The Newsletter of the Mood Disorders Support Group/New York Spring 2008

MOODS

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

Care for the Patient, Care for the Family: Family Inclusive Treatment for Mood Disorders

Igor Galynker, MD, PhD, Director of Beth Israel's Bipolar Family Treatment Center; Professor of Clinical Psychiatry, Albert Einstein College of Medicine

March 4, 2008

A new wave is sweeping the psychiatric community: the idea of involving families closely in the treatment of mood disorders early on. Many doctors feel that it's the key component to successful outcomes that's been missing for too long. Input from the family helps psychiatrists more accurately gauge the depth and intensity of symptoms, and the general quality of the person's life, explains psychiatrist Igor Galynker, one of the leaders in this approach and our March lecturer. "As a result, doctors have a more complete picture to work from when prescribing medication," he says. Anyone who wants the best treatment for themselves or a loved one will want to come hear the latest thinking on family-based treatment from one of the leading experts on the subject. Be sure to attend this important lecture

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Personalized Psychopharmacology

Richard A. Friedman, MD, Professor of Clinical Psychiatry, Director of the Psychopharmacology Clinic, Weill Medical College, Cornell University

April 1, 2008

Imagine a future where a simple blood test could tell doctors which psychiatric medication is most likely to work on an individual patient. The agonizing trial-and-error process that so many sufferers of mood disorders must endure before finding the right medication might be completely avoided. The truth is, such a blood test is only a few years from being ready to use in clinical practice. "Soon a simple genetic test will be able to help psychiatrists biologically personalize treatment," says Richard Friedman, a leading psychopharmacology researcher. Don't miss the chance to hear him explain the exciting possibilities of this cutting edge area of research.

Managing Stress and Anxiety: A Toolkit for People with Mood Disorders

Susan Palmgren, PhD

Director of the Adult Case Management Clinic, St. Luke's-Roosevelt Hospital Center

May 6, 2008

Stress and anxiety are particularly prevalent among people suffering from depression and bipolar disorder—and particularly hard to manage. But there are ways to cope. Psychologist Susan Palmgren, an expert, will discuss hands-on techniques and tools you can use to battle these persistent problems, and she'll involve the audience in an interactive, question-and-answer format. Don't miss her.

Have a question for one of our lecturers? Email it in advance.

Our lecturers have always fielded questions from the audience, but now attendees can e-mail questions in advance. If you have a question for any of our lecturers, send it, in 50 words or less, to lecture_questions@mdsg.org.

Lecturers will answer as many questions as possible, pending time restrictions.

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Archived Lectures Available

Recordings of past lectures are available on CD through the mail. Recent lectures are listed below. Please see our website, mdsg.org, for a listing of earlier lectures.

71 Marc Strauss, Esq: SSD Benefits and Mental Health
70 David Brody, MD: A Psychopharmacoligist On Therapy
69 Panel Discussion: Ask the Facilitators
68 Sanjay Mathew, MD: Treatment-Resistant Depression
67 Eric R. Kandel, MD: In Search of Memory
66 Ronald Fieve, MD: Bipolar II
65 Christopher Muran, PhD: Impasse and Failure in Therapy
64 Sarah Lisanby, MD: Out of the Pillbox
63 Maria Oquendo, MD: Antidepressants for Bipolar Disorder

All lectures are $13 each, $25 for two, or $35 for three (including postage and handling). To order, send your requested lecture numbers and a check payable to *MDSG Inc.* to: **Lecture Recordings, c/o MDSG, P.O. Box 30377, New York, NY 10011**.

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Ask the Doctor

Ivan K. Goldberg, M.D., Psychopharmacologist

A service club to which I belong wants to organize a suicide prevention hotline in our community. Is there any evidence that such hotlines actually prevent people from killing themselves?

Suicide-prevention centers and hotlines have been around for the past forty years. There have been numerous studies of their effectiveness, and there is essentially no evidence that the availability of such services in a community leads to a reduction in the number of completed suicides.

So what does work? The best method of suicide prevention is to ensure that people with depression are identified and adequately treated. This requires general practitioners and other non-psychiatric physicians to screen their patients for depression, just as they now screen them for diabetes and high blood pressure.

Another important strategy would be to require psychiatrists to treat depressed patients with adequate amounts of antidepressants or electroconvulsive therapy. Unfortunately, patients who see non-psychiatric physicians for depression are often undertreated as too many of them prescribe ineffectual doses of antidepressants.

I've been taking lithium for years. When I exercise vigorously, I often end up feeling nauseated and start to shake. What's going on?

In situations in which you sweat heavily (vigorous exercise, saunas, hot baths) or during illnesses which cause vomiting or diarrhea, your lithium level can increase to levels which cause increased side effects. Ask your doctor if you should reduce your dose of lithium or omit it totally for some period of time.

