National Alliance on Mental Illness

NAMI Syracuse Newsletter

NAMI SYRACUSE
A Better Understanding

MAY/JUNE 2019

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting
Third Tuesday of each month, 7:00pm
AccessCNY, 420 East Genesee Street, Syracuse 13202
(parking and entrance in rear of building)
NAMI Syracuse Family Support Group
Second Wednesday of each month, 10:00am
NAMI Syracuse office, 917 Avery Avenue, Syracuse 13204

Events Calendar

May 10, 2019	**Off the Mask Fundraiser** Hearst Media Center, Albany, NY
May 8, 2019	NAMI Syracuse Family Support 10:00am - NAMI Syracuse office
May 15, 2019	Peer Support Group - This Mind of Mine 5:30pm - NAMI Syracuse office
May 21, 2019	NAMI Syracuse Family Support 7:00pm - AccessCNY
June 12, 2019	NAMI Syracuse Family Support 10:00am - NAMI Syracuse office
June 18, 2019	NAMI Syracuse Family Support 7:00pm - AccessCNY
June 19, 2019	Peer Support Group - This Mind of Mine 5:30pm - NAMI Syracuse office
September 8, 2019	Harvest Hopela, Greenwood Winery
October 2, 2019	NAMI Syracuse Conference **Responding to Crisis** Rosamond Gifford Zoo *(see page 3)*

NAMI Syracuse is a not-for-profit, self-help organization of active and concerned families and friends of people who suffer from serious and persistent psychiatric illnesses, most commonly schizophrenia, bipolar disorder (manic depression), and severe depression.

CARING ***SHARING***
EDUCATION ***ADVOCACY***

Contents

NAMI Syracuse, Inc., 917 Avery Avenue, Syracuse, New York 13204
phone (315) 487-2085, FAX (315) 487-2154, email namisyracuse@namisyracuse.org, web site www.namisyracuse.org
NAMI Syracuse is the local affiliate of NAMI - New York State, 1-800-950-FACT, web site www.naminys.org and
National Alliance for the Mentally Ill (NAMI), 1-800-950-NAMI, web site www.nami.org

MESSAGE FROM THE PRESIDENT

Dear NAMI Syracuse family and friends,

My last letter was written in subzero weather and now we're looking at trees flowering, green grass, daffodils' bright yellow faces, and warm temperatures. Transitions can happen overnight or take months to occur.

We are transitioning to more reliance on social media and electronic communications.

PLEASE call or email the office with your current email address so we can send more of our newsletters electronically.

We ask all our members to "like" our NAMI Syracuse Facebook page and ask your friends to "like" our page. Share posts from NAMI's facebook page as another method to reach more people who may need our support.

Our social media committee is evaluating how to improve our webpage, Facebook, and twitter accounts. Hopefully it will better serve our membership and community.

We have been busy with presentations of the **Ending the Silence** program. Ann Canastra did another training at the NAMI office on 3/21 and trained 8 more volunteers in the signature programs. Thus far Tanisha Wiggins, Joe Ridgway, and myself have done 5 presentations reaching 155 people. Ann Canastra, Lacey Roy, Carol Notar have also been busy talking to groups about NAMI. Our veterans committee has been active with health fairs and writing grants for veterans programs. Sheila Le Gacy and Carol Notar are in the middle of the **Family to Family** educational series, Ann Canastra is conducting **HOMEFRONT,** and Kryssy Ridgway, Brad Webster and Jerry Simmons have finished the first **Peer to Peer** series.

Madeline Canastra is representing NAMI Syracuse in the "Off the Mask" fashion show in Albany, May 10th. See our website to donate to her fundraising effort.

Sunday, May 19th at 1pm we will be doing an hour long presentation on **Ending the Silence** at Onondaga Public Library on Route 375, open to the public. Please come out and support our presenters Becky and Danae Hidy, Tanisha Wiggins, and Joe Ridgway. Our **Nothing to Hide** photo/text display will be on the second floor of the library along with our brochures.

This year our annual **Hopela** fundraiser is tentatively scheduled for September 8th at Greenwood Winery, 6475 Collamer Road, East Syracuse. Our 25th annual educational conference, **Responding to Crisis** is Wednesday, October 2nd at the Rosamond Gifford Zoo.

