time but can be hastened with deep breathing and movement.

- Most panic attacks last a few minutes (although they can last longer). It is helpful to emphasize that once the panic attack starts – what they are feeling is a physiological response. Those with panic disorder are often experiencing a "false alarm." They are terrified, but there is no actual danger. I have found it helpful to explain to clients that the exact same hormones of panic are also secreted during times of excitement when people are feeling joy. So, while the feeling is scary, it is the cognitive experience that sets the tone. It takes some time to integrate this information, but knowing that it is time limited, and breathing deeply will help the chemicals resolve faster, can often help people move through the experience quicker. (This can also reduce anticipatory anxiety in the future.)

- Distraction (music, reading, watching a comedy) uses a different part of the brain from where anxiety is generated. Distracting yourself with a pleasurable experience can calm down the nervous system more quickly. (It should be noted that "distraction" is an underutilized coping skill, but one of the most easily accessible and pleasurable ways to quell anxiety.)

- Movement (e.g., going for a walk, yoga, exercise) helps "burn off" these hormones. It is also a "bottom up" message to the brain that you are not trapped. It is a form of "flight."

- It is *very important* to practice these skills (slow rhythmic breathing, distraction, exercise) when you are *not* anxious. This begins to create the synaptic connections that tell the brain, "It's ok. I'm safe."

While it is always helpful for people to be educated about how their body works and what helps them feel safe, teaching trauma survivors this information and these skills, as well as helping them put these principes into practice, begins the process of their taking back control of their body and their reactions. Education is always important. But being able to actively do something that alters one's responses becomes a centerpiece of empowerment and control.

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not shown that the vagus nerve causes or mitigates symptoms of irritable bowel syndrome (Özçağlayan et al., 2020), some theorists posit that polyvagal theory can explain the development of disorders, such as irritable bowel syndrome and fibromyalgia, following an acute trauma (Kolacz & Porges, 2023). Additionally, mindfulness may be an effective treatment strategy due to its innervation and toning of the vagus nerve (Marchand, 2014; Lucas, Keplin, Porges, & Rejeski, 2016; Gerritson & Band, 2018; Kalyani et al., 2011; Brown, Ryan, & Creswell, 2007).

A systematic review of the research suggested that polyvagal stimulation can be helpful in managing IBS symptoms (Veldman, Hawinkels, & Keszthelyi, 2025). This review concluded that electrostimulated vagal nerve toning may reduce IBS symptoms by reducing inflammation. Additional research into the impacts of the vagus nerve on IBS and gut health is still needed, but Polyvagal Theory may offer additional treatment mechanisms that can help manage both IBS symptoms directly and anxiety.

Polyvagal Exercises for IBS

There is preliminary evidence suggesting that there are some exercises to support vagal tone and reduce stress and improve physical health. Some evidence-based recommendations that could support with managing anxiety-induced IBS symptoms are:

1. **Cold stimulation**: A common DBT distress tolerance is to splash cold water on the face or fully immerse yourself in cold water. Research suggests that cold stimulation not only reduces stress but also improves cardiovascular function via vagal nerve toning (Jungmann et al., 2018).

2. **Mindfulness and mindful movement**: Evidence shows that vagal toning is the physiological explanation for the efficacy of meditation, deep breathing, yoga, and tai chi in reducing stress. These practices have been demonstrated to reduce inflammation, improve cardiac function, reduce symptoms of mood disorders, anxiety, and trauma-related stress, and improve cognition and attention (Gerritson & Band, 2018; Keefer & Blanchard, 2001; Lucas, Kelpin, Porges, & Rejeski, 2011; Brown, Ryan, & Creswell, 2001).

3. **"Om chanting"**: There is preliminary evidence that chanting 'om' deactivates

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the limbic system (sometimes called the emotional center of the brain) and the amygdala, which is a brain region activated in response to stressors (Kalyani et al., 2011). The authors of the "om chanting" study suggest that these effects are mediated by the auricular branches of the vagus nerve in the ears, rather than by stimulating the nerve via the throat (such as in gargling, which is a common polyvagal practice).

Conclusion

In sum, while research on the vagus nerve and its role in managing IBS, anxiety, and depression is still emerging, the existing evidence highlights a promising link between vagal tone and symptom relief. Approaches such as mindfulness, cold stimulation, and somatic practices may offer accessible ways to strengthen this connection, supporting both physical and mental health. As the field of gastropsychology grows, continued exploration of polyvagal theory and vagal toning exercises could provide more holistic, integrative treatment options for those managing the complex overlap of gastrointestinal and psychological distress.

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go unmet. Nevertheless, stakeholders of our behavioral healthcare system would be wise to temper their enthusiasm with the understanding this initiative, however well intended, must contend with deeply entrenched interests that perpetuate the dominance of the biomedical and pharmaceutical industries.

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connectedness among older adults (Lin et al., 2018). While promising, the research base examining VR specifically with and for older populations remains limited. Hughes and colleagues (2017) called for additional studies to better understand how older adults engage with VR and to determine best practices for use.