What is atypical depression ?

People with atypical depression have some classical depressive symptoms, such as a sad mood, negative expectations about the future, and indecisiveness, but they have some symptoms that are the reverse of those seen in patients with melancholic depression. Rather than losing their appetite and losing weight, people with atypical depression typically overeat and gain weight. Rather than having insomnia, the will frequently oversleep, sometimes well over twelve hours a day.

Most characteristically, people with atypical depression are exquisitely sensitive to rejection in romantic situations and have what's known as "leaden paralysis," a sensation that one must exert unusual amounts of energy to move because one's body is very heavy. Their sensitivity is often so great that they will avoid romantic involvements so as not to put themselves in a situation where they may experience painful rejections. Extreme lethargy when depressed is also frequent. Mood reactivity, which is the capacity to feel considerably better upon hearing good news during a depression, is also among the criteria for a diagnosis of atypical depression, but some research suggests that this criterion should be dropped.

Atypical depression is seen in 43 percent of depressed outpatients and it's more common in patients with bipolar II than major depression. It's more common in women than in men and among younger rather than older people. It's also more common among people with a family history of bipolar disorder.

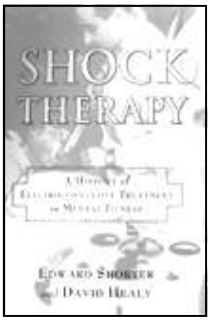
It's important to note, too, that because of the extreme rejection-sensitivity involved, people with atypical depression are frequently misdiagnosed as having borderline personality disorder.

The Reader's Corner with Betsy Naylor

Shock Therapy: The History of Electro-convulsive Treatment in Mental Illness

By Edward Shorter and David Healy
Rutgers University Press, $27.95

Controversy has always surrounded shock treatment, also known as electroconvulsive therapy or ECT, and probably always will. Now at last a readable book lays out the history of this bizarre-sounding procedure. So why is ETC so controversial? To begin with, the thought of electric current coursing through your brain is just scary. For many people, images of jumper cables and electric chairs come to mind. We have also scientology campaigns, Hollywood movies, and a long anti-psychiatry movement to thank for negative publicity. But ECT has survived because it works, helping those who have exhausted other options and saving the lives of the suicidally depressed.



The first shock treatment was given in Milan, Italy in 1936. The patient was a man suffering from auditory hallucinations and paranoia who had failed to respond to metrozole, an insulin-like drug that was the standard treatment for psychotic symptoms at the time. ECT successfully treated both the hallucinations and the paranoia, triggering a flurry of international research. One of the most remarkable things about this pre-50's history of ECT was that so many psychiatrists in several countries were so open with each other, even dependent on each other's studies. Of course, they sometimes disagreed, but their cutting edge work continued. This history flows along like an engaging story. The authors have created a sort of dialogue based on actual words written and spoken by the doctors working at the time. Dozens of studies contributed to the effectiveness of this new treatment and created a more patient-friendly process. Early on, for instance, ECT's grand mal seizures broke the bones of some patients, but the problem was alleviated when muscle relaxants and anesthesia were introduced.

After decades of exciting discovery, though, shock treatment began to fall out of favor after psychiatric medications like Thorazine and Tofranil were introduced in the 1950s. An even bigger factor, though, is that the procedure has always had a public relations problem, simply because it sounds so frightening. In the 1960's human rights demonstrators awakened fears that the procedure was similar to electrocution, and anti-psychiatry doctors Peter Breggin and Thomas Szasz fueled public sentiment against ECT and drugs. In 1972, presidential candidate George McGovern chose Missouri Senator Tom Eagleton as a running mate. It got out that Eagleton had a history of depression, and had even had shock treatments; he could not outlast what the public thought of that. Then in 1976, the movie *One Flew over the Cuckoo's Nest* further horrified the general public with its portrayal of ECT. Jack Nicholson's performance, as a hospital patient who started a rebellion, remains the only association many people have of the procedure. Over his screams of protest, Nurse Ratchett and her team rolled him away tied to a gurney for his "punishment," which was ECT. After being finished off with a lobotomy, he was rolled back to his ward a total zombie. No more trouble from him. With fear growing, ECT programs closed in many centers, and psychiatry residents were not taught ECT.

But ECT has never completely died out, and that, the authors argue, is because it works, despite its negative associations. Present day research continues to improve ECT as researchers fine-tune details like current strength, placement of electrodes, and number of sessions. And while common wisdom holds that ECT is only effective for suicidally depressed people, *Shock Therapy* tells us that it has potential for other illnesses and symptoms, too: mania, schizophrenia, and catatonia for example.