We continue to try new ideas, new presentations, and new ways to reach families who need our support and help. If you want to become more involved, call our office.

One easy way to help is to renew your membership and encourage family and friends to join. The greater our numbers, the bigger impact we have when we advocate for more services in our community.

Thank you for your time, devotion and support of NAMI.

Marla Byrnes

NAMI Syracuse President

Save the Date!

Sunday, September 8, 2019

5th Annual Harvest Hopela at Greenwood Winery

For the latest happenings at NAMI Syracuse visit us on **Facebook** and **LIKE** our page.

Like

facebook.com/NAMISyracuse

Register your current Amazon account with NAMI Syracuse Inc. today by going to:

smile.amazon.com

and Amazon will donate 0.5% of the price of your eligible AmazonSmile purchases to NAMI Syracuse!

RECEIVE THE NAMI SYRACUSE NEWSLETTER VIA EMAIL!

If you would like to receive this newsletter and other NAMI Syracuse correspondence through your email, please contact us at:

namisyracuse@namisyracuse.org

If we don't already have your e-mail address, please provide us with it.

Many of you have asked for this option for your convenience and to save NAMI Syracuse resources.

Please, take the time, and let us know.

2019 MARKS THE 25TH YEAR OF FALL CONFERENCES FOR NAMI SYRACUSE

Let's take a walk down memory lane with all the phenomenal educational conferences NAMI Syracuse has organized:

1994 Dr. Fred Frese, 1995 Dr. Kramer and Ed Knight, 1996 Dr. E. Fuller Torrey and Dr. Lewis Opler, 1997 Kimberly Littrell and Dr. Ralph Aquila, 1998 Margo Kidder, 1999 William Styron, 2000 Dan Kindlon, 2001 Xavier Amador, 2002 Dr. Papolos and David Kaczynski, 2003 Dr. E. Fuller Torrey and Ed Knight, 2004 Dr. Kay Redfield Jamison and Bill Mac Phee, 2005 Dr. Dewan and Sister Ann Smollin, 2006 Dr. Fred Frese, 2007 Dr. Michael Hogan, Ralph Blackshear, and Ann Costello, 2008 Dr. Thomas Schwartz, Dr. Dewan, Dr. Coolhart, Dr. Salerno, 2009 Dr. Kenneth Hershon, Dr. Brian Johnson, and Annette Becker, 2010 Dr. Mark Cattalani and Dr. Karen Winters-Schwartz, and Jan Saccone, 2011 John Allen and Dr. Ghaly, 2012 Bill Cross and Dr. Karen Winters - Schwartz, Dr. Morrissey, panel from Sunrise Recovery Center, 2013 Eric Weaver, Dr. Knoll, 2014 Dr. Abdul Ahmed, Stephen Kussisto, Dr. Rich O'Neill, Sheila Le Gacy, 2015 Dr. Sunny Aslam, Sherie Ramsgard 2016 Dr. Paula Zebrowski, 2017 Dr. Kelly Richards, Dr. Ghaly, Sherie Ramsgard, 2018 Dr. Malika Carter, Dr. Julio Licinio, Sherie Ramsgard.

Save the date for our 25th annual conference October 2, 2019 at the Rosamond Gifford Zoo. The theme for the day will be **Responding to Crisis**. It's a solid line up of Dr. Tarun Kumer - *Assessing Dangerousness to Self and Others*; Helio Health Staff, Jonathan Moe and Ron Wood - *Incorporating Crisis Response into Outpatient Services*; Sheila Le Gacy, *What Families Need to Know*; a panel of peers - *What Helps in Crisis and What Doesn't*; a CIT panel with Camillus Police Department and Liberty Resources Mobile Crisis Team. We look forward to this auspicious occasion.

UPDATE FROM CONGRESSMAN JOHN KATKO

Mental illness does not discriminate. It afflicts millions of Americans regardless of age, social status, incomes, or background. Far too many individuals and families in our community are coping with mental illness and do not have access to the resources and support they deserve. Since coming to Congress, I've made advocating for policies that reduce stigma, increase access to affordable mental healthcare, and strengthen early diagnosis efforts one of my top priorities. I'm glad to share with you the actions I have taken this Congress to continue these efforts and to close the gaps in our mental healthcare system.

