Northeast News

Newsletter of the Northeast Philadelphia Affiliate of The National Alliance for the Mentally Ill
Jan. - Feb. Mar. 2016 - Written by Ronni Flitter

Calendar of Events

As stated earlier, board meetings will be held only on an as needed basis. To see if there will be one, call Frank at 215-342-9553
Meetings are now at Friends Hospital, Adams & Roosevelt Boulevard. Enter from the Boulevard and then make the left before the Scattergood building and follow the driveway around to the right to the back building and park in one of the parking lots on the left. Walk past the sliding doors to the crisis center and enter by the stairs at the end of the walkway.
Listen for the calling post messages for information on upcoming speakers.

Sun. Jan. 10 Regular Meeting 2 - 4 p.m.

Sun. Feb. 14 Regular Meeting 2 - 4 p.m.

Sun. Mar. 13 Regular Meeting 2 - 4 p.m.

Refreshments will continue to be served at all meetings

Contact Information
Be sure to check our website at
http://philadelphia.nami.org
for information on events throughout the city

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Community Resources

Family Support Specialist Office - Angela Smith, 215-546-0300, x2357
AngelaSmith@PMHCC.org
Consumer Satisfaction Team 215-923-9627
The Family Resource Center Friends Hospital 215-831-4894
Mobile Emergency Team - 24 hours a day/7 days a week 215-685-6440
Northeast chapter NAMI - Frank Eichhorn
215-342-9553
The T.E.C. Family Center
Mary Catherine Lowery 267-507-3865
or mlowery@mhasp.org
"Ask the Pharmacist"
Larry DiBello 610-543-2966
Suicide and Crisis Intervention Hotline
(215) 686-4420
National Suicide Prevention Lifeline
1-800-273-TALK (8255)
Community Behavioral Health
1-888-545-2600 www.phila-bhs.org
Pro-Act - Addiction Education Program for Families 800-221-6333
Family Resource Network -
Kathleen Cantwell 215-599-5176
Veteran Affairs Medical Center, Phila. -
Mental Health Clinic 215-823-4300
Hoarding Task Force
Under 60 years of age: 215-751-1800
60 years or above: 215-545-5728

Crisis Response Centers

24 hours a day/7 days a week
FOR ALL CHILDREN AND TEEN-AGERS (under age 18), please go to Einstein Hospital at Germantown Community Center, 1 Penn Blvd.

Friends Hospital CRC
Northeast Philadelphia
4641 Roosevelt Blvd.
Philadelphia, PA 19124
215-831-2600

Mercy Hospital CRC
Southwest Philadelphia & West Philadelphia
501 S. 54th St. (54th & Cedar Ave.)
215-748-9525

Hall-Mercer/Pennsylvania Hospital CRC
Center City
South Philadelphia
245 S. 8th Street
215-829-5433

Temple/Episcopal Hospital CRC
North Philadelphia
100 E. Lehigh Ave.
215-707-2577

Einstein Hospital at Germantown Community Center
Northwest Philadelphia, Germantown & Roxborough
Assesses Children City Wide
One Penn Blvd.
(Near intersection of Chew Ave. & Olney Ave.) 215-951-8300

Become a Family-to-Family Facilitator

There will be a NAMI Family-to-Family Education Program Teacher Training in Paoli the weekend of February 26-28, 2016. If you are a graduate of the NAMI Family to Family Education Program, please consider becoming a teacher and helping other families affected by mental illness. Applicants must be NAMI members in good standing and be recommended by their NAMI affiliate. There is no cost to participants.
For more information or to express your interest, contact Judy Green (F2FMainLine@aol.com or 610-668-7917) or Kristine Songster (coordinator@NAMIpaMainLine.org or 267-251-6240). If you are interested, it would be most helpful to hear from you as soon as possible to guarantee a spot in the training.