Older adults are often perceived as non-users of technology, which may create barriers to program adoption. However, as VR becomes more accessible and older individuals gain experience and confidence, stigma (both internalized and external) will likely diminish (Hughes et al., 2017). Novelty, adaptability, portability, and customization potential of VR make it a suitable tool for addressing diverse needs, including cultural considerations, trauma histories, and individual preferences. While self-stigmatizing barriers were expected, participants did not indicate that these barriers affected their engagement with the intervention.

Methods

Virtual reality (VR) enables users to engage in fully immersive, digitally created environments through specialized headsets. In this study, PROS participants collectively explored a range of experiences, including virtual travel abroad, piloting an F-16 fighter jet, and climbing Nepal's highest peaks. Lightweight, user-friendly devices were provided by Viva Vita VR for the purpose of this study. Several participants reported mild dizziness during a downhill skiing simulation; however, participants noted that symptoms subsided with time and did not interfere with participation. For safety, all participants remained seated throughout the intervention.

Twelve PROS participants, all aged 60 or older, volunteered to take part in a four-week VR program. Sessions were held twice weekly, each lasting 45 minutes, in small groups to allow for individualized guidance. Groups were facilitated by the Primary Investigator (PI) and staff. Each session followed a consistent structure, beginning with 5–10 minutes of group discussion to collaboratively select the VR content. This was followed by 10–20 minutes of guided immersive experience using the VR headsets. Sessions concluded with approximately 10 minutes of debriefing, during which participants reflected on their experiences and provided feedback. A trauma-informed (TI) framework (Bargeman et al., 2021) guided all phases of implementation, from recruitment through post-intervention focus groups. Applying TI principles promoted safety, trust, and empowerment, providing reassurance for participants with potential trauma histories.

Data Collection

Twelve participants completed anonymous baseline and post-intervention surveys including the De Jong Gierveld Loneliness Scale (De Jong Gierveld et al., 2006) and the Social Connectedness Scale (Lee et al., 1995). Both instruments employed Likert-type response formats. Surveys were administered to participants at baseline and immediately following the final VR session. Data were analyzed using descriptive statistics to summarize central tendency (mean and standard deviation). Paired sample t-tests were subsequently conducted to evaluate whether observed changes in mean scores between baseline and post-intervention assessments reached statistical significance.

Results

Participant responses showed measurable improvements from baseline to post-testing, with loneliness scores decreasing, and social connectedness scores increasing. Post-intervention focus groups provided qualitative feedback directly from participants. Responses to eight open-ended questions were coded and analyzed using Thematic Analysis (Nowell et al., 2017), identifying key patterns and gaining insight into participant experiences. Participants noted improvements in mood, sharing reactions such as "mood was better," "felt happier," "I felt lighter," and "(VR) took away stress." Other comments included "wonderful feeling," "feel good, calmer," and one participant said, on several occasions, that the VR experience "takes mental illness away."

Conclusion

Both qualitative and quantitative data demonstrated that VR increased participants' feelings of connectedness and lessened their feelings of loneliness. Post-intervention focus groups indicated that participants looked forward to their VR experiences and expressed a desire to continue using VR both in the PROS program and at home if possible. As a result, VR programming has been integrated into the Envision Wellness PROS program. According to a PROS counselor, participants recently enjoyed virtual art gallery tours; although some participants reported initial hesitation, once engaged with the headsets they demonstrated enthusiasm and noted that the experience was more manageable than anticipated.

In summary, although quantitative data did not demonstrate statistically significant changes, the qualitative data indicated otherwise and suggested that the use of VR

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Suicide Risks from page 24

risk. Favril, et al. (2022) added to this list interpersonal conflicts. These should be obvious as risk factors for suicide but here we are listing them as contributing factors. The difference being that contributing factors can be more readily addressed. Naturally, we would want to address the depression and/or anxiety, but the presence of these contributing factors heightens the risk of suicide and removing them can lower that risk.

More importantly. Orsolini, et al. (2020) concluded: "the identification of a range of suicide risk factors…is clinically relevant for clinicians and should always be considered for prevention" [P. 216]. We simply cannot ignore the contributing factors that increase the risk of suicide even further. We must assess if there are contributing factors present. If we identify the individual is also experiencing loneliness, we should also address the loneliness, perhaps considering the use of peer support as a protective factor. Often, there may be a peer specialist available, but groups of similar individuals can also be considered.

Interpersonal conflicts, especially among people with close relationships, should also be addressed. Counseling for marital or other relationship issues should be combined with therapy to address depression and/or anxiety. I recently participated in a psychological autopsy for an individual experiencing depression and situational anxiety. A discussion with his wife about potential divorce seems to have been the final straw before he took his life.

Berardeli, et al. (2018) also identified lifestyle behaviors as possible contributing factors. They identified factors such as substance use, occupational difficulties, social isolation, and sedentary lifestyles as contributing factors. We have always tended to silo mental health and substance use issues, but it is becoming increasingly clear that both must be addressed together. Not one first and the other- together. It is vital to dig deeper for contributing factors to the depression and/or anxiety so they can be made part of therapy. It is important to know about occupational difficulties or sedentary lifestyles. We are more likely to have identified these risk factors and perhaps even addressed them in therapy, but it is important they not be overlooked.

Suicide rates continue to be unacceptably high. We must look beyond simple diagnoses and look at contributing factors. Only by addressing both can we make a serious dent in those numbers.