With only one third of those with a mental illness receiving mental health treatment, it is critical that we address the lack of accessible mental healthcare in our country. I am proud to have introduced two bipartisan pieces of legislative that will broadly improve access to mental health treatment: The Mental Health Access Improvement Act and the Mental Health Services for Students Act. The Mental Health Access Improvement Act expands Medicare coverage of mental health professionals to include marriage and family therapists and mental health counselors. Older Americans have some of the highest rates of mental illness, and this bill takes an important step towards ensuring every senior in need has access to mental health treatment. In addition to rising rates of mental illness amongst older Americans, we are seeing increasing rates amongst our youth. My bill, the Mental Health Services for Students Act, establishes a program to increase mental health services on public school campuses across the country. The earlier children with mental health concerns are diagnosed and receive treatment and appropriate supports, the better outcome they have. I will continue to be a champion for these policies and others that increase access to mental health screening and treatment.

Across the country, including in Central New York, communities are experiencing a shortage of mental health professionals, driving up treatment costs and reducing access to quality care. In the coming weeks, I will reintroduce the Mental Health Professionals Workforce Shortage Loan Repayment Act, legislation that seeks to increase the amount of certified mental health practitioners. The bill incentivize individuals to enter the mental health field and practice in an underserved area through a student loan repayment program. Reducing the burden of student loans on mental health practitioners who decide to practice in underserved areas creates a reliable labor force of mental health professionals, addressing a critical labor shortage that is impacting mental healthcare in our community and countless others across the country.

Mental illness is a public health concern that must be addressed as the epidemic it is. Whether I am in Central New York or Congress, I will always stand up for the victims of mental illness and advocate for policy which raises awareness of mental illness and increases prevention, early identification, and treatment for those suffering.

LEADERSHIP CHANGE AT NAMI NATIONAL OFFICE

NAMI, the National Alliance on Mental Illness, has announced the resignation of its Chief Executive Officer, Mary Giliberti, effective April 24th, as she departs to pursue more time with her family.

Angela Kimball, NAMI national director of advocacy and public policy, has been named by the NAMI Board of Directors to serve as acting CEO. Kimball will lead an executive management team of internal leadership to ensure the organization continues its successful trajectory of growth and impact.

Leadership Changes at the NYS Office of Mental Health

After almost 12 years in the role of Chief Medical Officer of the NYS Office of Mental Health, Dr. Lloyd Sederer is stepping down from this role. He will continue with OMH in the capacity of Distinguished Psychiatrist Advisor.

Dr. Thomas Smith has been appointed as the new Chief Medical Officer of the NYS Office of Mental Health.

PSYCHIATRY'S INCURABLE HUBRIS - THE BIOLOGY OF MENTAL ILLNESS IS STILL A MYSTERY, BUT PRACTITIONERS DON'T WANT TO ADMIT IT

book review by Gary Greenberg, April 2019

Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness by Anne Harrington Norton

In 1886, Clark Bell, the editor of the journal of the Medico-Legal Society of New York, relayed to a physician named Pliny Earle a query bound to be of interest to his journal's readers: Exactly what mental illnesses can be said to exist? In his 50-year career as a psychiatrist, Earle had developed curricula to teach medical students about mental disorders, co-founded the first professional organization of psychiatrists, and opened one of the first private psychiatric practices in the country. He had also run a couple of asylums, where he instituted novel treatment strategies such as providing education to the mentally ill. If any American doctor was in a position to answer Bell's query, it was Pliny Earle.

Earle responded with a letter unlikely to satisfy Bell. "In the present state of our knowledge," he wrote, "no classification can be erected upon a pathological basis, for the simple reason that, with slight exceptions, the pathology of the disease is unknown." Earle's demurral was also a lament. During his career, he had watched with excitement as medicine, once a discipline rooted in experience and tradition, became a practice based on science. Doctors had treated vaguely named diseases like ague and dropsy with therapies like bloodletting and mustard plasters. Now they deployed chemical agents like vaccines to target diseases identified by their biological causes. But, as Earle knew, psychiatrists could not peer into a microscope to see the biological source of their patients' suffering, which arose, they assumed, from the brain. They were stuck in the premodern past, dependent on "the apparent mental condition [his emphasis], as judged from the outward manifestations," to devise diagnoses and treatments.