TEC Schedule

(weather permitting)* Call 267-507-3865 and the greeting will indicate if the session has been cancelled for the month.
Registration preferred, but not required for all offerings. To register or for more information, contact 267-507-3863 or TECinfo @mhasp.org

Educational Support Group for Family Members of People with Traits of Borderline Personality Disorder

4th Tuesday Evenings 7 – 9 PM
All Discussion Topics are followed by a support group
Belmont Center, 4200 Monument Ave (Room 139), Philadelphia PA 19131
1/26, Responding Effectively to Anger Toward You
2/23 How Our Family Workshop Could Help You
3/22/16 How Much Independence to Expect
Free if you or your loved one lives In Phila.
Otherwise $25/person, $35/couple

MORNING FAMILY& FRIENDS GROUP

3rd Thurs.: 10 AM – Noon
These sessions start with a 45-minute focused discussion around a topic of interest to family members, presented by a guest speaker or facilitator, followed by a support group.
1/21 "Winter Blues" vs. Depression
2/18 Caregiving Tips for Schizophrenia
3/17 The Challenges of Adjusting Expectations
Mental Health Association
1211 Chestnut St. (11th Floor conference room)
Free for everyone

Support group for adult siblings, sons & daughters of people with mental illness.

2016 MEETINGS WILL BE HELD EVERY MONTH, 3RD TUESDAYS, 7 to 9 PM
1/19 Helpful Books, Web Sites & Films
2/16 Interacting with a Psychotic Parent or Sib
3/15 What's New in the World of Therapy
Belmont Center, 4200 Monument Ave (Room 139), Philadelphia PA 19131
Pre-registration preferred Free for everyone.

Getting Off the Emotional Roller Coaster

10-Week Skill Building Workshop for Families & Friends of People with Bipolar Disorder, Major Depression or Borderline Personality Disorder
Spring, 2016 10 weekly weeknights 7 – 9 PM
The Philadelphia workshop is free if you or your loved one live In Philadelphia. Otherwise the fee is $300/person and $550 for 2 people

Individualized Family Consultation:
One-on-one support, information, problem solving or referral by phone or private consultation

Classes From Montgomery County NAMI
For information call their office at 215-361-7784.

Scientists Figure Out Genes Tie to Obesity

A faulty version of FTO causes energy from food to be stored as fat rather than burned.
Scientists have finally figured out how the key gene tied to obesity makes people fat, a major discovery that could open the door to an entirely new approach to the problem beyond diet and exercise.
The work solves a big mystery: Since 2007, researchers have known that a gene called FTO was related to obesity, but they didn't know how, and could not tie it to appetite or other known factors.
Now experiments reveal that a faulty version of the gene causes energy from food to be stored as fat rather than burned. Genetic tinkering in mice and on human cells in the lab suggests this can be reversed, giving hope that a drug or other treatment might be developed to do the same in people.
The work was led by scientists at MIT and Harvard University and published online by the New England Journal of Medicine.
The discovery challenges the notion that, "when people get obese it was basically their own choice because they choose to eat too much or not exercise," said study leader Melina Claussnitzer, a genetics specialist at Harvard–affiliated Beth Israel Deaconess Medical Center. "For the first time, genetics has revealed a mechanism in obesity that was not really suspected before" and gives a third explanation or factor that's involved.
Independent experts praised ,the discovery.
"It's a big deal," said Clifford Rosen, a scientist at Maine Medical Center Research Institute and an associate editor at the medical journal.
A lot of people think the obesity epidemic is all about eating too much, "but our fat cells play a role in how food gets used", he said. With this discovery, "you now have a pathway for drugs that can make those fat cells work differently."
Researchers can't guess how long it might take before a drug based on the new findings becomes available. But it's unlikely it would be a magic pill that would enable people to eat anything they want without packing on the pounds.
Obesity affects more than 500 million people worldwide and contributes to a host of diseases.
In the United States, about one–third of adults are obese and another one–third are more modestly overweight.
This raises an interesting question for people on anti-psychotic medications since so many of them are obese. Do their meds affect any part of the FTO pathway? I think NAMI and NIMH need to become involved with this research.