Shorter and Healy tell a genuinely interesting story, failures and disagreements all there. But their basic position is to convince us that ECT works, and that it is not as traumatic as it used to be. In doing so, they gloss over some very real concerns, specifically the matter of memory loss, which usually takes about two months to get straightened out. They also fail to mention the whys and wherefores about the number of treatments and what to do about a relapse.

If you have an appointment soon for ECT, you might not want to immerse yourself in this history right now; *Shock Therapy* is not a touchy feely book. But for anyone who is curious about the historical path of ECT, or who wants to hear the evidence that it works, this is a good read.

Mood Disorders Support Groups and Lectures Spring 2008

Support Groups

Manhattan – West Side/Columbus Circle
Every Wednesday

Doors open at 7:00 p.m., and groups begin at 7:30 p.m.
St. Luke's/Roosevelt Adult Outpatient Psychiatric Clinic
910 Ninth Avenue (between 58th and 59th streets)

Manhattan – East Side/Downtown
Every Friday

Doors open at 7:00 p.m., and groups begin at 7:30 p.m.
Beth Israel Medical Center, Bernstein Pavilion
2nd floor, Enter on Nathan Perlman Place
(between 15th & 16th streets, First & Second avenues)

Support groups enable participants to share personal experiences, thoughts, and feelings in small, confidential gatherings. Separate groups are available for newcomers, unipolar (depressive), bipolar (manic depressive), family members, and friends. At *both* locations, groups meet at the same time, including the under-30 group. Support groups are free for members, and a $5 contribution is suggested for nonmembers.

Spring Lectures

New location*

March 4 **Tuesday** **7:30 p.m.**	**Igor Galynker, MD, PhD** Director, Beth Israel's Bipolar Family Treatment Center; Professor, Albert Einstein College of Medicine	**Care for the Patient, Care for the Family: Family-Inclusive Treatment for Mood Disorders** Family members can be invaluable in helping doctors better know their patients. Anyone who has a mood disorder or has a loved one who does should be sure to attend.
April 1 **Tuesday** **7:30 p.m.**	**Richard A. Friedman, MD** Director of the Psychopharmacology Clinic, Weill Medical College, Cornell University	**Personalized Psychopharmacology** Coming soon: a simple blood test that may be able to eliminate the agonizing trial-and-error of finding the right medication. Don't miss this important lecture.
May 6 **Tuesday** **7:30 p.m.**	**Susan Palmgren, PhD** Director of the Adult Case Management Clinic, St. Luke's-Roosevelt Hospital Center	**Managing Stress and Anxiety: A Toolkit for People with Mood Disorders** Get hands-on techniques and tools you can use to battle these persistent problems.

Lectures are *usually* held on **Tuesdays** (call and listen to message for last-minute changes). Doors open at 7:00 p.m., lectures begin at 7:30 p.m. in Podell Auditorium, ***Bernstein Pavilion,** Beth Israel Medical Center (enter at Nathan Perlman Place between First and Second Avenues and 15th and 16th Street). Lectures are free for members; a $5 contribution is suggested for nonmembers.

Contact us for more information and a copy of our newsletter.
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Self Help

Why seek therapy?

By Ngaere Baxter PhD

Like most professionals in the mental health field, MDSG views depression and manic depression as disorders that usually respond best to a combination of psychopharmacology and psychotherapy. But in practice, medication often turns out to be the center of treatment with the emphasis on finding a good doctor and taking the right meds. As a result, many people with mood disorders have questions about the role psychotherapy (also known as talk therapy) should play in their treatment. "Why would I need a psychotherapist if the meds are working?" they may ask themselves if they've never tried therapy. Or if they have, they may not know how much to expect and wonder why they still have conflicting or self-doubting feelings. "Was that therapist I was seeing just irrelevant?"

Examples from the real world should be able to shed some light on what kinds of concerns therapy can help with. These examples are paraphrased from people who have since made good use of therapy.

"The antidepressant I'm taking seems effective. I've got my energy back and I can enjoy my kids again, but I'm still nervous going in to the city and shopping in large supermarkets and malls. Why is this and what can I do about it?"

"The antidepressant I'm taking seems effective. I've got my energy back and I can enjoy my kids again, but I'm still nervous going in to the city and shopping in large supermarkets and malls. What can I do about this?"

"My doctor wants me to go to bed at ten and be up by six. What's this all about? He says making changes in my daily routine could reduce the risk of further episodes. But what about my social life?"

"My wife is so grateful that I'm not lying on the sofa all day anymore but she doesn't seem to understand that I can't just relax and enjoy the coffee group after church. People are always asking me things that I don't want to explain or they make me self-conscious."

"My father is still silent with me. Even though I'm back at work, he always seems to be looking at me sideways, like he's waiting for me to fail."

"As I look back, my depression was a dark cloud and I can't remember everything that happened then. I feel significantly different now, but I worry that people still carry a bad impression of me. And one of my supervisors seems like he'll never forget the important deadline I once missed."