The protracted attempt to usher psychiatry into medicine's modern era is the subject of Anne Harrington's Mind Fixers: Psychiatry's Troubled Search for the Biology of Mental Illness. As her subtitle indicates, this is not a story of steady progress. Rather, it's a tale of promising roads that turned out to be dead ends, of treatments that seemed miraculous in their day but barbaric in retrospect, of public-health policies that were born in hope but destined for disaster.

Some of the episodes Harrington recounts are familiar, such as Egas Moniz's invention of the lobotomy, which garnered him a Nobel Prize in 1949, at just about the same time that the psychiatrist Walter Freeman was traveling the United States using a surgical tool modeled on an ice pick to perform the operation on hapless asylum inmates. She has retrieved others from history's dustbin. In the 1930s, for example, insulin was used to render mental patients comatose in hopes that they would wake up relieved of their psychoses. And in at least one case-the deinstitutionalization of mental patients in the 1960s and '70s-she has given an old story a new twist. That movement, she argues convincingly, was spearheaded not by pill-happy psychiatrists convinced that a bit of Thorazine would restore their patients to full functioning, but by Freudians. They saw the antipsychotic drugs invented in the 1950s as a way to render patients suitable for the outpatient treatment that psychoanalysts were equipped to provide.

From ice baths to Prozac, each development Harrington describes was touted by its originators and adherents as the next great thing-and not without reason. Some people really did emerge from an insulin coma without their delusions; some people really are roused from profound and disabling depressions by a round of electroconvulsive therapy or by antidepressant drugs. But in every case, the treatment came first, often by accident, and the explanation never came at all. The pathological basis of almost all mental disorders remains as unknown today as it was in 1886-unsurprising, given that the brain turns out to be one of the most complex objects in the universe. Even as psychiatrists prescribe a widening variety of treatments, none of them can say exactly why any of these biological therapies work.

It follows that psychiatrists also cannot precisely predict for whom and under what conditions their treatments will work. That is why antipsychotic drugs are routinely prescribed to depressed people, for example, and antidepressants to people with anxiety disorders. Psychiatry remains an empirical discipline, its practitioners as dependent on their (and their colleagues') experience to figure out what will be effective as Pliny Earle and his colleagues were. Little wonder that the history of such a field-reliant on the authority of scientific medicine even in the absence of scientific findings-is a record not only of promise and setback, but of hubris.

That word does not appear in Mind Fixers, despite its repeated accounts of overreach by enthusiastic doctors who are often the last to recognize the failure of their theories. As Harrington tells us at the outset, she is committed to restraint. "Heroic origin stories and polemical counterstories may give us momentary emotional satisfaction," she writes. But the result-"tunnel vision, mutual recrimination, and stalemate"-is not very useful. By presenting a just-the-facts narrative of the attempt to find biological sources of mental suffering, particularly in the brain, she hopes to get the "fraught" enterprise of psychiatry back on the path to progress.

Harrington is right to sigh over what has too often proved to be a yelling match between equally deaf opponents-members of an ambitious profession convinced that psychiatry is making strides toward understanding mental illness, and critics who believe it is at best a misguided attempt to help suffering people and at worst a pseudoscience enabling social control at the expense of human dignity. Indeed, since the sides first squared off, more than half a century ago, they seem to have learned little from each other.

As Harrington ably documents, a series of fiascoes highlighted the profession's continued inability to answer Clark Bell's question. Among them was the 1973 vote by the American Psychiatric Association declaring that homosexuality was no longer a mental illness. The obvious question-how scientific is a discipline that set-

tles so momentous a problem at the ballot box?-was raised by the usual critics. This time, insurers and government bureaucrats joined in, wondering, often out loud, whether psychiatry warranted their confidence, and the money that went along with it.

The association's response was to purge its Diagnostic and Statistical Manual of Mental Disorders (DSM) of the Freudian theory that had led it to include homosexuality in the first place. When the third edition of the DSM came out, in 1980, its authors claimed that they had come up with an accurate list of mental illnesses: Shedding the preconceptions that had dominated previous taxonomies, they relied instead on a theoretical descriptions of symptoms. But as Harrington points out, they did have a theory-that mental illness was no more or less than a pathology of the brain. In claiming not to, she argues, they were being disingenuous. They believed that biological....markers and causes would eventually be discovered for all the true mental disorders. They intended the new descriptive categories to be a prelude to the research that would discover them.