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Anticipatory Anxiety from page 22

That is why it is important we help our clients verbalize feelings of worry or dread as soon as they start.

Strategies to Identify and Address Anticipatory Anxiety

I once worked with an adult client who expressed anticipatory anxiety to me about going in for her first-ever mammogram after recently learning that a close friend had been diagnosed with late-stage breast cancer. She was having catastrophic thoughts about the exam and the potential that she might screen positive for cancer herself. We employed a few strategies to help her acknowledge and address her dread and equip her with ways to recognize signs of it in the future.

1. Shift Your Focus to Your Body and Your Senses

Both anticipatory and clinical anxiety trigger a response in the part of our brain called the hypothalamus. It sets off an alarm system that works to address a perceived threat, whether it be small, in the future, or acutely in the present. Hormonally, we respond to perceived threats with two hormones: adrenaline and cortisol. Adrenaline increases our heart rate, speeds up blood flow, and gives us bursts of energy to confront the perceived threat. Cortisol slows down any essential functions that inhibit fighting the threat, like digestion, reproductive systems, and mood control. When someone is experiencing anticipatory anxiety, this can result in avoidance, irritability, and worry. It can also result in sleep dysfunction, increased heart rate and changes in appetite.

I try to help my clients who experience anticipatory anxiety to find ways to do things that regulate their nervous system, engage their senses, and re-calibrate their mind and hormonal function. Leading up to the stressful event, I suggest things like

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belly breathing, hydration, nutritious food, getting sunlight, or taking a hot shower.

In the case of my client and her upcoming mammogram, she expressed that she was having poor appetite and struggling with low energy. She was an avid runner, but her worry was preventing her from feeling motivated to go running. To soothe her adrenal and cortisol response, I suggested she take a walk outside in the sunlight to slow her heart rate down, while also allowing her body to move and build up a bigger appetite. This helped her to manage her stress response leading up to the appointment and make it easier to manage her catastrophic thinking.

2. Focus On What You Know and What You Can Control

One of the biggest reasons anticipatory anxiety progresses to clinical anxiety is because one does not take time to acknowledge all the information available to anticipate outcomes of the event and prepare effectively. A strategy I employ with clients is to ask and answer a series of "who," "what," "where," "when," and "how," questions to assess what information you already know about the anticipated event, what information you need to be more informed about it, and what information is out of your control due to it being in the future and unknown. For my client, those questions played out like this:

1. <u>Who</u> is going to be at my appointment?

I encouraged her to look up the physicians and hospital administering the exam, learn about their background, and come up with any questions she might bring to the appointment to feel grounded in their expertise. I also encouraged her to think about having a friend or partner accompany her to her appointment for social support.

2. <u>What</u> will they do at the appointment, and <u>what</u> will the potential results be?

I suggested my client research exactly what the mammogram would entail, what to expect, and what all the potential outcomes could be. We also used our therapy sessions to talk through scenario planning to equip her nervous system with tools to leverage in the event any of them occurred.

3. <u>Where</u> will the mammogram take place, and <u>where</u> will I be before and after the appointment?

This particularly helped my client structure her day to be soothing toward her nervous system and hormonal stress response, incorporating scheduled activities that prioritized relaxation and stress reduction before and after the appointment. For her, it meant she walked or ran the morning before the appointment and made plans with her friends afterwards to decompress.

4. <u>When</u> will I get my results?

It was important for my client to have an awareness of how long she should expect to wait before she received the results of her exam. She researched this information and called the office ahead of time to inquire about what to expect. This helped her plan and schedule nervous system soothing activities during the waiting period, and alert loved ones that she may need extra support while she waited for her results.

5. **<u>How</u> can I be sure I'm doing all I can to prevent cancer already?**

My client was already quite healthy with her lifestyle habits. It was an exercise in strengths-based and positive psychology to remind her that she was an athlete, a healthy eater, had a balanced work-life schedule, and was already doing a lot of what most doctors recommend to prevent illnesses, like cancer. I also encouraged her to probe her family about their medical history. This helped her ground herself in what she could control and prioritize before, during, and after the exam.

These strategies helped my client prevent her anticipatory anxiety from becoming clinical by empowering her to quell her worry, center her nervous system, and ground herself in what she could control. Whether you are engaged in therapy or not, if you are experiencing anticipatory anxiety, these strategies can help you to mitigate symptoms and manage your well-being ahead of a difficult event. Lastly, anticipatory anxiety is normal, and it happens to everyone at some point in their lives. Remind yourself of all the things you have already overcome and lived in life. The power of your mind will rarely fail you, if you trust it.

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did in fact promote change with older adults in a PROS program related to feelings of loneliness and social connectedness. The primary limitation of this study was the small sample size (n = 12) and the short duration of the intervention. Nevertheless, all participants who enrolled completed the program and actively engaged in the data collection process.

It is important to note that without a strong implementation science framework, evidence-based programs risk limited viability, potentially leading not only to wasted resources but also to compromised trust among participants who might have otherwise benefited from a more sustainable, long-lasting intervention (Cabassa, 2016). The consistently positive experiences reported by participants in this project demonstrate the promise of virtual reality as a tool for enhancing well-being and social connectedness. These findings highlight the potential value of integrating VR into myriad public health programs, offering meaningful benefits for individuals across the lifespan.