Acknowledging The Voices

Ron Cameron has been hearing voices that no one else hears for 36 years.
For the first 10 of them, he was homeless or hospitalized with schizophrenia. During the remainder, the quick–witted Scotsman learned to live with the voices and teach others how to do it, too.
Coleman and his wife, came to Philadelphia as emissaries of what is known as the hearing voices movement. It argue's that taking psychotic voices seriously and developing a relationship with them can help people with serious mental illnesses have fulfilling lives.
"Hearing voices is a normal human experience," Coleman said.
The problem is not hearing voices. The problem is how people respond to voices.
The Coleman's conducted a workshop for people who work with the mentally ill, psychiatric consumers, and their families at Resources for Human Development, a national social–services provider based in Germantown. A couple of dozen people attended.
The hearing voices movement began in Europe in the late 1980s after a Dutch psychiatrist became curious about the experiences of voice

hearers. Locally, it has a foothold in Montgomery County, where Berta Britz, a former social worker who is now a peer counselor, has started several groups. After decades of disabling symptoms of schizophrenia, she said, the movement's approach has greatly improved her ability to function:

Arthur C. Evans Jr., commissioner of the Philadelphia Department of Behavioral Health and Intellectual Disability Services, is a strong supporter of the recovery model, which asserts that serious mental illnesses such as schizophrenia and bipolar disorder need not lead to lifelong disability. It parallels the addiction recovery movement.

Treatment providers, Evans said, have traditionally had the unrealistic goal of eliminating all symptoms. He called the hearing voices philosophy a "very important development" that is "very consistent with our goal, which is to help people recover to the extent that they can."

He sees the approach as an “adjunct" to other forms of treatment, not an alternative,

A University of Pennsylvania schizophrenia expert who has worked with the city to provide cognitive behavioral therapy to people with psychosis, said only about 20 percent of patients respond well to antipsychotic medicines. Many continue to hear voices after treatment. The hearing voices movement, he said, has done those patients a "world of service" by helping them feel less alone,

Coleman said that 3 to 4 percent of the population hears voices, but that only about a third of that group gets psychiatric treatment.

Typically, psychiatrists have considered voices a symptom of a mental illness, but have not cared about who those”meaningless” hallucinations, sounded like or what they said. Both workshop leaders think that's a mistake. Coleman said the voices often can be traced to specific traumas or belief systems. They are a way to understand what hearers feel and a route to recovery.

“If we don't engage with the voices, don't enter or at least understand some of these different–world experiences, how do we help? We have to know what it’s about in order to work through it.”

Coleman said he began hearing voices after being abused by a priest, finding his first wife dead of suicide and being unable to engage in his coping mechanism – rugby – because of an injury.

When he was younger he often heard the voice of his priest abuser. “It’s your fault. You led me into sin,” the voice would say.

“All the power came from the fact that I blamed myself for the abuse, like many people," Coleman said.

Now that he understands what those voices represented and is emotionally healthier, the voice he most often hears is from what he thinks of as a wiser, version of himself. On the rare occasions when the priest resurfaces, he knows it's time to relax

During the training session non–voice hearers were asked to talk to each other while voice hearers stood close to them and said the sort of things their voices say. “You really need a bath” "You cause suffering.”

When it was over, those in the group told of feeling anxious, frustrated and overwhelmed. They had trouble speaking normally. Coleman, pointed out that many of their “symptoms” flowed directly from hearing the voices.

Later he orchestrated a compelling visual representation of what it's like to hear voices with the help of a 22–year–old Maryland woman. Using other members of the group, he created a "sculpture" of her surrounded by her voices.

A deeply religious woman who had struggled to stay awake earlier, she came alive as she helped arrange other participants according to how she hears their voices. "God" stood on a chair to tower above her. The voice of wisdom, which says, "You're a fool," stood to the side. Two "demons" were behind her. Voices representing her struggle with bisexuality stood in front and in back. Her, voices were not kind. They accused her of cruelty and sin.

She revealed that close friends bullied her in high school after she told them she was attracted to women. Those conversations replayed in her head as she tried to sleep. Now,

after a religious conversion, her voices all have moral messages.
Coleman instructed all the "voices" to speak at once and let her real mother stand inside their mean circle. "Dear God," she said after she emerged. "That was really overwhelming."
The woman rather enjoyed it. "Yes, this is what it's like" she said.
At the end, she said, "I don't trust that this voice of God I'm hearing is God."
That, Coleman said later, was a place to start. Maybe she would come to see that those demons were her bullies and that she needs to face how they made her feel.
"They're all her," he said. "They're all aspects of herself that she's struggling through.
What I thought was wonderful was that she clearly was able to see the struggle."

