NAMI Lubbock

An Affiliate of the National Alliance on Mental Illness & NAMI Texas

A Grassroots Coalition of Families, Friends, and People Living with Mental Illness

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October 2005 **Volume 18, Issue 9**

"It's Time to Get Down to Business"

As you probably know, NAMI Lubbock's "Legends" took part in the NAMI Texas NAMIWalks earlier this month. NAMIWalks is an event to raise funds and stigma awareness. This year, the *Lubbock Legends* consisted of 10 members and friends that represented us in Austin. Our walk effort was extremely successful. We made our goal due to the efforts of a lot of people. The local NAMIWalks captain is Andy Gibson who has a report elsewhere in this newsletter you need to read. We had a great time there and as the old saying goes, "wish you were here." The walk followed the NAMI Texas Conference and topped off a wonderful weekend.

Now that we have some funds in the treasury, we now have the opportunity to put into place the programs that we have always wanted to do, but there was never enough money. Interestingly enough, our next meeting is the annual business meeting and election of officers. This election will be very interesting, as I think NAMI Lubbock has reached a crossroads. We now have the money to step up our involvement and presence in Lubbock, but oddly enough, I can't find enough people to serve on the board of directors to oversee and direct our efforts. I could not decide on anyone to serve on the nominating committee as those who knew the positions are running for office already, so I decided to handle the nominations myself. To date, I have been turned down by more people than have accepted the invitation to join our board. I am quite confused. Do we want to do more in Lubbock, or do we just want to sit back and continue to be a well-kept secret with our support and education? Needless to say, I need your input. The business meeting is this Tuesday night at 7:15 pm and is in lieu of a program.

I want to know where the members want to go with NAMI Lubbock and who they want to lead them there. An equally important question, however, is what will you do to help? Our mission is clear -- support, education and advocacy. How to make it happen -- is up to you.

David

What's Happening in October?

This month's meeting, our **Annual Business Meeting and Election,** will be on **Tuesday, October 25th.**

6:30p.m. - Support groups - ***NAMI C.A.R.E.*** (consumers)
- ***With Hope in Mind*** (family members and friends)

7:15p.m. - Annual Business Meeting

LOCATION: Oakwood Baptist Church, 6002 Ave. U (60th and Ave. U)

Due to the construction, please enter the church on the west side. Look for the "NAMI Lubbock" sign.

T hank you..

…to all of our NAMIWalks 2005 contributors!

Fun Facts about NAMI Lubbock NAMIWalks Contributors

- **$6,385** was raised by the ***Lubbock Legends***
- **115** In-Kind and Financial Contributors
- Contributions were in the range from **$5 - $500**
- **Sheryl Bybee,** *Lubbock Legends* teammate, was **2nd in the state** in most money raised on-line - **$805**
- **NAMI Lubbock** ranked **2nd** in money raised by **NAMI Texas affiliates**, behind only NAMI Austin (where the Walk was held)
- The ***Lubbock Legends*** ranked **1st** in **team affiliate fundraising**
- **Over half** of the contributors were from **outside** of Lubbock
- Contributions were collected from **all over the state**
- Several contributions came from **out of state,** including New Mexico, Ohio, Oklahoma, Maryland, Florida, and Tennessee
- Total **Business** Contributions - **$905**
- Total **Professional** Contributions - **$550**
- Total **Individual** Contributions - **$4,765** (and counting....)
- **In-Kind** Contributions - Appraised at around **$400**

Thank you letters with tax-exemption status will be mailed out soon. Contributors will be honored in next month's newsletter.

It's not too late to donate!

Weekly Support Groups

Family Support Group

With Hope in Mind is provided for family members and friends of people living with mental illness.

Facilitators: Phyllis Pusser and Bruce Roark — Oakwood Baptist Church
Tuesday evenings, 6:30 – 8:00p.m. — 60th and Ave. U
For more information, call 793-8576 or 797-2579.

Note: On the fourth Tuesday of the month, *WHIM* will meet in conjunction with the NAMI Lubbock meeting (see page 1).

Consumer Support Group

NAMI C.A.R.E. is provided for individuals with a serious mental illness diagnosis or a related disorder.

Facilitator: Andy Gibson — Oakwood Baptist Church
Tuesday evenings, 6:30 – 8:00p.m. — 60th and Ave. U
For more information, call 783-9268.