"*The critical thing to understand is that building for a historically marginalized group results in better outcomes for everyone.*" (Annie Jean-Baptiste retrieved from www.mckinsey.com)

Heidi Billittier, DSW, LMSW, is Chief Operating Officer at Envision Wellness WNY. Heidi is committed to using innovative strategies, including technology, to dismantle aging stereotypes and promote the health and well-being of older adults. Correspondence and requests for data from the VR program should be addressed to Heidi Billittier, at hbillittier@envisionwellnesswny.com.

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Mind-Body Model from page 23

(Firth et al., 2019). These limitations are especially concerning for individuals with complex, comorbid presentations. The need for more comprehensive, biopsychosocial approaches has grown increasingly clear, as clinicians and researchers recognize the bidirectional interactions between mental and physical health.

At the Westwood Institute for Anxiety Disorders, we designed a multidisciplinary treatment framework that integrates behavioral therapy, expressive writing, mindfulness-based interventions, and physiological supports tailored to sleep and digestive health. This article presents outcome data from our intensive outpatient program, with a focus on treatment effectiveness and the practical benefits of a mind-body model.

Intervention and Methods

The treatment program included 40 participants (21 males, 19 females) between the ages of 10 and 54 (M = 27.5, SD = 10.2), all presenting with moderate to severe OCD, defined as having a baseline Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) score greater than 16. No participants were excluded based on comorbid conditions, allowing for a naturalistic assessment of real-world clinical complexity. The average duration of treatment was six weeks (range = 2 to 21 weeks), delivered in 3- or 6-hour intensive outpatient sessions, three to five days per week.

Each treatment plan was individualized based on clinical severity and patient availability. The integrative model included the following core components:

- **Exposure and Response Prevention (EXRP):** Delivered weekly by licensed therapists trained in evidence-based OCD treatment. EXRP sessions involved graduated exposure to distressing stimuli while patients practiced inhibiting ritualistic responses.

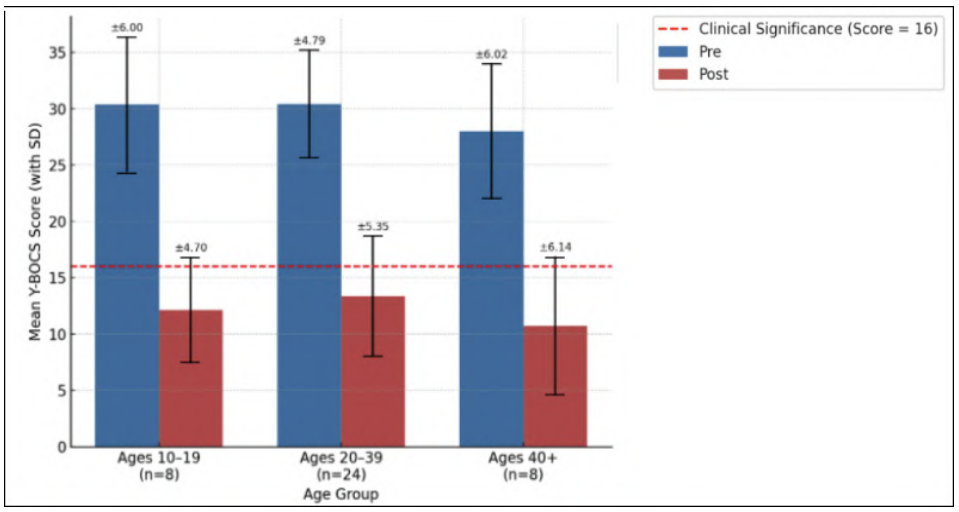
- **Mindfulness-Based Therapy:** Patients engaged in guided breathwork, body scanning, and cognitive diffusion techniques to develop distress tolerance and awareness of internal states.

- **Expressive Writing:** Participants completed structured journaling exercises and imaginal exposure scripts using detailed, first-person narratives that simulated feared scenarios. These were reviewed in session to promote cognitive reappraisal and emotional processing.

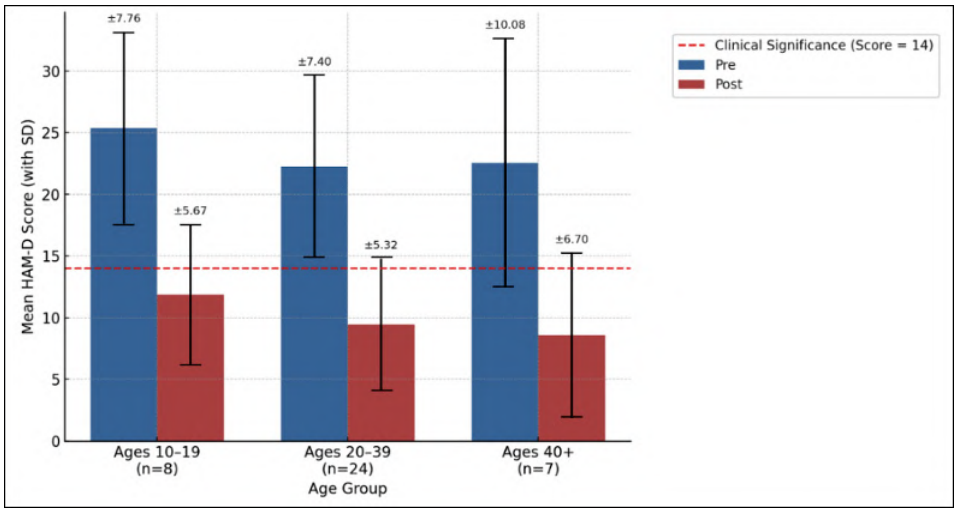
- **Lifestyle Coaching:** Tailored recommendations on nutrition, sleep hygiene, and digestive support were developed in collaboration with medical providers, including endocrinologists and gastroenterologists.

