

MOODS

Serving People with Unipolar and Bi-polar Illness, Their Families and Friends, since 1981

July 2016

MDSG Celebrates 35th Anniversary

The Mood Disorders Support Group celebrates its 35th anniversary this year. Since many of you are new to MDSG, here is a description of the early days taken from the article published on the 20th anniversary.

Before MDSG came along there was nothing like it in New York City. There was no place to share with others the challenges of living with mood disorders. Richard Satkin, Betty Mackintosh, Marylou Selo, and Ngaere Baxter, Ph.D., co-founders/early attendees of MDSG talked about why, when, and how this remarkable organization got started.

In 1981, Satkin and Mackintosh wrote a letter inquiring about a support group to Ronald Fieve, M.D., at the Foundation for Depression and Manic Depression where Dr. Baxter (formerly Dr. Goldring), a psychologist, was clinical director.

“The foundation was undergoing some major changes, and there was nobody who particularly wanted to take on such a task,” said Dr. Baxter. “But it seemed to me something I would very much like to do, so I invited the two of them to my office on 67th Street. I remember the day vividly.

“We immediately found that we shared many common ideas about how valuable a support group would be in an era when treatment of depression and manic depression had become heavily

‘medicalized’ and ‘clinicized.’ Many people couldn’t afford psychotherapy, but they needed some support in addition to medication.

“So we set about putting everything in place—deciding where and when we should meet. I was running around buying cookies and making coffee for the meetings,” she said.

“I would like to give a lot of credit to Dr. Fieve and Ngaere, because they knew people from different walks of life and different situations who, like us, had made some inquiries,” said Mackintosh.

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Ask the Doctor with David Hellerstein, M.D.

With so many antidepressants out there, how does a psychiatrist choose where to start? Which one/s do you start first?

In general, all antidepressants currently available in the USA have about the same chance of working to treat depression. Any one medicine is likely to work in about 1/2 to 2/3 of people. The main issue to consider, as a result, is how tolerable the medicine will be.

Various medicines do have significant differences in both safety profiles and in side effects. Older drugs, including monamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs), are very effective in treating depression but can have significant toxicities.

The MAOIs require that people avoid certain foods (containing the amino acid tyramine) and certain medicines (such as Demerol) which can be highly toxic, even lethal, when combined with MAOIs. The TCAs, while very effective in usual doses, can have toxic effects on the heart in overdose: just a week to 10 days supply taken at once can cause cardiac arrest.

Consequently, most doctors have long ago switched to starting treatment with the newer classes of medicines. The serotonin reuptake inhibitors (SRIs) (including fluoxetine (Prozac), sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro), and paroxetine (Paxil and Paxil CR), are often first choice these days, since they are generally very

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Ask the Doctor

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safe. Also the SRIs have 'broad spectrum' effects, working for depression as well as panic disorder, social anxiety disorder, and obsessive compulsive disorder. On the other hand, a medicine like bupropion (Wellbutrin, which comes in immediate release, sustained release, and extended release forms) works well for depression but less well for panic disorder. Bupropion can be helpful for people needing increases in energy or concentration, in contrast to the SRIs which are particularly helpful for anxiety. Other classes of medicines, introduced over the past fifteen years or so, include the serotonin-norepinephrine reuptake inhibitors (SNRIs) (such as venlafaxine (Effexor), Cymbalta (Duloxetine), desvenlafaxine (Pristiq) and levomilnacipran (Fetzima), and have been shown to often be helpful for people who haven't responded to SRIs alone; they may also be used as first line drugs these days. There are other medicines too, such as the long-available mirtazapine (Remeron) and newer ones like vortioxetine (Trintellix) and vilazodone (Viibryd), but they are rarely first line choices, either because they are harder to use (mirtazapine can be sedating at low doses and, paradoxically, quite activating at higher doses), or are expensive because still on patent (vortioxetine, vilazodone).

The other major thing that psychiatrists consider when starting medicine is a person's previous history of responding (or not responding) to particular medicines. Something that has worked well in the past is often worth retrying; whereas a medicine that wasn't helpful or had terrible side effects is probably better avoided. Sometimes family history can be helpful in deciding: 'my brother/mother/sister responded to escital-

opram' may increase the odds that it will work for you too.

In all, we are, alas, still in the trial-and-error era of psychopharmacology. We still can't make very good predictions of who will respond to which medicines. Several companies have introduced tests that may improve the odds of choosing the right medicine up front, based on genotypes, enzyme levels, and other measures, but these tests tend to be high-cost (depending on your insurance coverage), and may rely on proprietary formulas, so it's hard for independent researchers to test them. Rarely if ever have these new tests been compared head-to-head one against the other to find the most effective one. Thus, they're not yet routinely used up-front by most doctors, who tend to reserve them for use when first-line drugs haven't proven to be effective.