Note: On the fourth Tuesday of the month, *NC* will meet in conjunction with the NAMI Lubbock meeting (see page 1)

Many thanks to Lubbock Regional MHMR Center for their ongoing support for the printing and mailing of this newsletter. We appreciate you!

From www.schizophrenia.com

Tips For Handling a Crisis

The following is from the NAMI Washington (State) via NAMI Hamilton County (Ohio). It has suggestions on how to handle a family member who is becoming psychotic. Note that each person is an individual and these suggestions may not apply to all.

There are some actions that can diminish or avoid disaster. Try to reverse any escalation of the psychotic symptoms and provide immediate protection and support to your loved one with a mental illness.

Remember: Things always go better if you speak softly and in simple sentences. Seldom will a person suddenly lose total control of thoughts, feelings, and behavior. Warning signs include: sleeplessness, ritualistic preoccupation with certain activities, suspiciousness, unpredictable outbursts, etc.

During these early stages, a full-blown crisis can sometimes be averted. If your loved one has ceased taking medications, encourage a visit to the physician. The more psychotic the person, the less likely you'll succeed. Trust your feelings. If you are frightened, take immediate action. Your task is to help the person regain control. Do nothing to agitate the scene. The person is probably terrified by the subjective experience of loss of control over thoughts and feelings. The "voices" may be giving life-threatening commands: messages may be coming from the light fixtures; the room may be filled with poisonous fumes; snakes may be crawling on the window.

Accept the fact that your loved one is in an "altered reality state" and may "act out" the hallucination, e.g. shatter the window to destroy the snakes. **It is imperative that you remain calm.** If you are alone, call someone to stay with you until professional help arrives. Your loved one may have to be hospitalized. Try to convince him or her to go voluntarily; avoid patronizing or authoritative statements. If necessary, take steps to start the involuntary treatment process. If indicated, call the police but instruct them not to brandish any weapons. Explain that your loved one has a mental illness and that you have called them for help.

- **DON'T THREATEN** - This may be interpreted as a power play and increase fear or prompt assaultive behavior.
- **DON'T SHOUT** - If the person isn't listening, other "voices" are probably interfering.
- **DON'T CRITICIZE** - It will make matters worse; it can't make things better.
- **DON'T SQUABBLE WITH OTHER FAMILY MEMBERS** - over "best strategies" or allocations of blame. This is no time to prove a point.
- **DON'T BAIT THE PERSON** - into acting out wild threats; the consequences could be tragic.
- **DON'T STAND OVER THE PERSON** - if he is seated. Instead, seat yourself
- **AVOID CONTINUOUS EYE CONTACT OR TOUCHING.**
- **COMPLY WITH REQUESTS** - that are not endangering or beyond reason. This gives the person the opportunity to feel somewhat "in control."
- **DON'T BLOCK THE DOORWAY** - But keep yourself between the person and an exit.

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Trauma-Related Substance Abuse Persists after Mental Health Symptoms Abate

Mental health symptoms that New York City residents developed following the September 11, 2001, terrorist attacks resolved significantly within 9 months, but residents continued to report elevated levels of tobacco, marijuana and alcohol use. Rates of depression and PTSD, which were high 1-2 months after the attacks, dropped in 6-9 months. Substance abuse rates, however, which also were elevated 1-2 months after the attacks compared with pre-attack levels, did not decline substantially.

Telephone interviews of 1,570 randomly selected adults reported that nearly 10 percent of participants reported smoking more cigarettes in the month before the survey than they remembered smoking in the month before the attacks; 17.5 percent said they drank more alcohol and 2.7 percent said they smoked more marijuana – elevations similar to those reported of NYC residents 1-2 months after the event.

For the entire group of participants, key findings on the relationship between mental health symptoms and substance abuse 6-9 months after the disaster are:

- more individuals who increased smoking reported current PTSD symptoms (4.3%) compared with those who did not (1.2%);
- symptoms of depression were more common among those who increased substance use compared with those who did not: 14.6% vs. 5.2% for smoking; 11.8% vs. 5.2% for marijuana abuse; and
- fifteen percent of those directly affected by the attacks smoked more cigarettes, compared with 8 percent of those not directly affected.

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NAMI Announces Spanish Language Newsletter

NAMI is pleased to announce Avanzamos! its upcoming Spanish Language Newsletter. This newsletter will not only serve as a means of communication between NAMI and its Spanish speaking members, it will also be an outreach tool for NAMI affiliates to their local Latino community. This free quarterly magazine will feature news from NAMI states and affiliates, research and policy updates specific to Latino issues, educational resources, personal stories and more.