Results

Symptom changes were measured using the Y-BOCS for OCD severity and the Hamilton Depression Rating Scale (HAM-D) for depressive symptoms. Both instruments were administered pre- and post-treatment by trained assessors. On average, Y-BOCS scores declined by 57.2%, and 82% of participants demonstrated a reduction of greater than 50%. HAM-D scores showed a 53% mean reduction. These improvements were statistically and clinically significant ($p < .01$).



Y-BOCS reduction by Age Group



HAM-D reduction by Age Group

Participants also reported qualitative improvements in sleep, gastrointestinal function, and energy levels. Notably, symptom improvements were consistent across all age and sex groups. Adolescents (ages 10–19) exhibited particularly strong reductions in both OCD and depressive symptoms, as did adults over 40, a group often considered less responsive to behavioral therapy.

The Role of Expressive Writing

One of the most impactful tools in this model was guided expressive writing for imaginal exposures. Many individuals with OCD find it difficult to confront distressing thoughts through verbal dialogue alone. By writing about feared scenarios in detailed, first-person narratives, patients were able to process emotions more deeply and challenge their underlying beliefs. This form of imaginal exposure allowed patients to simulate feared outcomes, confront them with structured support, and gradually loosen the grip of obsessional thinking. In those with high intolerance of uncertainty, a common trait in OCD, this narrative approach proved particularly effective.

Why Integration Matters

What sets this model apart is its emphasis on treating the whole person. Rather than viewing OCD symptoms in isolation, we considered how chronic stress, inflammation, and dysregulation in systems like the gut-brain axis may reinforce emotional distress (Cryan & Dinan, 2012; Brander et al., 2019). This was especially important for patients with physical symptoms such as IBS or insomnia, which often exacerbated compulsions.

By collaborating with gastroenterologists and endocrinologists, we were able to create targeted interventions that addressed the physical dimensions of each patient's presentation. Sleep routines, nutritional changes, and tailored mindfulness strategies helped stabilize physiological systems, which in turn reduced the severity of intrusive thoughts and compulsive behaviors.

Toward Scalable, Person-Centered Care

This intervention demonstrates that flexible, individualized care can be delivered in a scalable way. Patients attended daily intensive sessions tailored to their availability, and treatment components were adapted based on clinical need. Our findings suggest that integrative models, when properly coordinated, can produce substantial change within a relatively short timeframe. Most importantly, they offer hope to patients who have not responded to traditional care.

Limitations and Future Directions

This was a real-world clinical intervention, not a randomized controlled trial. While the symptom reductions were both significant and consistent, future research should examine long-term outcomes and explore how these models can be adapted for community-based and telehealth settings.

Conclusion

Effective treatment of OCD and comorbid depression requires more than symptom management. It requires addressing the full context of a person's experience, including their emotional, physiological, and cognitive landscape. Our results suggest that integrative care models grounded in collaboration, personalization, and body-mind connection may offer a powerful path forward for patients with complex clinical needs.

Author Note: We have no known conflicts of interest. Correspondence concerning this article should be addressed via mail to Dr. Eda Gorbis, 921 Westwood Blvd., Suite 223, Los Angeles, California 90024, United States. Or by email to The Westwood Institute for Anxiety Disorders at thewestwoodinstitute@gmail.com.

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Your Pharmacist's Role
in Managing Polypharmacy

Pharmacists play a critical role in medication management to prevent the adverse impacts of polypharmacy in individuals with anxiety, depression and other conditions. Pharmacists are uniquely qualified and situated to monitor drug regimens for potential interactions and to collaborate closely with providers and insurance companies on finding suitable drug alternatives. Further, pharmacists can educate individuals and their caregivers about drug interactions and side effects to watch out for.

Long-term care pharmacies play an important role in supporting facilities such as group homes, assisted living centers, nursing homes and drug treatment programs. A critical part of this role is unifying the medication management process through regular communication among prescribers and conducting detailed monthly medication regimen reviews, with special attention to residents prescribed medications for anxiety and depression. Consultant pharmacists regularly evaluate potential interactions, duplications and unnecessary therapies, working closely with providers to optimize outcomes while minimizing

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risk. This work is increasingly supported by pharmacy software that can flag potential issues such as medication allergies, duplications and interactions.