.Ask the Doctor

Send your questions about depression and bi-polar illness to

newsletter@mdsg.org

Questions will be answered by a psychiatrist or psychologist as appropriate. Questions will be answered as space in MOODS permits.

Recent Books of Interest

Mohammad, Akikur. The Anatomy of Addiction: What Science and Research Tell Us About the True Causes, Best Preventive Techniques, and Most Successful Treatments. Tarcher, 2016. 288p.

Brogan, Kelly. A Mind of Your Own: What Women Can Do About Depression That Big Pharma Can't. Harper Wave, 2016. 352p.

Goldman, Lee. Too Much of a Good Thing: How Four Key Survival Traits Are Now Killing Us. Little Brown, 2015. 35wp. [the traits are obesity, high blood pressure, depression and heart disease]

Noonan, Susan J. When Someone You Know Has Depression: Words To Say and Things To Do.. Johns Hopkins, 2016. 160p. [also bipolar]

Griffiths, Jay. Tristimania: A Diary of Manic Depression. Counterpoint, 2016. 224p.

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“They did the ground work and the initial telephone phone calling and offered us the space to meet. . . . Basically, if it wasn’t for them, we would never have gotten started—at least in this context.

“It seemed incredible to me then,” she continued, “that there was no support group in the city that dealt with patients’ and family members’ issues.”

“I don’t find it that surprising,” said Satkin. “Because back then—even more so than now—many psychiatrists dispensed medication only. They had little or no interest in starting support groups. It was up to consumers to do that.”

In the meantime, in May of 1981, Selo was released from Roosevelt Hospital after she suffered what was called “a nervous breakdown.” “A social worker there told me I would never work again, and that I could forget about returning to my career as an interpreter, translator and tour guide,” Selo said.

“I was told the best I could hope for would be volunteer work somewhere. Quite by coincidence, I found the foundation of Dr. Fieve. He was looking for someone to work the telephones, and I remember I never did a job as badly as I did this one. It was a nightmare.

“One day Dr. Fieve came storming down the stairs, because I had misconnected him again, and he said: ‘What did you do before this?’ I said I was an interpreter, and he said ‘What are you doing here?’

“I told him a little bit about my history, and he said, ‘I think it would be very good for you to be in a support group,’” recalled Selo. “I had never heard of a support group. I didn’t even know what one was.”

She attended the first meet-

ings of MDSG. (Oh, and by the way, eventually she did work again, and her career now takes her around the world.)

In the early years, psychiatrists were “suspicious” of mental-health support groups, according to Satkin and Selo. “Rich and I were hand delivering notices about MDSG to doctors’ offices,” she said. “In 1984, we had very simple brochures, and we wanted to give them to psychiatrists attending the American Psychiatric Association Convention at what was then the Americana Hotel (now the Sheraton).

“We had to stand on the sidewalk or out on the steps of the hotel to hand them out, because we were seen as evil—as anti-psychiatry.”

Added Satkin: “Today there are many more psychiatrists open to support groups. . . . We know that. Doctors want to come to us. They’re our friends, but they weren’t in 1981.”

“Perhaps the perceived threat was their fear that we might encourage people not to take their medication or to do something that was not medical—some alternative thing,” said Mackintosh.

But, of course, that’s not what happened.

Early groups met in the Medical Arts Center “to swap war stories,” Mackintosh remembers. “We usually had only one space, two if we were lucky. When we broke up into discussion groups, group number one would be over here for family members like me. Group number two would be over there and so on. Every group would be talking at once.”

Now, of course, groups meet—if not in their own rooms—then in their own partitioned space.

Have the original goals of MDSG been met or exceeded?

“Exceeded, definitely,” said Selo.

“They were met a long time ago,” said Satkin. “The initial goal was to form a place where we could meet and talk and learn something.” But the organization, he added, quickly branched out to offer a telephone information line and extensive group facilitator training. The mission, however, has remained the same.

“When I first got sick in 1976,” said Selo, “I thought, ‘Okay, they tell me this is going to take six or eight weeks. Then I’m going to be able to go home, take the cast off, so to speak, and walk again.’

“No one told me that this illness might come back. No one told me I would have to stay on my medications to keep the episodes from coming back—that I was in this for the rest of my life—that there was no cure.” She learned much about her bipolar illness from support-group members.

If you could say one thing your experience with MDSG has given you personally, what would it be?

“With the success of MDSG, I have the personal satisfaction of having been a part of creating something good in the world,” Mackintosh said. “It was a healing experience for us after the trauma of the years of illness before. It was a way of putting ourselves back together again.”

“My work with MDSG has brought me enormous fulfillment,” said Selo, who helped set up in 1986 the National Depression and Manic-Depression Association [now DBSA], which became MDSG’s “parent” organization.

“But most of all,” Selo added, “now that my family is gone, the friends I’ve made at MDSG have become my family.”