MOODS The Newsletter of the Mood Disorders Support Group/NY

Serving people with depression and manic depression, their families and friends since 1981

Weekly Support Groups

Doors open at 7:00 p.m. Groups begin at 7:30 p.m.

Manhattan West Side on Wednesdays

St. Luke's Roosevelt Adult Outpatient Psychiatric Clinic

411 West 114th St (bet. Amsterdam Ave. and Morningside Drive.)

Manhattan East Side on Fridays

Beth Israel Medical Center, Bernstein Pavilion, 2nd floor,

Nathan Perlman Place (bet. 15th & 16th Streets, First & Second Aves)

Support groups allow participants to share their thoughts, feelings and personal experiences in small, confidential gatherings. Separate groups are available for:

- newcomers
- unipolar (depressive)
- bipolar (manic depressive)
- Under-30s
- family and friends.

Groups meet simultaneously. Support groups are free for members, and $5 for nonmembers.

Upcoming Lecture — Summer 2013

Does Diagnosis Matter?

Joseph Goldberg, M.D.
Clinical Professor of Psychiatry
Icahn School of Medicine at Mount Sinai

June 11, 2013

With the release of the DSM-5, the news has been full of the tweaks and tugs that have been made to the Bible of mental health diagnoses. But how much of all this matters down in the trenches, where real people with real illnesses live? Our June speaker, Joseph Goldberg, M.D. will help us find out.

Let's begin by asking what a diagnosis is. Is it a label? A name for a problem? Dr. Goldberg says that psychiatric diagnoses are a form of shorthand. They're a quick way of communicating enough information about a pattern of problems so that a doctor can come up with a treatment plan. In other areas of medicine we have lab tests and x-rays and MRIs to confirm a diagnosis, but that's not (yet) the case with psychiatry. In mental health we have to rely on assessments and clinical interviews.

On the one hand your diagnosis is important: you can't know what treatments might work until you know what problem you're trying to treat. On the other hand, there's a lot of imprecision involved. Similar symptoms can be caused by completely different problems, and how any one person presents may differ from the prototypical case. And, too, the definition of what makes someone "qualify" for a diagnosis changes when the Diagnostic and Statistical Manual of Mental Disorders changes!

So what's different in the world of mood disorder diagnoses now that the DSM-5 is making its way onto bookshelves? How big were the changes that were made, and how do they affect you? Join us on June 11 to hear Dr. Goldberg speak.

What's New Inside

With this issue we introduce a new column by a familiar person. Li Faustino, long-time MDSG Board member and practicing psychologist, joins us to share the wisdom and insight she's accumulated as a group facilitator and MDSG member. Her column, Psychology Corner, will be included in each issue.

We've also included a thoughtful reflection on having Bipolar Disorder written by a member, "Helen Miller". We welcome submission to MOODS from MDSG members. If you have something you'd like us to consider, email it to **info@MDSG.org**.

News Briefs

A study that tracked Google data found that there was far more seasonality to searches on mental health symptoms than previously thought. Bipolar searches declined 16% during the summer. **Source: *Medical News Today***

The Oregon State Insane Asylum, which was used as the backdrop for the movie *One Flew Over the Cuckoo's Nest* has been turned into a museum of mental health. **Source: *The New York Times*, March 31, 2013**

ScoutingNY.com, a blog run by a movie location scout, has a great photo essay (with memories from residents) of the abandoned Rockland Country Psychiatric Center. Take a look! **Source: scoutingny.com/?p=6520**

Ask the Doctor Ivan K. Goldberg, M.D.

Q. **My psychiatrist wants me to start taking pindolol together with my Paxil. She says this will help me respond faster to the Paxil. Will it?**

A. A number of studies have found that when SSRIs are taken with pindolol (Visken), the time to an antidepressant response is shortened. This effect has been most reliably reported in patients taking a combination of paroxetine (Paxil) and pindolol. In others studies, pindolol was also found to increase the effectiveness of antidepressants.

Q. What other medications are there besides pindolol that might shorten the response time to an antidepressant?

A. Adding thyroid hormones, lithium or risperidone may reduce the amount of time it takes for an antidepressant to begin showing effects.

Q. I've never had psychotic symptoms, but my psychiatrist wants me to take an atypical antipsychotic medication along with an antidepressant. Why?

A. Antipsychotic medications such as olanzapine (Zyprexa) and risperidone (Risperdal) have been shown to help some people respond better to antidepressants. This potentiating effect may be seen in the first week of therapy and in people without psychotic symptoms. When used for this purpose, risperidone is usually prescribed in a dose of ½ mg to 1mg per day. Olanzapine is usually prescribed in a dose of 10mg or 15mg a day.

Q. If one takes an SSRI and fails to improve, does this mean no SSRI is likely to work?

A. Over 50% of people who do not benefit from one SSRI will benefit from another. When effectiveness of SSRIs is measured across groups of people, the drugs are equal, but an individual may find that one SSRI is much more effective than the others.

Psychology Space Li Faustino, PhD.