Long-term care pharmacists must also collaborate closely with the facility's care team to make actionable recommendations. For high-risk medications, especially central nervous system (CNS) active agents, systematic monitoring of reactions and side effects is paramount. A good pharmacy provides facility care teams with tools and checklists that staff can use to track side effects like sedation, agitation or falls. It is also critical for the pharmacists to review the care team's incident reports and behavioral monitoring logs during monthly reviews, to identify issues that may be related to medication.

Another critical service pharmacists provide is assisting with prior authorizations and helping find clinically appropriate alternatives when insurance coverage is an issue. A good pharmacist will proactively streamline communication between prescribers and insurers to reduce delays and ensure individuals receive timely treatment.

Education should be core to every pharmacist's services. In addition to providing training and resources for long-term care facility staff, long-term care pharmacists can and should educate residents and their families about potential drug interactions, side effects and safer alternatives.

Both in and out of the long-term care setting, pharmacists can be an invaluable source of knowledge about medication interactions and a vital partner for managing polypharmacy.

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Footnotes

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Caregivers from page 25

family caregivers, creating a perfect storm of vulnerability:

High Care Burden: Providing 20 or more hours per week of intensive care leads to exhaustion, sleep deprivation, and overwhelming feelings of responsibility (Marshall et al., 2023; Rosato et al., 2019). This level of intense caregiving is consistently associated with worse mental health outcomes.

Pre-Existing Mental Health Struggles: For caregivers who have previously battled depression, anxiety, or trauma, the relentless pressure of caregiving can push them beyond their coping capacity (Joling et al., 2019; O'Dwyer et al., 2021; O'Dwyer et al., 2024).

Financial Hardship: The economic strain of covering medical bills, depleting savings, or losing wages can cause significant stress. Research shows that financial difficulties can coincide with increased suicide risk, particularly after a loved one's death (Viola et al., 2024).

Social Isolation: When society labels caregivers as "heroes" but fails to check on their wellbeing, profound loneliness can develop. The mindset of "I have to be strong" or "I don't want to burden anyone" can deepen feelings of despair and isolation (Phillips et al., 2023; Sud et al., 2024).

Declining Personal Health: Chronic health issues, often triggered by caregiving stress, increase fatigue and stress while elevating suicide risk (O'Dwyer et al., 2014; Sud et al., 2024).

Entrapment and Grief: Live-in care can feel inescapable, and losing the person you've cared for can lead to devastating feelings of purposelessness (Lewis, 2014; O'Dwyer et al., 2021; Zwar et al., 2023; Sharma et al., 2022).

Lack of Training and Crisis Tools: Without proper training to handle mental health crises, caregivers can feel helpless and powerless, leading to dangerous "what's the point" thinking patterns (Lavers et al., 2022; Le Moal et al., 2018; Marshall et al., 2023).

Protective Factors and Hope

Despite these sobering realities, research also reveals encouraging protective factors that can significantly reduce mental health risks among caregivers:

Manageable Hours and Good Baseline Mental Health: Caregivers with lighter caregiving loads (1-19 hours per week) who don't report poor mental health prior to caregiving show decreased suicide risk. These manageable hours create opportunities to maintain work, hobbies, and social connections that help maintain emotional balance (O'Reilly et al., 2015; Rosato et al., 2019).

Multiple Social Roles: Evidence suggests that maintaining employment or volunteering alongside caregiving can diversify one's identity across multiple roles, helping alleviate mental health decline—assuming relatively stable current mental health and manageable caregiving responsibilities (Rosato et al., 2019).

Positive Identity Shifts: For some individuals, stepping into a caregiving role provides a valued identity that may lower suicide risk (Chen et al., 2021).

Strong Support Network: Regular breaks, peer support groups, respite services, and crisis-management training can effectively counter the loneliness and helplessness that often accompany intensive caregiving (Byrne et al., 2008; Lavers et al., 2022; Phillips et al., 2023).

Establish Your Support System

If you're struggling with the stress and weight of caregiving responsibilities, remember that seeking help isn't a sign of weakness. It is a crucial step in protecting both your mental health and your ability to continue caring for your loved one.

Build a Support Network: You don't have to face these challenges alone. Lean on your community—family members, friends, colleagues, or fellow congregants. Surrounding yourself with positive people who encourage help-seeking is a critical aspect of suicide prevention. Identify people you can confide in and contact anytime and express your appreciation for their companionship.

Create a Safety Plan: Develop a comprehensive safety plan that includes recognizing personal warning signs, such as thoughts, images, moods, situations, and behaviors that indicate a crisis may be developing. List coping strategies you can use independently, identify supportive people and social settings that can provide a distraction during difficult times, and compile contact information for family, friends, mental health professionals, and crisis resources like the 988 Suicide & Crisis Lifeline.

Utilize Community Programs: Family caregivers face a wide range of challenges, from balancing their own needs with those of their loved ones to navigating complex systems of care. Access to community-based support is essential, offering practical tools and programs that benefit both caregivers and the people they support. For example, Vibrant Emotional Health offers a variety of programs in New York City aimed at supporting youth behavioral and educational development, as well as helping parents and guardians navigate complex, child-serving systems, coordinate care and advocate for their needs – ultimately strengthening family resilience and easing adult caregiver demands.