Order your copies though the NAMI bookstore today at www.nami.org/store. Subscribe to the electronic version at www.nami.org/subscribe.

> Even if you're on the right track, you'll get run over if you just sit there. -Will Rogers

Book review from nami.org

Lincoln's Melancholy: How Depression Challenged a President and Fueled His Greatness

Abraham Lincoln lived with mental illness. It ran in his family. He experienced two major depressive episodes. His friends put him on suicide watches. He also liked popcorn, oysters, and a strong cup of coffee.

Just in time for Mental Illness Awareness Week (October 2-8*), Lincoln's Melancholy: How Depression Challenged a President and Fueled His Greatness* by Joshua Wolf Shenk is appearing in bookstores. It is more than a "stigmabusting" profile from which to draw inspiration. It is also a gripping, carefully documented narrative and scholarly social history that will alter how Americans view the formative years of our 16th president -- going well beyond tales of log cabins and splitting rails that children learn about in elementary school.

It reveals how Lincoln developed coping strategies, perspective, and a personal sense of mission in response to chronic depression, which would help him lead the Union through the Civil War.

Author Josh Shenk was a contributor to the best-selling *Unholy Ghost: Writers on Depression* and has written for *The New Yorker* and other publications. Part of his work on the book was supported by a Mental Health Journalism Fellowship from the Carter Center in Atlanta.

Shenk's own history of depression enriches his insights and interpretations of Lincoln's chronic illness*The Atlantic Monthly* magazine features the book in its October issue. In the months ahead, he is interested in speaking to NAMI conferences and other mental health audiences. For information, contact mail@shenk.net.

For Lincoln, learning to live with depression was a process that involved not so much transformation as integration -- a distinction still relevant in how we think about recovery today.

"Hope and despondency, pleasure and pain," Lincoln wrote in a poem in the 1850s, "are mingled together in sunshine and rain."

Lincoln considered "nervous temperament" as the general cause of melancholy, serving as a "key and conductor" for specific, triggering causes -- an assessment not unlike the concept of genetic predisposition. In a letter to a friend, he identified three kinds of specific causes: exposure to bad weather, thinking too much -- as the result of disengagement from business or friends -- or a moment of great crisis and converging conflicts requiring exhaustive focus. Lincoln's life fit the formula.

Lincoln's family history is full of evidence indicating mental illness.

His father lived with periods of gloom and withdrawal. His first cousin, Mordecai, had severe mood swings, eventually becoming paranoid. Living like a hermit, he would drop by occasionally to visit relatives. Without saying a word, he would pace the room, playing a violin, while sobbing.

In 1867, Mary Jane Lincoln, the daughter of another cousin, was committed at age 39 to the Illinois State Hospital for the Insane after a trial by jury. She had been ill for 13 years and jurors found "the disease is with her hereditary." A family member called it "the Lincoln horrors."

In 1835, Lincoln experienced his first major depression. He had left home four years before, and at 26, was at an age when the onset of serious mental illness frequently occurs. Shenk acknowledges that it is difficult to identify precisely what factors may trigger a depressive episode. But Lincoln was studying law intensely and had isolated himself from friends. Fever swept the community. Death was all around. One victim was Anne Rutledge, whom some believe was the first love of Lincoln's life.

Lincoln collapsed emotionally. "That was the time the community thought he was crazy," one woman later recalled.

"He told me that he felt like committing suicide often," said a local schoolteacher. Lincoln began taking long walks alone in the woods, carrying a gun. His friends mobilized to keep him safe. An older couple took him into their home for two weeks, which apparently marked a turning point. Years later, Lincoln told a friend that to fight his melancholy, he learned to seek out the company of others -- and from then on he no longer dared carry a knife in his pocket.

Lincoln's second major depression in 1841 similarly occurred during a period of physical and emotional exhaustion -- and loss.

He had campaigned hard statewide for William Henry Harrison in the 1840 presidential election. Harrison won the presidency, but lost Illinois. Lincoln himself was reelected to the state legislature only narrowly, polling the fewest votes of any victorious candidate. His political star was plummeting.