Talk Therapy Found to Ease Schizophrenia

John Kane, chairman of the psychiatry department at Hofstra North Shore-LIJ School of Medicine, who led a study on the treatment of schizophrenia.

More than two million people in the United States have a diagnosis of schizophrenia, and the treatment for most of them mainly involves strong doses of antipsychotic drugs that blunt hallucinations and delusions but can come with unbearable side effects, like severe weight gain or debilitating tremors.
Now, results of a landmark government-funded study call that approach into question. The findings, from by far the most rigorous trial to date conducted in the United States, concluded that schizophrenia patients who received smaller doses of antipsychotic medication and a bigger emphasis on one-on-one talk therapy and family support made greater strides in recovery over the first two years of treatment than patients who got the usual drug-focused care.
The report, to be published on Tuesday in The American Journal of Psychiatry and funded by the National Institute of Mental Health, comes as Congress debates mental health reform and as interest in the effectiveness of treatments grows amid a debate over the possible role of mental illness in mass shootings.

Lives Restored
Its findings have already trickled out to government agencies: On Friday, the Centers for Medicare & Medicaid Services published in its influential guidelines a strong endorsement of the combined-therapy approach. Mental health reform bills now being circulated in Congress "mention the study by name," said Dr. Robert K. Heinssen, the director of services and intervention research at the centers, who oversaw the research.
In 2014, Congress awarded $25 million in block grants to the states to be set aside for early-intervention mental health programs. So far, 32 states have begun using those grants to fund combined-treatment services, Dr. Heinssen said.
Experts said the findings could help set a new standard of care in an area of medicine that many consider woefully inadequate: the management of so-called first episode psychosis, that first break with reality in which patients (usually people in their late teens or early 20s) become afraid and deeply suspicious. The sooner people started the combined treatment after that first episode, the better they did, the study found. The average time between the first episode and receiving medical care — for those who do get it — is currently about a year and half.
The more holistic approach that the study tested is based in part on programs in Australia, Scandinavia and elsewhere that have improved patients' lives in those countries for decades. This study is the first test of the approach in this country — in the "real world" as researchers described it, meaning delivered through the existing infrastructure, by community mental health centers.
The drugs used to treat schizophrenia, called antipsychotics, work extremely well for some people, eliminating psychosis with few side effects; but most who take them find that their bad effects, whether weight gain, extreme drowsiness, or emotional numbing, are hard to live with. Nearly three quarters of people

prescribed medications for the disorder stop taking them within a year and a half, studies find.

"As for medications, I have had every side effect out there, from chills and shakes to lockjaw and lactation," said a participant in the trial, Maggie, 20, who asked that her last name be omitted. She did well in the trial and is now attending nursing school.

Doctors praised the study results.

"I'm very favorably impressed they were able to pull this study off so successfully, and it clearly shows the importance of early intervention," said Dr. William T. Carpenter, a professor of psychiatry at the University of Maryland School of Medicine, who was not involved in the study.

Dr. Mary E. Olson, an assistant professor of psychiatry at the University of Massachusetts Medical School, who has worked to promote approaches to psychosis that are less reliant on drugs, said the combined treatment had a lot in common with Open Dialogue, a Finnish program developed in the 1980s. "These are zeitgeist ideas, and I think it's thrilling that this trial got such good results," Dr. Olson said.

In the new study, doctors used the medications as part of a package of treatments and worked to keep the doses as low as possible — in some cases 50 percent lower — minimizing their bad effects. The sprawling research team, led by Dr. John M. Kane, chairman of the psychiatry department at Hofstra North Shore-LIJ School of Medicine, randomly assigned 34 community care clinics in 21 states to provide either treatment as usual, or the combined package.

The team trained staff members at the selected clinics to deliver that package, and it included three elements in addition to the medication. First, help with work or school such as assistance in deciding which classes or opportunities are most appropriate, given a person's symptoms. Second, education for family members to increase their understanding of the disorder. And finally, one-on-one talk therapy in which the person with the diagnosis learns tools to build social relationships, reduce substance use and help manage the symptoms, which include mood problems as well as hallucinations and delusions.