A Call for Recognition and Action

It's time to shift the narrative around family caregiving. While we rightfully honor the dedication and love that drive people to care for their family members, we must also acknowledge the very real mental health challenges they face and provide concrete support systems.

Caregiving doesn't have to be a solitary journey marked by sacrifice and suffering. The strength to care for others begins with caring for yourself. With proper support, manageable expectations, and access to mental health resources, caregivers can maintain their own wellbeing while providing compassionate care to their loved ones.

If you or someone you know is struggling with mental health challenges, emotional distress, or simply needs someone to talk to, remember that help is available 24/7. Call or text 988, or chat at 988lifeline.org. Visit Vibrant Emotional Health's Safe Space for additional resources and explore NYC-based resources at vibrant.org.

Following World Mental Health Day, let's commit to supporting the supporters, because every caregiver deserves to thrive, not just survive.

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tribute to mental health conditions. However, medication works best when it's part of a comprehensive treatment plan rather than a standalone solution.

The combination of medication and therapy has been extensively studied, with research consistently showing better outcomes than either treatment used alone. Medication can provide the stability needed to engage fully in therapy, while therapy addresses the underlying issues that medication alone cannot resolve.

Importantly, holistic practices don't conflict with medication – they enhance its effectiveness. Studies show that people who combine medication with practices like yoga and meditation often experience improved treatment outcomes and reduce risk of relapse.

How Integration Creates Synergy

The magic happens when these different approaches work together. Each treatment addresses mental health from a different angle:

Medication works "bottom-up," targeting brain chemistry and providing symptom relief that creates space for other interventions to take effect. Psychotherapy works "top-down," helping people understand their patterns, develop coping skills, and process underlying trauma or life experiences.

Holistic practices work through the body and nervous system, teaching stress management, emotional regulation, and self-awareness that support both medication and therapy. Combining psychotherapy with mindfulness-based interventions results in greater improvements in depression than either treatment individually. The research is very compelling regarding findings around the benefits of incorporating holistic practices for treating depression.

Real-World Benefits of Integration

People who use integrated treatment approaches report several advantages:

- **Better Symptom Management:** Different treatments target different aspects of mental health conditions. While medication might reduce the intensity of panic attacks, CBT teaches skills for managing anxious thoughts, and yoga provides techniques for calming the nervous system when symptoms arise.

- **Increased Treatment Engagement:** Holistic practices can make traditional therapy more accessible. For someone with severe depression who struggles to concentrate in therapy sessions, meditation training might improve their ability to focus and participate.

- **Enhanced Self-Efficacy:** Learning multiple approaches gives people a toolkit of strategies they can use independently. This builds confidence and reduces dependence on any single treatment method.

- **Addressing Root Causes:** While medication provides symptom relief, the combination of therapy and holistic practices can address underlying trauma, stress patterns, and life circumstances that contribute to mental health challenges.

Starting Your Integrated Journey

Beginning an integrated approach doesn't mean diving into everything at once. Many people start with one primary treatment – often medication or therapy – and gradually add complementary practices. Work with qualified professionals who understand both traditional and holistic approaches. Many therapists now incorporate mindfulness techniques into their practice, and some treatment centers, such as The Recovery Team, offer integrated programs that combine multiple modalities.

Start small with holistic practices. Even five minutes of daily meditation or a weekly yoga class can begin to create positive changes. Brief interventions can be as effective as longer ones for many people.

Be patient with the process. Integrated treatment often takes time to show full benefits, but studies indicate that people who stick with combined approaches experience more durable improvements and lower relapse rates.

Safety and Considerations

Integrated treatment is generally safe, but coordination is important. Always inform all your healthcare providers about every treatment you're using, including holistic practices. Some herbal supplements can interact with medications, and certain breathing practices might need modification if you have specific medical conditions.

The goal isn't to replace proven treatments but to enhance them. Evidence-based therapies like Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) remain the gold standard for many conditions, with holistic practices serving as powerful complements rather than substitutes.

The Future of Mental Health Care

The integration of evidence-based and holistic approaches represents a shift toward truly personalized mental health care. Rather than choosing between traditional and alternative treatments, the most effective approach often involves thoughtfully combining methods that address the unique needs of each individual.

This integrated model recognizes that mental health involves the whole person, not just brain chemistry or thought patterns, but also physical health, stress levels, social connections, and spiritual well-being. By addressing all these dimensions, integrated treatment offers the best chance for complete and lasting recovery.

Research continues to support this comprehensive approach, with studies showing that people who combine evidence-based therapies with holistic practices experience better outcomes, greater satisfaction with treatment, and improved quality of life. As our understanding of mental health continues to evolve, the integration of different therapeutic approaches promises to make effective treatment accessible to more people in more ways than ever before.

Mental health recovery works best when it treats the whole person, mind, body, and spirit—through a blend of approaches that fit individual backgrounds, lifestyles, and goals. By combining evidence-based therapies like CBT and DBT with holistic practices such as meditation and yoga, and incorporating medication when appropriate, an integrated plan delivers more durable, satisfying outcomes than any single method alone.