Immediately after the election, Lincoln had nine cases pending before the state supreme court. He also served as floor leader for the Whig party during a special session of the legislature -- which turned into a disastrous defeat marked by considerable personal humiliation. At one point, Lincoln jumped out of a window with other legislators in order to prevent a vote. During the same time period, Lincoln broke an engagement with Mary Todd (whom he later married). His best friend was preparing to move to another state.

Friends recalled that Lincoln "went crazy as a loon" and sank into an immobilizing depression. They removed knives and razors from his room. His illness was the talk of town. One newspaper made fun of it. People wrote friends and relatives in other towns describing the meltdown.

Lincoln saw a doctor, but nineteenth century medicine was not much of a comfort. Some evidence exists that he may have taken "blue pills," containing mercury, as well as possibly opium and cocaine. For the most part, he found his therapy elsewhere: from supportive friends, writing poetry, telling stories and bawdy jokes -- provoking great laughter -- as well as painful reflection.

Six years would pass before Lincoln held elected office again. During his time in the wilderness, he also made a clear commitment to life -- a conscious, willful choice -- and more fully embraced an ambition of wanting to do something great, even if he was not sure what it would be.

Shenk observes that the first step in recovery sometimes is simply getting out of bed, out of an instinct for survival or a sense of duty. For the long haul, it involves "keeping sight of great potential."

Lincoln's melancholy stayed with him throughout his life. He was permanently sad, often withdrawing into himself. But it gave him the vision to look beyond the horrors of the Civil War toward a greater good -- beyond the nation's imperfect

tions and dangers toward progress and redemption. Depression produced "depressive realism" reflecting a painful, but accurate view of the world that may enable a person to achieve "melancholic success" and "tragic optimism." In times of great crisis, it may be the strongest character forged for leadership.

Purchase now from Amazon.com and a portion of your purchase will benefit people with mental illness.

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For those who attended the NAMI National Convention, there were two opportunities to hear Ms. Campbell -- in the Spirituality and Faith session and at her "reading" where she previewed several of her books.

A Portrait of Pain Is Drawn With Care

By Claudia Dreifus (June 28, 2005)

Like many novelists, the best-selling author Bebe Moore Campbell often starts her books with experiences from her own life.

In "Singing in the Comeback Choir," she wrote of intergenerational relationships in a black family. In "Brothers and Sisters," she examined the difficulties of friendships between blacks and whites.

And in her just-released "72 Hour Hold," the author tells of Keri, a determined African-American woman who sometimes imagines herself as Harriet Tubman as she tries to save her teenage daughter from bipolar disorder. (The title refers to the amount of time persons with mental illness in California can be hospitalized without their consent.)

Ms. Campbell's own family has experienced a case of mental illness, firing her passion and advocacy. Three years ago, she helped start the Inglewood, Calif., chapter of the self-help organization the National Alliance for the Mentally Ill.

"Support groups like NAMI are a good way to cope with the seemingly insurmountable problems people face when a loved one is mentally ill," Ms. Campbell, 55, said in a recent interview in New York City. She traveled to the East Coast to receive a writing award from BlackBoard, which compiles best-seller lists from African-American bookstores.

"Making people aware that there is help out there has become my personal mission," she said.

Q. You're a writer of popular fiction: your books are entertaining. How do you write a popular novel about a subject as grim as mental illness?

A. Well, I hope the book will be popular. It's meant to be. This issue certainly affects a lot of people. The National Alliance for the Mentally Ill estimates that one in four families will grapple at some time with a form of mental illness.

Yet mental illness is stigmatized. Americans will much more readily say "I'm drug addicted" than admit to having bipolar disorder. And this is particularly true within the communities of color where mental illness is more stigmatized. African-Americans, Latinos, Asians, we already feel stigmatized by the color of our skin, and here's something else to relegate us to a lower rank of human being.

So it's: "I'm not going to tell you my relative has bipolar disorder. I'm going to tell you she doesn't like being around a lot of people."

Q. Why is it a mistake to put a positive spin on something as devastating as a mental illness?

A. The loved one probably won't get the help they need in terms of medication or psychiatry. There are behaviors that require treatment.

And there's another issue here. If you're a mentally ill African-American and you're not getting treatment, some really bad things could happen to you. The kind of acting out that some mentally ill people do can easily land you in prison, if you're black.

Q. How exactly did this issue begin for you?

A. The hard way. I have a mentally ill family member, and as I began seeing changes in my loved one's behavior, I shut down.