For example, some patients can learn to defuse the voices in their head — depending on the severity of the episode — by ignoring them or talking back. The team recruited 404 people with first-episode psychosis, mostly diagnosed in their late teens or 20s. About half got the combined approach and half received treatment as usual. Clinicians monitored both groups using standardized checklists that rate symptom severity and quality of life, like whether a person is working, and how well he or she is getting along with family members.

The group that started on the combined treatment scored, on average, more poorly on both measures at the beginning of the trial. Over two years, both groups showed steady improvement. But by the end, those who had been in the combined program had more symptom relief, and were functioning better as well. They had also been on drug doses that were 20 percent to 50 percent lower, Dr. Kane said.

"One way to think about it is, if you look at the people who did the best — those we caught earliest after their first episode — their improvement by the end was easily noticeable by friends and family," Dr. Kane said. The gains for those in typical treatment were apparent to doctors, but much less obvious.

Dr. Kenneth Duckworth, medical director for the National Alliance on Mental Illness, an advocacy group, called the findings "a game-changer for the field" in the way it combines multiple, individualized therapies, suited to the stage of the psychosis.

The study, begun in 2009, almost collapsed under the weight of its ambition. The original proposal called for two parallel trials, each including hundreds of first-episode patients. But recruiting was so slow for one of the trials that it was abandoned, said Dr. Heinssen.

"It's been a long haul," Dr. Heinssen added, "but it's worth noting that it usually takes about 17 years for a new discovery to make it into clinical practice; or that's the number people throw around. But this process only took seven years."

Mental Illness and Violence

By Mark Salzer a professor and the chair of the department of rehabilitation sciences at Temple University as it appeared in the Philadelphia Inquirer

A Republican candidate for president tells heartbreaking stories of violence committed by a few Mexican immigrants as evidence that they are rapists, murderers, criminals, and drug dealers. He depends on outrage and fear to gain support for building a 2,000-mile fence and detaining and deporting millions of individuals.

A similar tactic is being used to influence national policies about people with serious mental illnesses in the wake of well-publicized mass murders. The intention is to cause fear by linking violence and mental illness, and then blaming the illnesses and the mental health system for the problems. The proposed solutions? A return to asylums; more involuntary outpatient commitment; attacks on a federal agency that has spearheaded advances in mental health policies and services; and challenges to the nation's emphasis on protecting the rights and freedoms of all citizens.

This strategy perpetuates inaccurate beliefs, is ineffective and harmful to those who are targeted, and will cost billions of dollars if implemented.

Mass murders committed by people with mental illnesses are exceedingly rare. A recent study published in the American Journal of Public Health demonstrated that people with mental illnesses are no more likely to kill others with a gun than the general population. Authors of a previous article in the same prestigious journal concluded that solutions to gun violence that target people with mental illnesses are unlikely to have an effect.

The percentage of people with serious mental illnesses is virtually identical around the world. Yet only in the United States are violence and crime seriously discussed as being related to those with mental illnesses. And the mental-health system in the United States, while not close to being perfect, is arguably among the most advanced in the world, undermining arguments that it is at fault.

In addition to being misleading, playing the "violence and crime card" maintains, and possibly exacerbates, ingrained prejudices and discrimination toward people with mental illnesses. Ironically, these narratives more likely drive people away from needed services out of fear of being labeled "crazy" and "violent."

In addition, individuals with serious mental illnesses report having less meaning in their lives and being lonely, which contributes to the horrifyingly high suicide rate among this population that is not talked about enough.

The proposed solutions are equally problematic. Mental institutions are anything but the idyllic healing settings that some supposed experts have claimed. And like building a 2,000-mile border fence or rounding up millions of people already in the United States, they would come at a great cost without the desired impact.

Commitment laws already balance the rights of the individual with the necessities of protecting society and these individuals from harming themselves. Regrettably, these laws do not prevent all harms from occurring, but they do prevent the damage that invariably comes from casting an overly broad net.

Finally, attacks on the Substance Abuse and Mental Health Services Administration (SAMHSA) also seem strangely off course. This federal agency has dutifully carried out the wishes of legislators who passed the Americans with Disabilities Act (ADA), the Supreme Court that upheld the ADA, and President George H. W. Bush, who launched the New Freedom Initiative to enhance the lives of American citizens with mental illnesses and other disabilities.