The DSM-3's gesture at science proved sufficient to restore the reputation of the profession, but those discoveries never followed. Indeed, even as the DSM (now in its fifth edition) remains the backbone of clinical psychiatry-and becomes the everyday glossary of our psychic suffering-knowledge about the biology of the disorders it lists has proved so elusive that the head of the National Institute of Mental Health, in 2013, announced that it would be "re-orienting its research away from DSM categories."

The need to dispel widespread public doubt haunts another debacle that Harrington chronicles: the rise of the "chemical imbalance" theory of mental illness, especially depression. The idea was first advanced in the early 1950s, after scientists demonstrated the principles of chemical neurotransmission; it was supported by the discovery that consciousness-altering drugs such as LSD targeted serotonin and other neurotransmitters. The idea exploded into public view in the 1990s with the advent of direct-to-consumer advertising of prescription drugs, antidepressants in particular. Harrington documents ad campaigns for Prozac and Zoloft that assured wary customers the new medications were not simply treating patients' symptoms by altering their consciousness, as recreational drugs might. Instead, the medications were billed as repairing an underlying biological problem.

The strategy worked brilliantly in the marketplace. But there was a catch. "Ironically, just as the public was embracing the 'serotonin imbalance' theory of depression," Harrington writes, "researchers were forming a new consensus" about the idea behind that theory: It was "deeply flawed and probably outright wrong." Stymied, drug companies have for now abandoned attempts to find new treatments for mental illness, continuing to peddle the old ones with the same claims. And the news has yet to reach, or at any rate affect, consumers. At last count, more than 12 percent of Americans ages 12 and older were taking antidepressants. The chemical-imbalance theory, like the revamped DSM, may fail as science, but as rhetoric it has turned out to be a wild success.

Harrington's dispassion as she chronicles the rise and fall of various biological theories of mental illness will make this book of value to historians of medicine. It may even allow critics and advocates of biological psychiatry alike to gain a deeper appreciation of the historical stream in which they are swimming, and to stop trying to drown one another. But her restraint carries a risk: that she will underplay the significance of the troubles she is reporting.

Modern medicine pivots on the promise that portraying human suffering as biological disease will lead to insight and cures. Inescapably, this enterprise has a sociopolitical dimension. To say which of our travails can (and should) come under medicine's purview is, implicitly if not explicitly, to present a vision of human agency, of the nature of the good life, of who deserves precious social resources like money and compassion. Such questions, of course, aren't always pressing; the observation that a broken leg is a problem only in a society that requires mobility seems trivial.

But by virtue of its focus on our mental lives, and especially on our subjective experience of the world and ourselves, psychiatry, far more directly than other medical specialties, implicates our conception of who we are and how our lives should be lived. It raises, in short, moral questions. If you convince people that their moods are merely electrochemical noise, you are also telling them what it means to be human, even if you only intend to ease their pain.

In this sense, the attempt to work out the biology of mental illness is different from the attempt to work out the biology of cancer or cardiovascular disease. The fact that the brain is necessary to consciousness, added to the fact that the brain is a chunk of meat bathing in a chemical broth, does not yield the fact that conscious suffering is purely biological, or even that this is the best way to approach mental illness. Those unresolved, and perhaps unanswerable, moral questions loom over the history that Harrington traces here. The path she has chosen may require her to steer clear of such knotty concerns as the relationship of mind to brain or the relationship of political order to mental illness. But her account doesn't just skirt the polemics she decries. It also overlooks the consequences of psychiatrists' ignoring those questions, or using scientific rhetoric to conceal them.

At the risk of being polemical, let me suggest that Harrington's word disingenuous fails to describe the cynicism of Robert Spitzer, the editor of the DSM-3, who acknowledged to me that he was responding to the fact that "psychiatry was regarded as bogus," and who told me that the book was a success because it "looks very scientific. If you open it up, it looks like they must know something." Nor does ironic accurately describe the actions of an industry that touts its products' power to cure biochemical imbalances that it no longer believes are the culprit. Plain bad faith is what's on display, sometimes of outrageous proportion. And like all bad faith, it serves more than one master: not only the wish to help people, but also the wish to preserve and increase power and profits.