We didn't talk about it outside of the immediate family. One day, I sort of confessed to a close friend. She begged me to call her friend, a wonderful woman named Nancy Carter, who also had a mentally ill loved one. "I don't want to put my business out in the street," I said.

It took me a year to phone Nancy. She called some other people and got six African-American women in the same situation to come to a meeting. We called ourselves the Sisters Support Group. We talked, prayed and sometimes even took in a movie. It was just the greatest thing to be in this room full of people saying, "I have someone I love who has a mental illness and I need help."

That original group evolved into the Inglewood chapter of the National Alliance for the Mentally Ill. In three years, we've grown to 100 members. We run support groups, give courses, speak at churches.

Q. When you take the cause of the mentally ill to the churches, what do you say?

A. We seek out clergy and ask them to buy into the idea that when it comes to the mentally ill, prayers could be answered through medication and therapy. Often there's a reticence about drugs. People feel we've been drugged too much already.

We've done well with some of the younger ministers who've been trained in counseling. But sometimes you run into clergy who have a mind-set about the way they perceive the intervention of God. They want to pray mental illness away. I feel that medication and therapeutic intervention are the answers to prayers. Some of these ministers, they're hard to convince.

Q. Do some African-Americans avoid treatment for mental illnesses because it's too costly?

A. Sure. You know, our community doesn't have as much money so we don't always have as much insurance. And even for the insured, a lot of plans don't cover mental illness adequately. We're more likely to end up with our loved ones at home and with an elderly parent taking care of them. That's devastating to families sometimes just barely surviving.

But there are some resources out there. In L.A., there are county beds. There are locked facilities which the county pays for, but one must get wait-listed for them. Psychologists cost money, yes. But there are places where people can go on

sliding-scale fees. Drug companies have free programs for medications, if you do the right paperwork.

Q. In their classic 1968 work, "Black Rage," the psychiatrists William Grier and Price Cobbs suggested that the daily indignities of black life were enough to bring on mental illness. Do you think that's true?

A. What I've learned is that there are people predisposed to mental illness. It's in their genes.

So if a saleswoman follows me around a department store because she assumes I'm a shoplifter that might not precipitate a mental illness in me. But for someone with a predisposition, everyday racism could be one of many triggers pushing them toward mental illness.

Q. Having come through this storm with a family member, what changes would you like to see?

A. First and foremost, for an individual where there's mental illness in the family, I'd say get yourself to a support group. I'd urge families to petition their insurers to cover mental illness just as they would any other disease. Because mental health care is so costly, I would start talking about the development of hospice-type situations - cheaper, good care.

On a policy level, I would look for people to get involved in the criminal justice situation, to decriminalize some of the crimes of the mentally ill. And I'm not being Pollyannaish here. Some people need to be behind bars, but others need help. At the very least, the system needs mental health jails where prisoners are given medication.

Finally, I would ask Hollywood to stop making fun of "crazy" people. In fact, we should stop using the word altogether. To me, it's something like the n-word. Bottom line: more sensitivity, more caring, more openness.

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Little Difference Found in Schizophrenia Drugs

By Benedict Carey - New York Times (9-20-05)

A landmark government-financed study that compared drugs used to treat schizophrenia has confirmed what many psychiatrists long suspected: newer drugs that are highly promoted and widely prescribed offer few - if any - benefits over older medicines that sell for a fraction of the cost.

The study, which looked at four new-generation drugs, called atypical antipsychotics, and one older drug, found that all five blunted the symptoms of schizophrenia, a disabling disorder that affects three million Americans. But almost three-quarters of the patients who participated stopped taking the drugs they were on because of discomfort or specific side effects.

One of the newer drugs, Zyprexa, from Eli Lilly, helped more patients control symptoms for significantly longer than the other drugs. But Zyprexa also had a higher risk of serious side effects - like weight gain - that increase the risk of diabetes.

The study, released yesterday and to be published Thursday in *The New England Journal of Medicine*, was widely anticipated because it is by far the largest, most rigorous head-to-head trial of the newer antipsychotics conducted without significant drug industry financing. The new drugs account for $10 billion in annual sales and 90 percent of the national market for antipsychotics.

The findings may not significantly alter the prescribing patterns of doctors in private practice, who often do not have to worry about cost, psychiatrists said. But they are likely to have an enormous effect on state Medicaid programs, many short on funds in part because of the high cost of schizophrenia drugs.