SAMHSA has clearly served people with serious mental illnesses, including those who are homeless, are suicidal, have limited access to health care, or lack the resources to live successfully in the community. The agency's efforts have produced service delivery concepts and approaches that have been adopted by every state and municipality in the United

States — and, in some cases, by countries around the world. The elimination or curtailment of SAMHSA would be a major blow to progressive mental-health policies in the United States, and attacks on the group's protection and advocacy efforts fly in the face of liberty and human rights.

While it's among the best systems in the world, we can all agree that mental-health services in the United States are not perfect. Millions of Americans with the most serious mental illnesses are not living lives in the community like everyone else. These individuals do not have opportunities to work, go to school, parent, and love and be loved, all of which promote mental health and wellness.

These serious public health issues are only exacerbated by the violence-and-crime narrative, which in turn only inflames prejudice and discrimination.

Prescription Drug Assistance

The following list provides contact information for resources to obtain information about how to acquire relief from the costs of prescription drugs:

- General Information about Prescription Drug Assistance Programs (government programs, non-profit organizations and pharmaceutical company relief programs):
  - http://bit.ly/1thWlcQ
- Needymeds.com (Philadelphia-based nonprofit): www.NeedyMeds.com
- Together RX Access Card (drug discounts to the uninsured):
  - www.Togetherrxaccess.Com or
  - 1-800-444-4106
- Simple Fill: 1-877-386-0206
- Select Care: 1-800-858-9060
- The RX Advocates: 1-866-949-7353
- Partnership for Prescription Assistance (information about drug company programs): www.Pparx.Org
- PA Department of Aging, PACE or PACENET (depending on income): 1-800-955-0989
- NJ Department of Health and Senior Services, PAAD: 1-800-792-9745

LIHEAP Program Can Help with Heating Costs the Winter

Understanding LIHEAP is as easy as 1-2-3:

1. LIHEAP Cash: Pays at least $100 to help with a heating bill. This includes bills for electricity, gas, water, oil, propane, kerosene, or other fuel types.

NEW FOR 2015-16: $70 Supplemental Grant for "Vulnerable Households" defined as "a household containing at least one member who is elderly (age 60 or over), disabled, or age 5 and under" at the time the LIHEAP Cash application is submitted.

2. LIHEAP Crisis: Pays up to $500 to stop a shut-off of utility service, to get service turned back on, or to get fuel if a household is out of fuel or about to run out of fuel.

3. LIHEAP Crisis Weatherization: Help for home-heating emergency: broken furnace, broken windows, frozen pipes, little or no insulation, cracks or other damage to roofs.

For more information and to download LIHEAP Applications in English and Spanish, go to: http://www.dhs.state.pa.us/foradults/heatingassistanceliheap/index.htm

SSRIs Appear to Decrease Youth Suicide Overall

Research using large databases, published reports, and cohort-matching techniques has found that, overall, antidepressants — particularly selective serotonin reuptake inhibitors (SSRIs) — may reduce the risk for suicide in children and adolescents. However, youngsters who have been recently hospitalized for a suicide attempt may be at increased risk for suicide with antidepressant use and should be watched closely, researchers said.

Mark Olfson, MD, MPH, clinical professor of psychiatry at Columbia University in New York City, described his work at the American Psychiatric Association's 58th Institute on Psychiatric Services. He drew data from multiple sources and various time periods. These included Medicaid and other federal government databases, prescribing information from drug companies, Alleghany County

(Pennsylvania) medical data, private entities that collect health data, published journal articles, and death certificates. He was even able to obtain Social Security numbers from the federal government so he could connect Medicaid data with death certificate data.

Dr. Olfson observed that there has been a "slow, steady decline" in youth suicide since the 1980s, and "a big increase" in rates of antidepressant use in children after the introduction of SSRIs. "More than half of all the young people who present with depression in the United States receive antidepressants," he said. Taken as a whole, these observations suggest that antidepressant medications are having a protective effect.