"When I was manic, I got into some pretty destructive relationships, but one person I hung out with a lot is my cousin and another works in a local bank. I can't avoid these people, and I don't want to, but they're always making so-called jokes and allusions to past events, and I don't know how to handle this. How much do I have to keep justifying or explaining myself?

"I really do feel different on lithium, if anything a bit low, but I can't stop worrying that I'm going to have another episode. How can I help myself avoid being hospitalized again?

"Crazy as it seems, now that I'm over the depression and back at school, I feel like I would do well in some kind of helping profession, and I'd like to try for a social work degree. My grades are good enough to apply to a good school, but everyone treats me like I'm fragile and mustn't expect too much. Are they just being over-protective? Can I really try for a professional job where I could make a difference?"

"I know I'm better off on the medication, and I'm too scared to try messing with the dose or anything, but I really miss that exuberant person I used to be. I could make anybody laugh, but now I feel like a vacuum. Will I ever feel like the person I used to be?"

"Before lithium I was the life a of the party, a little too much maybe, but I really could entertain people. Now my friends are all kidding me and asking when I'll have the next party, or burn a great mix on CD. I wonder sometimes if I was actually their clown. Do I have to play that role again to be accepted?"

"My doctor tells me to think about going back to work, but I'm a 'mental patient' and I can't seem to avoid that thought. Am I really ready?'

A therapist with experience in mood disorders can help "reality test" or validate these kinds of problems and powerfully supplement the medication treatment. An example, also drawn from a real case, is that of a woman who struggled for weeks over the decision to tell a friend about taking an antidepressant. Her therapist helped her to decide that the friend's support would be very valuable and when she spoke up she found that the woman had been considering seeing a doctor herself about depressed symptoms and was glad to hear from someone who had already benefited from treatment.

Dr. Baxter is a clinical psychologist in private practice and former MDSG board member.

Contest

Days of Wine and Mood Swings

By Howard Smith

I was out to dinner recently with two friends who are, quite frankly, wine snobs, and I didn't know whether to laugh or cry as they jabbered on about their chosen vino. "I love this fruity roundness?" posited one after a small, careful sip. "But I definitely feel that the parched finish is too tense and rubbery—too anachronistic." "I agree," replied the other, "this wine exudes exquisite tonalities, but the grapes should certainly have spent a few less sunny days on the vine, which gave it those tendils of burnt cellophane. And the flavor bursts too quickly upon opening."

Huh? Well, I thought, if it's true that no two oenophiles describe wine the same way, then it's also true that a depression is not felt in exactly the same way by any two people. As Albert Schweitzer said, "No matter what the illness, each sufferer suffers in his own special way of suffering."

So here's our latest contest: Using wine tasting lingo as a model, write a description of depression, your own or someone else's, that's humorous, but has a ring of truth. Here are a few examples.

My depression started with a dreary flavor of dread, followed by musty notes of sadness and a suicidal finish and an unfortunate aftertaste of permanence.

Mine was a pale depression, slightly nutty, blending into a discerning sweetness tinged with mellow psychosis.

It started sad, dark, bleak, but opened to a grim fullness with undertones of Hell.

Each entry should be less than 50 words each, but you can submit as many as you like. Enter by e-mail, newsletter@mdsg.org with *Wine Lingo Contest* in the subject line, or by snail mail addressed Wine Lingo Contest, MDSG-NY, P.O. Box 30377, New York, NY 10011. All entries must be received by April 5, 2008. Winning entries will be published in the next newsletter. Here are a few more examples to get you on your way.

My most recent episode had a heady whiff of personality disorder, with a long shimmer of self-destructive behavior developing into a kind of noirish downer, not unlike living in New Jersey.

A bouquet of insanity, touched with black thoughts, wrapped around a rich burst of gothic delusions redolent of my foolish attempts at self-medication with alcohol, cocaine and dangerous amounts of wasabi.

Overcooked obsessive thoughts overwhelmed the flat affect, leaving that smoky dryness of electro-shock therapy and a mouthful of low self-esteem.

My crying was complex, yet balanced, allowing my insomnia to ripen into a full palette of intense agitation which surprisingly dissipated upon the arrival of the Mobile Crisis Unit.

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We Get By with a Little Help from our Friends . . .

MDSG provides award-winning services to thousands of New Yorkers—through more than 600 individual support groups a year, our distinguished lecture series, our telephone information service, our website, and this newsletter. And all at the lowest possible cost, through our volunteers.

The $5 contribution for meetings doesn't cover all our expenses—we need your help to pay the phone bill, print the newsletter, promote MDSG in the media, and meet other needs.

Our annual membership is $45 for individuals and $65 for families. Your membership card is a free ticket to support groups and most lectures, and your contributions are tax-deductible. Thanks for your support.

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