Harrington ends her book with a plea that psychiatry become "more modest in focus" and train its attention on the severe mental illnesses, such as schizophrenia, that are currently treated largely in prisons

and homeless shelters-an enterprise that she thinks would require the field "to overcome its persistent reductionist habits and commit to an ongoing dialogue with....the social sciences and even the humanities." This is a reasonable proposal, and it suggests avenues other than medication, such as a renewed effort to create humane and effective long-term asylum treatment. But no matter how evenhandedly she frames this laudable proposal, an industry that has refused to reckon with the full implications of its ambitions or the extent of its failures is unlikely to heed it.

Two Regional Behavioral Health Agencies are Merging

Helio Health and **Central New York Services**, two of the Syracuse area's biggest nonprofit behavioral health agencies are merging.

The combined operation, which will keep the Helio Health name, will have a $70 million annual budget and 729 employees.

Helio Health, formerly known as Syracuse Behavioral Healthcare, serves people with substance abuse and mental health disorders in Syracuse, Rochester, Binghamton and Utica.

Central New York Services provides services to people with mental illness, substance abuse problems and developmental disabilities in Onondaga and Oneida counties.

Jeremy Klemanski, currently president and CEO of Helio Health, will remain in that position when the agencies merge.

John Warren, executive director of Central New York Services, will become vice president of residential construction and development.

~~from The Syracuse Post-Standard, James T. Mulder, April 14, 2019

DOCTORS SAY HOW TO QUIT ANTIDEPRESSANTS: VERY SLOWLY

by Benedict Carey, March 5, 2019

Mustering solid evidence, two researchers have denounced the standard psychiatric guidelines for how best to wean patients from depression medications.

Patients who very gradually reduced their daily dose of antidepressants over time, after years of use, were less likely to experience withdrawal symptoms.

Thousands, perhaps millions, of people who try to quit antidepressant drugs experience stinging withdrawal symptoms that last for months to years: insomnia, surges of anxiety, even so-called brain zaps, sensations of electric shock in the brain.

But doctors have dismissed or downplayed such symptoms, often attributing them to the recurrence of underlying mood problems.

The striking contrast between the patients' experience and their doctors' judgment has stirred heated debate in Britain, where last year the president of the Royal College of Psychiatrists publicly denied claims of lasting withdrawal in "the vast majority of patients."

Patient-advocacy groups demanded a public retraction; psychiatrists, in the United States and abroad, came to the defense of the Royal College. Now, a pair of prominent British psychiatric researchers has broken ranks, calling the establishment's position badly mistaken and the standard advice on withdrawal woefully inadequate.

In a paper published recently in Lancet Psychiatry, the authors argued that any responsible withdrawal regimen should have the patient tapering off medication over months or even years, depending on the individual, and not over four weeks, the boilerplate advice.

The paper is by far the strongest research-backed denunciation of standard tapering practice by members of the profession.

"I know people who stop suddenly and get no side effects," said Dr. Mark Horowitz, a clinical research fellow at Britain's National Health Service and University College London, and one of the paper's authors.

But many people, he said, "have to pull apart their capsules and reduce the dosage bead by bead. We provided the science to back up what they're already doing."

The field of psychiatry has conducted few rigorous studies of antidepressant withdrawal, despite the fact that long-term prescription rates in the United States and Britain have doubled over the past decade, with similar trends in other Western countries.

More than 15 million Americans have taken the medications for at least five years, a rate that has almost more than tripled since 2000, according to a New York Times analysis of federal data.

Outside researchers who have studied withdrawal said the new paper was a welcome contribution. "I think what they've presented really reinforces what I've observed in clinical practice in many patients, and it's almost identical to the tapering regimen I use," said Dr. Dee Mangin, the chair of family medicine at McMaster University in Canada, who was not involved in the paper.

Dr. Mangin, who is completing her own two-year study of Prozac withdrawal, added, "The other important thing is that it validates patients' own reports of their experiences. It's tremendously frustrating when patients describe a different experience than physicians expect, and don't feel they're being heard."

Dr. Horowitz and his co-author, Dr. David Taylor, a professor of psychopharmacology at King's College London and a member of the South London and Maudsley N.H.S. Foundation Trust, decided to address the topic in part because of their own experiences with medication.