To study how recent hospitalization for a suicide attempt might affect suicide rates in youth and adults who took SSRIs, Dr. Olfson identified completed suicides who had been recently hospitalized. He then identified 4 or 5 age-, location-, days in hospital–, and diagnosis-matched controls for each of them. (Recent hospitalization for a suicide attempt is a known risk factor for subsequent suicide.) The numbers were small — he found 8 suicides among people aged 18 years and younger and 39 suicides among those aged 19 to 64 years who met criteria. All patients were Medicaid recipients.
Among the adults, antidepressant use had no observable effect on completed suicide rates, Dr. Olfson said. But 50% of children and adolescents who completed suicide had been taking SSRIs compared with 37.5% of the matched controls. What remains unknowable is whether the youngsters who received SSRIs had more severe depression than the controls.

While suicide is a leading cause of death among people aged 15 to 19 years in the United States, in a population-based analysis, "youth suicide, thankfully, is very uncommon," Dr. Olfson said. Fewer than 1500 suicides occur annually. Consequently, "There will never be a randomized trial that is large enough" to study this issue in youth or adults, even if the trial were worldwide, because suicide is rare. "Obviously, that's a very good thing," he added.

David A. Fox, MD, associate clinical professor at the University of California Medical Center in Fresno, called Dr. Olfson's lecture "a wonderful survey of the data that's out there."
Dr. Fox had asked Dr. Olfson about the effect of the US Food and Drug Administration's "black box" warning regarding the risk of suicide and paroxetine (Paxil) in adolescents. The warning was issued in October 2004. "Obviously, parents in particular are well aware of any published data and will ask about it, always," Dr. Fox told Medscape.

The FDA warning affected practices at his institution. "Pediatricians who previously had been very comfortable writing prescriptions for antidepressants for kids became much less comfortable," Dr. Fox said. "Pediatricians called me and said, 'I don't want to prescribe this for these kids anymore, you do it.' "

Dr. Fox estimated that his referrals from pediatricians who initially prescribed an SSRI increased about 20% to 25%, "even if the kid was fine." He added that this is "mostly, probably, a good thing," because many pediatricians do not have the time to follow such patients closely.

Genetic On-off Switch

Scientists at Johns Hopkins have developed a mouse model for schizophrenia in which a mutated gene linked to schizophrenia can be turned on or off at will.
The researchers developed the transgenic mouse by inserting the gene for mutant Disrupted- In-Schizophrenia-1 (DISC-1) into a normal mouse, along with a promoter that enables the gene to be switched on or off. Mutant DISC-1 was previously identified in a Scottish family with a strong history of schizophrenia and related mental disorders.

The study was performed in the laboratory of Mikhail Pletnikov, M.D., Ph.D., in the Department of Psychiatry and Behavioral Sciences.
Last month, another Hopkins researcher in the Department of Psychiatry and Behavioral

Sciences, Akira Sawa, M.D., Ph.D., and his team, developed a comparable mutant DISC-1 mouse model for schizophrenia. Pletnikovâ €TMs is the first model in which researchers can control the expression of this mutated gene, and the model illuminates additional aspects of the biology of the disorder.

Researchers turn off the mutant DISC-1 gene by feeding the mice a nontoxic chemical that controls a genetically engineered switch mechanism to turn on production of the DISC-1 protein.
The study, which appears in Molecular Psychiatry, showed that male mice with the mutant DISC-1 gene were significantly more active than control mice without the mutated gene. The investigators also observed that the male mutant DISC-1 mice had altered social interactions with other mice and were more aggressive. Females with the mutated gene had a more difficult time remembering how to navigate a maze. Schizophrenia is a human disorder, so we cannot say the symptoms displayed by the mouse model are schizophrenic. But they are in line with the kinds of behavioral changes we see in humans with schizophrenia, says Pletnikov.
The research showed other strong similarities between the mouse model and humans with schizophrenia.
Examination of the brains of the mutated mice using MRI scans showed significant enlargement of the lateral ventricles (fluid-filled areas in the front of the brain), very similar to MRI findings in humans with schizophrenia.
Tissue culture studies showed that there was an abnormality in the development of brain cells in the part of the brain generally associated with schizophrenia. Also, the transgenic mice had abnormal levels of certain proteins.