When I facilitated support groups at MDSG there were often discussions about therapy. Many of the same questions came up, year after year. There weren't always clear answers, but there was always support and the knowledge that you were not alone with your questions. Here are some. Feel free to send in more questions that have come up in group, or just on your own.

Q. If I don't like my therapist, how long should I give them before I fire him?

A. Rather than give a definitive time frame, it would probably be best to look at *why* you are not happy with this therapist. There are many reasons a relationship may not work, but the important thing to remember is that the therapist is a person, too. Even with professional training, a therapist can't read your mind! It's possible he is unaware that you are unhappy. Or they are aware of a problem, but are working on how to approach it with you.

If you feel comfortable, it would be best to bring up what's bothering you and talk about it. A therapist of almost any theoretical orientation can be open to this. Whether the issue is that the therapist said something that offended you, you feel they don't understand you, you're not clear what kind of therapy you are supposed to be doing, or you feel your therapist doesn't talk enough, the conversation can offer something of value. In the end, you might be able to decide *together* if and when you should terminate.

Q. Which do I deal with first, drinking or my mood disorder?

A. Because so many who suffer with mood disorders seek comfort or escape in drinking or using substances, this question comes up often. Ideally, everything can be addressed at once. In reality, it's nearly impossible to make progress treating mood disorders when episodes of depression and mania are exacerbated by substance abuse. For example, alcohol feels good temporarily, but it's actually a depressant.

Unfortunately, eliminating substance use requires a lot of support, and feeling terrible from a mood disorder makes quitting very difficult. In general, if addiction is present, it's usually treated first. However, because of the very stark, vulnerable place this can leave people, it is best to start addiction treatment when one is already in therapy. The next step is to work with a psychiatrist to address the mood disorder as soon as possible.

Mood Disorders Support Group
New York
MOODS

MDSG is affiliated with the Depression and Bipolar Support Alliance.

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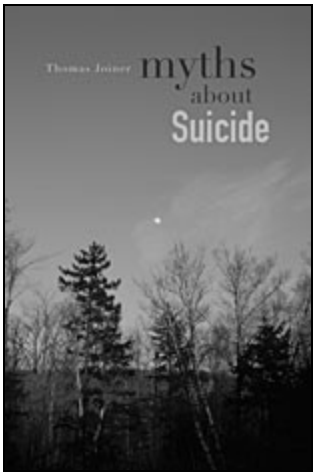
Myths About Suicide

Thomas Joiner, PhD
Harvard University Press, 2011



People don't know what to make of suicide, so we turn to the myths and assumptions we have always heard. Take these myths, for example:

- children don't do it (yes, they do);
- people kill themselves on impulse (there's an element of impulse, but most have wanted to die for a long time);
- if a suicide attempt is stopped, the person will eventually find a different way (often not true).

If you can be curious and a little bit objective, this fascinating book will teach you a great deal.

Myths About Suicide by psychologist Thomas Joiner debunks many false beliefs. Joiner notes that the basic reasons people commit suicide are that they feel disconnected and alienated from others, and/or they feel they are of no value and are a burden. Those who have a sense of connection and commitment to people have is a major deterrent to considering suicide an option..

The author notes that "at least 90% of those who die by suicide have at least one *full syndrome* mental disorder (not partial syndrome or sub-clinical variant) at the time of their suicide." That percentage is based on numerous well-validated psychological autopsies. This relates to the question of whether suicide is genetic, and if so, in what way? Everyone knows of families where more than one person has died from suicide, but studies thus far have found no direct genetic links. The essential element of depression, however, does have a hereditary component. I personally believe that when a relative commits suicide, it opens up the possibility for similar behavior in present and future generations. The behavior is familiar, making suicide seem to be a viable option.

Yet the gut-level instinct to stay alive exists even in people who want to die. People go on living, making plans for lunch next week, placing cheerful phone calls for dentist appointments – and then they kill themselves. This double message leaves family and friends completely baffled when trying to understand what happened. We look for rational reasons and provide excuses: her baby died, he lost his job, it was stress. Although a life event may be the tipping point for a suicide planned and considered for a long time, the underlying cause is what is in the mind: an inescapable, never-ending pain.

The long-term buildup of pain has one good aspect: it creates a window of opportunity for others to intervene.

Often there's no clear explanation for why people choose suicide, since only 25% of people who kill themselves leave a note. Joiner's father killed himself in a one-person car crash. The note he left said, "Is this the answer?" to which was added, "Police, the car keys are in my pocket. Please drive my car home. My daughter needs it to drive back and forth to work." Suicide notes rarely contain words of affection, because when a person who is determined to die he or she does not feel any connection to others.

Some people have claimed that women who have breast implants commit suicide in high numbers, but studies have found no proof this is so. Some people believe that suicide can be an act of anger and revenge. Not usually. And what about suicide by cop? Again, unlikely.

Other common myths speak of the slow suicide of smokers and anorexics. There's simply no evidence that this is the intention of people who have these addictions. (Although the death rate for anorexics is high, the vast number of deaths come from suicide, not from malnutrition.) *Myths About Suicide* is an interesting read, especially if you've know someone who died this way. You're sure to find a different perspective on, and perhaps a deeper understanding of, what really lies behind the tragedy.