This approach goes beyond symptom relief to build self-efficacy and resilience, allowing strategies to adapt over time, where mindfulness can calm acute stress while therapy reshapes deeper cognitive and emotional patterns. The collaborative, person-centered process empowers informed choice, aligns care with lived experience, and leverages synergy across modalities to improve emotional regulation, stress management, and overall quality of life.

In short, integration isn't choosing between traditional and holistic care; it's uniting the best of both into a personalized roadmap for lasting wellness, where the whole becomes greater than the sum of its parts.

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have better outcomes, and post-heart attack recovery improves dramatically when mental health is addressed. As demands on psychiatric services skyrocket, our technological approaches can't remain stuck in the past. The modern psychiatric unit needs tools that are both clinically sophisticated and contextually sensitive — technology that supports healing without impeding it.

How Ambient Monitoring Can Transform Care

Ambient monitoring offers a new path forward – one that bridges the gap between safety and healing. Continuously monitoring vital signs, sleep, and movement, allows clinicians to intervene earlier and more precisely, without disrupting the patient. These tools don't replace human judgment and care, but are complementary, and can empower an already-stretched workforce by providing more complete information to make better informed decisions.

Psychiatric care deserves the same technological innovations that have transformed other medical specialties. As the goal of zero harm guides us, we need to invest in technologies designed specifically for psychiatric care. Technology like ambient monitoring can provide continuous visibility without disruption, meaning that patients can have uninterrupted rest, while enabling staff to monitor risk indicators continuously and noninvasively. Ambient monitoring offers a low risk, exponentially higher reward compared to traditional rounding.

Through innovation, we can transform mental health care from an industry that's been playing catch-up to one that's leading the way in patient-centered care.

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between apathy and decreased brain volume (Grool et al., 2014).

Mild Cognitive Impairment (MCI)

The interval between normal forgetfulness resulting from aging and the development of early dementia is mild cognitive impairment (MCI) (Simjanoski et al., 2022; Teixeira et al., 2012). If you have MCI, you can be sluggish, lack motivation and have reduced emotional responses. MCI includes forgetfulness, slowed thinking and difficulty focusing or conversing with others. You may be moody, and even difficult and disruptive. Your bipolar depression may sometimes mimic apathy or MCI (Solé et al., 2017).

Studies in the past 10 to 12 years have shown that MCI, with its symptoms of poor concentration and reduced emotional response, leads to decreased social interaction, and this social isolation can lead to dementia or Alzheimer's disease (Anderson, 2019). These studies could not prove cause and effect, but they most certainly show negative health outcomes. Researchers have shown that any kind of MCI is worrisome, especially if you have the additional diseases mentioned previously of aging (Charles et al., 2016; Goldstein et al., 2009). A clear diagnosis by the family doctor or a psychiatrist can ensure support and appropriate treatment.

Therapeutic Interventions

You need to maintain a routine when you have bipolar disorder at any age, but it is especially important when you have older age bipolar disorder (OABD). You should keep a rigid daily schedule to reduce confusion and counteract lack of motivation. If you follow a schedule for eating, sleeping, and engaging in routine activities, you will achieve effective mood management and decrease cognitive impairment. At home, do picture puzzles, crossword puzzles, word searches, or memory games to keep your mind engaged. Find activities that will challenge you.

You can reduce isolation by maintaining a social life, such as attending free classes or going to a neighborhood senior center on a regular basis. Participate in the arts by attending free concerts or art classes. Your local Parks and Recreation Department and many senior communities can provide a guide for activities such as these and more.

Physical activity is especially important to maintaining good mood and brain health. Gentle chair exercise, walking, yoga, or tai chi will improve brain fitness as well as physical fitness (Anderson-Hanley et al., 2018; Karssemeijer, et al., 2017; Gates et al., 2013).

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Other Interventions

You should depend on your healthcare professional and family caregiver for regular medical evaluations and monitoring of your medications. There is also a type of modified cognitive behavioral therapy (CBT) adapted for older adults (Chand & Grossberg, 2013), if you feel you need counseling. Allow your family or caregiver to help you evaluate your moods on a regular basis.

It's important that you recognize and respond to your bipolar disorder and its emotional, cognitive, and psychological aspects. Cultivate a network of compassionate family, friends, and caregivers for good mental health.

Resources

National Alliance for Mental Illness Info HelpLine

- 800-950-NAMI (6264)
- Chat or text "helpline" to 62640
- In a crisis? Call or Text 988

National Institute of Mental Health

- Call toll free 866-615-NIMH (6464)

Mental Health America

- MHA Crisis Text Line: 741741

Jill Hanika Stout has spent 38 years working in the medical and mental health professions and was diagnosed with bipolar disorder in 1984. In 2002, she founded a bipolar support group with Mental Health America in Wabash, Indiana, and from 2003 to 2014, she wrote a quarterly newsletter for individuals living with mental illness. After earning her BA in Psychology in 2011, she served as Executive Director of the nonprofit until 2014, before relocating to the Asheville, North Carolina area. She later worked as a direct support professional with developmentally disabled clients for Easter Seals UCP of NC and WV. In addition to her professional work, Jill has contributed to the blog for the Indianapolis-based TV show Great Day TV and, since retiring in 2024, she now writes full-time. For more information, email jhstout50@yahoo.com or call (828) 243-6013.

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