Several states, including Kentucky, West Virginia and Maine, have limited access to newer drugs, which cost 3 times to 10 times more than the older drugs. "The new study presents an opportunity but also a risk," said John Goodman, president of the National Center for Policy Analysis, a policy research group based in Dallas, which estimates that Medicaid programs spend at least $3 billion a year on antipsychotics, more than for any other drug class.

"The opportunity is to lower the cost of these drugs," Dr. Goodman said. "The risk is that state Medicaid programs use this excuse to entirely deny some patients access to more effective and more expensive drugs which work for those patients."

The government study set out to judge each drug by how long patients and their doctors continued the therapy, a criterion rarely used in studies by drug makers but crucial in real-world practice. People with schizophrenia struggle with delusional thoughts, private voices, blunted emotions and other symptoms, and most try multiple drugs in trying to avoid severe side effects.

The researchers, led by psychiatrist Dr. Jeffrey Lieberman, then at the University of North Carolina and now at Columbia University, recruited 1,493 people with the disorder and assigned them to receive one of five drugs: Risperdal, from Johnson & Johnson; Seroquel from AstraZeneca; Geodon from Pfizer; Zyprexa; and an older drug, perphenazine.

After 18 months, the researchers found, 64 percent of the patients taking Zyprexa had stopped, and at least 74 percent had quit each of the other medications. The most common reasons were that the drug was not effective; the patient could not tolerate taking it; side effects like sleepiness and weight gain or neurological symptoms like stiffness or tremors.

Doctors' concerns about neurological side effects in particular have sped the switch to newer schizophrenia drugs over the last decade. Studies have shown that these medications carry a lower risk than the older drugs of tardive dyskinesia, a disorder that causes tics, lip smacking, and other involuntary movements.

But the study found that at more modest doses, the older drug, perphenazine, while just as effective, was not significantly more likely to cause neurological symptoms. Dr. Lieberman said that there was no reason to believe that modest doses of other older drugs, like Haldol, would perform differently.

The patients on Zyprexa were less likely to be hospitalized because their condition worsened than those taking the other drugs, the study found. But these patients also gained the most weight, adding an average of two pounds a month while on the drug, and their lipid levels increased more than those of people on the other drugs. Weight gain and elevated lipids are risk factors for diabetes.

In the doses used in the study, a month's supply of perphenazine costs about $60, compared with $520 for

Zyprexa, $450 for Seroquel, $250 for Risperdal and $290 for Geodon, according to Drugstore.com.

"Probably the biggest surprise of all was that the older medication produced about as good an effect as the newer medications, three of them anyway, and did not produce neurological side effects at greater rates than any of the other drugs," said Dr. Lieberman in an interview.

Dr. Robert Baker, who directs the neuroscience group at Eli Lilly, said that he was pleased with the findings. He said the weight gain and other side effects of Zyprexa were "very consistent with what we' ve seen in our studies" and that the company tells doctors about these symptoms.

"I think what we can conclude from this study is that there is no one-size-fits-all treatment for schizophrenia," Dr. Baker said.

Spokesmen for Johnson & Johnson and AstraZeneca said that the study supported their drugs and the importance of tailoring treatment to individual patients. "The efficacy results for Risperdal did not demonstrate the full efficacy of Risperdal because many patients in the trial received doses that were too low," Dr. Ramy Mahmoud, of Janssen Pharmaceutica, the unit of Johnson & Johnson that makes Risperdal, said in an e-mail message.

One thing that all agreed on was that the current state of schizophrenia treatment leaves a lot to be desired, and that the field longs for new and different drugs.

"The message is the glass is half full," Dr. Lieberman said. "The drugs work but they are not satisfactory to many patients, and three-quarters of the people in our study voted with their feet and discontinued the drugs."

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Social Rhythm Therapy Helps Manage Bipolar Disorder

NEW YORK (Reuters Health) Sept 23 - Interpersonal and social rhythm therapy appear to be a useful addition to pharmacotherapy in the management of patients with bipolar I disorder, researchers report in the September issue of the Archives of General Psychiatry

As lead investigator Dr. Ellen Frank told Reuters Health, "Our results suggest that a relatively short-term psychotherapy that focuses on leading a life characterized by regularity of routines -- especially a regular sleep-wake cycle -- can add significantly to the protective effect of medication."

Dr. Frank and colleagues at the University of Pittsburgh School of Medicine note that recent studies have suggested that psychoeducational or psychotherapeutic interventions may be useful in bipolar patients.