It is known from previous research that those proteins are key players in brain cell development and maturation, and several prior studies of brain tissue from humans with schizophrenia showed abnormal levels of them.
This model supports the idea that schizophrenia is a disease associated with abnormal brain development, says senior co-author of the study Christopher Ross, M.D., Ph.D., of the Department of Psychiatry and Behavioral Sciences. Being able to regulate the timing of expression of the mutant protein provides an opportunity to study the timing and mechanism of specific abnormalities -- a tool that could eventually lead to the discovery of drugs that could potentially control or even prevent the disease.
This study was supported by the Stanley Medical Research Institute, a NARSAD Distinguished Investigator Award, the National Institute of Mental Health and the National Institute of Neurological Disorders and Stroke.

Cardiovascular Risks of Haloperidol Highlighted

The US Food and Drug Administration (FDA) and Johnson & Johnson have informed healthcare professionals of a revision to the prescribing information for haloperidol, an antipsychotic marketed as Haldol, Haldol decanoate, and Haldol lactate, to include a new cardiovascular subsection highlighting the risk for sudden death, QT prolongation, and torsades de pointes (TdP), particularly when given intravenously or at doses higher than those recommended.
"Although injectable haloperidol is approved by the FDA only for intramuscular injection, there is considerable evidence from the medical literature that intravenous administration is a relatively common 'off-label' clinical practice, primarily for the treatment of severe agitation in intensive care units," the FDA alert notes.
There have been at least 28 case reports of QT prolongation and TdP, some with fatal outcomes, in the context of off-label IV use of haloperidol, the alert notes.
Updated warnings note that:

* Higher doses and IV administration appear to be associated with a higher risk for QT prolongation and TdP.

* Although cases of sudden death, QT prolongation, and TdP have been reported even in the absence of predisposing factors,

particular caution is advised when physicians are treating patients with any formulation of haloperidol who have other QT-prolonging conditions such as electrolyte imbalance (particularly hyperkalemia and hypomagnesemia); have underlying cardiac abnormalities, hypothyroidism, or familial long-QT syndrome; or are taking drugs known to prolong the QT interval.

* ECG monitoring is recommended if haloperidol is given intravenously.
* Haloperidol is not approved for intravenous administration.

Based on case reports alone, however, they are unable to estimate the frequency with which QT prolongation or TdP occurs with use of these drugs.

"Healthcare professionals should consider this new risk information when making individual treatment decisions for their patients," the alert concludes. The FDA will continue to monitor postmarketing reports and consider further regulatory action as additional information becomes available, it notes.

Here are some tips on how to make yourself feel better when you're stressed:

1. **Calm down**
   Before anything else, calm yourself down. Don't panic. Close your eyes and take a deep breath.

2. **Feed your mind with positive thoughts**
   When you're depressed, it's easy to fall into a vicious cycle of negative thoughts. It's important that you break this cycle. To do that, feed your mind with positive thoughts. You may read spiritual texts, motivational books, or inspiring quotes. You may also listen to positive tapes.

3. Remember good things
Direct your mind to the positive. Remember the good things in your life. Remember the good people around you.

4. Look at the big picture
An event that seems bad might not seem that bad if you look at the big picture. Put the event in context.

5. Believe that everything will be all right
What you believe has a big effect on you. If you believe that things will go wrong, that would usually be the case. On the other hand, if you believe that everything will be all right, you will have a winning attitude.

6. Exercise
When you're depressed, take time to exercise. Exercise relieves the symptoms of depression and anxiety.

7. Forgive
Sometimes one reason you feel bad is because you don't forgive. Perhaps you had made mistakes in the past and you blamed yourself for it. You need to forgive yourself. Or perhaps someone mistreated you. You need to forgive them.

8. Take action
Things won't get better if you just sit and do nothing. Instead of thinking about how bad things are, think of what you can do to solve the problem and take action.

9. Say something positive
Negative words have devastating effect on your confidence and motivation. So whenever you're about to say something negative, stop yourself and take a deep breath. Reframe what you're going to say and make it positive.

10. Think about other people
One of the best ways to make yourself feel better is simply by taking the focus away from yourself. Start thinking about other people and how you can help them. When you do that, your problems will no longer seem so hard.

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