"Yet the gut-level instinct to stay alive exists even in people who want to die."

The Mood Disorders Support Group

Upcoming Lecture — Summer 2012-13

Held at the Podell Auditorium, Bernstein Pavilion, Beth Israel Medical Center
Enter at Nathan Perlman Place between First and Second Avenues and 15th and 16th St.
Doors open at 7:00 p.m., lectures begin at 7:30 p.m. $4 for members, $8 for non-members.

Does Diagnosis Matter?

June 11, 2013

Joseph Goldberg, M.D.
Clinical Professor of Psychiatry
Icahn School of Medicine at Mount Sinai

What's your diagnosis… and how much difference does it make? The new DSM-5 has changed the definition of several mood disorders. How big are the changes, and why were they made? Come hear noted psychiatrist Joseph Goldberg speak on a matter that affects every one of us.

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Groups begin at 7:30 p.m.

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The Self for Which We Are Responsible

H. Miller

At the age of 19, while in a severe manic episode Bipolar I), I was hospitalized. After the collapse of my world and a most unpleasant stay in the Underworld, I got my university degree with distinction, a PhD fellowship, and a funded academic stay at another top university. There was no gap in my CV; I lived with a continuous inexplicable wonder that it seemed as if nothing had taken place, other than my decision to delve into my chosen field of academic expertise.

While I pursued my career and meticulously hid my bipolar nature, I allowed no gaps in my lithium. After 15 years I decided I should finally ask: had I achieved all this with the help of -- or despite -- the lithium? It was my deeply-rooted hope that my accomplishements were due entirely to my own efforts.

The time comes to find out the truth, since the desire to know ourselves outweighs any other hopes. My psychoanalyst was reluctant to believe I am Bipolar, and agreed we should try reducing the lithium carefully. A deep depression and unambiguous psychotic symptoms followed. I simultaneously witnessed the gradual collapse of my mind, discerned the lithium's side-effects, and discovered my true nature. Unsurprisingly, I opted for the side-effects and lithium: a stranger for so long, ever since a lover I will never expel again, not even in my weirdest thought experiments.

Academia is strenuous for me, not only as a woman, which is obvious (so many bullying machos around!), but also as a manic-depressive, which I conceal. I fear times have not changed since Jamison's experience. If I ever decide to speak up, it will be in order to sensibilize my colloeagues to mental illness, and hopefully contribute to establishing equality.

For now, I simply say that bipolar disease is a biologically-rooted disorder of the mind. Nonetheless, there is *plenty of room* for us to be ourselves beyond chemical reactions and necessary treatment. We have room for freedom, self-knowledge and virtue; these things we share with all human beings.

I have observed that our disease roots itself in a characteristic attitude which *we* cultivate: We "feel" as if we were the centre of the world, both when sinking into black oceans and while flying toward the burning source of light. But this self-centered drive cannot save us (even if it *may* help us survive now and then).

Although we may be able to detect a spectacular spectrum of colors, people around us stare at equally and differently rich colors of their own rainbows. When we cry out, "You cannot understand me!" we block communication. If we regulate our sometimes overflowing egocentricity, we enrich our own divings and flights, and decrease our feelings of loneliness. We achieve a deeper understanding of others.

We were given, simultaneously with the gift of life, a most resistant material to work on: manic depression. This was not our choice. That said, we cannot evade the responsibility of accounting for what we have been, who we are, and what we will be making out of this disease till our death. Not even this bad luck called mood disorder is responsible for the Self; crafting that is up to us.

The Facts: Relationships

Mind, the largest mental health charity in the UK, recently released results of a survey of more than 1,000 people with experience in being in a relationship with someone with mental health problems. Take this quick quiz to see how accurate your assumptions are!

More information about this survey (and other interesting facts!) can be found online at medicalnewstoday.com/releases/259593.php.

1. What percentage of people with mental health problems reported that their partners were "not fazed" when informed of the problems?
   a) 13%
   b) 23%
   c) 43%
   d) 63%

2. What percentage of people with mental health problems said those problems affected their sex life?
   a) 60%
   b) 70%
   c) 80%
   d) 90%

3. What percentage of the *partners* of people with mental health problems said those problems affected their sex life?
   a) 60%
   b) 70%
   c) 80%
   d) 90%

4. What percentage of people with mental health problem actively discuss their mental health with their partners?
   a) about 25%
   b) about 50%
   c) about 75%
   d) almost everyone

Answers:

1. **D.** Nearly 2/3 of respondents said their partners were "really understanding" when first told of their illness.
2. **C.** The problems most often reported were loss of libido, loss of confidence, and feeling self-conscious.
3. **A.** Partners perceived fewer problems than the person who was mentally ill.
4. **C.** Three quarters of participants talk regularly with their partners about their mental health.

MDSG, Inc.

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Stay Healthy, Keep MDSG Healthy

We all know it takes a huge amount of work to keep ourselves stable and healthy. MDSG plays a key role in supporting us in those efforts. The cost of membership and lecture admission doesn't come close to covering our expenses. Your financial support is crucial. Please give what you can.

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