To investigate further, the researchers conducted a study of 175 patients, all of whom were receiving pharmacotherapy. They were also randomized to receive clinical management or interpersonal and social rhythm therapy during an acute preliminary study phase.

Interpersonal and social rhythm therapy concentrated on items such as the links between mood symptoms and quality of social relationships as well as stressing the importance of daily routines.

The clinical management program included education about bipolar disorder and treatment and a careful review of symptoms and medication effects, as well as non-specific support.

Following stabilization, the patients went on to a 2-year preventative maintenance phase at the start of which they were randomized to continue with their initial protocol or switched to the alternative method.

The researchers saw no difference between treatment strategies in the time it took for patients to reach stabilization. However, those randomized to the rhythm therapy group during the acute phase went significantly longer without a new affective episode. This was regardless of subsequent assignment.

These patients were also more likely to remain well for the full 2 years of the maintenance phase. This, say the researchers, "appeared to be mediated by the substantially increased regularity of social routines" among these subjects.

The investigators call for further and more stratified trials, but concluded that the approach "appears to add to the clinical armamentarium" for managing such patients, "particularly with respect to the prophylaxis of new episodes."

Arch Gen Psychiatry 2005;62:996-1004.

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There's Still Time to Make a Difference in the Texas Workplace!

Don' t forget to complete the online survey (www.namitexas.org/survey.html) NAMI Texas is conducting in collaboration with Texas A & M University. If you have a mental illness and have held a job in the last five years, then please participate in this survey. It will only take 30 minutes, and you will have an important voice in research that investigates problems or difficulties that persons with mental illness may face in the workplace.

About the Survey

If you are over the age of 18 and have experienced mental illness, you now have the opportunity to participate in an online survey conducted by NAMI Texas and Texas A & M University. In this survey you will be asked about a variety of feelings you may have had, behaviors you may have experienced, or even the way others treated you.

Dr. Ramona L. Paetzold, a professor in the Department of Management and a member of NAMI Texas, has designed this survey to identify typical workplace experiences (feelings, behaviors, treatment) and how participants attribute those experiences to their mental illness or treatment.

The data will enable Dr. Paetzold and NAMI Texas to explore the "disconnect" between employers' expectations about employees and employees' own experiences, thus leading to further study of how workplaces may need to be modified in order to serve the needs of those experiencing mental disability.

The survey can be completed online at www.NAMITexas.org/survey.html and will take approximately 30 minutes to complete. It is designed for people who themselves have experiences with mental illness and not for other interested persons such as their family members or other caregivers.

You can be a vehicle for change in Texas! Complete the survey today!

Brain Disorders . . .

·Often strike people during their most productive years.
·Are not caused by weak character or poor parenting.
·Can be managed with support, education, and proper medical treatment.

Schizophrenia:

Symptoms may include hallucinations and delusions, poor judgment and reasoning, disconnected and confusing speech.

Open Your Mind

Depression:

Loss of interest in daily activities, suicidal thoughts or tendencies, lose of appetite, despondency.

Bipolar Disorder:

Great energy and enthusiasm, grandiose ideas with poor judgment, impulsive behavior, rapid switch to severe depression.

Mental Illnesses are Brain Disorders

Anxiety Disorders:

A variety of disorders including Obsessive-Compulsive Disorder and Agoraphobia.
A pattern of inappropriate stress responses which rob capacity to take in new information, plan appropriate response and carry out complex activities.

NAMI Lubbock Membership

_____ Individual/Family Membership $20 _____ Benefactor $50+ _____ New Member

_____ "Open Door" (limited income) $5 _____ Professional $25 _____ Renewal

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Email Address _____

Permission to publish name as member? Yes No

NAMI Lubbock, Inc. is a 501(c)(3) non-profit organization.
Dues payment includes membership in NAMI Lubbock, NAMI Texas and NAMI (National), along with newsletters from all three levels.
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Please check all that apply:

- I am a mental health consumer.
- I have an adult child with a mental illness.
- I have a minor child with a mental illness.
- I have a sibling with a mental illness.
- I have a spouse with a mental illness.
- I have a parent with a mental illness.
- I have a friend with a mental illness.
- I am a professional care provider.

Mental Illnesses I am interested in:

- Bipolar Disorder
- Depression
- Schizophrenia or Schizoaffective
- OCD and/or Anxiety Disorders
- Other _____