Dr. Horowitz said he had severe withdrawal symptoms after tapering down after 15 years on antidepressants. Dr. Taylor had previously written about his own struggles trying to taper off.

The two researchers began by visiting online forums in which people on antidepressants advised one another how best to withdraw. Those sites consistently recommended "micro-dosing," reducing doses by ever smaller amounts over months or years, sometimes by removing one bead at a time from capsules.

(continued next page)

The two researchers dug into the literature and found a handful of studies that provided evidence for that method.

In one 2010 study cited in the new paper, Japanese researchers found that 78 percent of people trying to taper off Paxil suffered severe withdrawal symptoms. The research team had them taper much more slowly, over an average of nine months and for as long as four years. With this regimen, only 6 percent of subjects experienced withdrawal.

In another study, Dutch researchers in 2018 found that 70 percent of people who'd had trouble giving up Paxil or Effexor quit their prescriptions safely by following an extended tapering regimen, reducing their dosage by smaller and smaller increments, down to one-fortieth of the original amount. This is the regimen recommended in the new paper.

Dr. Horowitz and Dr. Taylor also cited brain-imaging evidence. Antidepressants such as Paxil, Zoloft and Effexor work in part by blocking the serotonin transporter, a molecule that works in the synapses between brain cells to clear out the chemical serotonin, which is thought to help impart a sense of well-being in some people. By blocking the transporter, antidepressants prolong and enhance serotonin's effects.

But the brain-imaging studies found that inhibition of the transporter increases sharply with addition of the drug and, by extension, also drops sharply with any reduction in dosage. The standard medical advice, to reduce dosage by half - for instance, by taking a pill every other day - and end medication entirely after four weeks, does not take this into account, the two researchers argued.

"Doctors have in mind that these drugs act in a linear way, that when you reduce dosage by half, it reduces the effect in the brain by a half," Dr. Horowitz said. "It doesn't work that way. And as a result, there's a huge load in terms of the effect on brain receptors, and patients are being advised to come off way too quickly."

Laura Delano, executive director of Inner Compass Initiative, a nonprofit organization that runs The Withdrawal Project and focuses on helping people learn about safer psychiatric drug tapering, said: "I didn't know about the benefits of slow tapering when I came off five meds in five months, and had a very difficult time in withdrawal."

The new paper, she added, "speaks to how hard it is to get this information into the clinical world. We laypeople have been saying this for a long time, and it's telling that it took psychiatrists coming off meds themselves for this information to finally be heard."

Dr. Horowitz and Dr. Taylor called for more, and more careful, research to be done on withdrawal, to bring their field up to speed, and to develop withdrawal strategies tailored to individual patients and individual drugs.

"I think psychiatrists are taught to learn things from textbooks and from well-conducted studies," Dr. Horowitz said. "We don't have many of those for withdrawal, so it makes it hard to believe it's real. And psychiatrists spend a lot more time prescribing things than stopping them."

Benedict Carey has been a science reporter for The Times since 2004. He has also written three books, "How We Learn" about the cognitive science of learning; "Poison Most Vial" and "Island of the Unknowns," science mysteries for middle schoolers.

Dementia Care 2019
May 22, 2019 8:00am-4:00pm
Holiday Inn Syracuse

Dementia Care 2019 is the eighth annual conference for dementia in Central New York. Our programs, expo and speakers will empower dementia caregivers with practical solutions they can apply immediately.

Main speaker, Teepa Snow is North America's leading dementia educator.

Registration fee, $80.00, includes access to all sessions and interactive expo, a conference manual, continental breakfast and lunch.

Registration closes on May 15th. To register online, visit www.alz.org/cny and click the Dementia Care 2019 link. To register by phone or for more information, call 315-472-4201.

May is National Mental Health Month

Mental Health Month raises awareness of trauma and the impact it can have on the physical, emotional and mental well-being of children, families, and communities. Mental Health Month was established in 1949 to increase awareness of the importance of mental health and wellness in American's lives, and to celebrate recovery from mental illness. Mental health is essential for a person's overall health. Prevention works, treatment is effective, an people can recover from mental disorders and live full and productive lives.

Throughout the month of May, our NAMI Syracuse "Nothing to Hide: Mental Illness in the Family" photo/text exhibit will be displayed at the Onondaga Free Library, 4840 West Seneca Turnpike, Syracuse 13215. This photo/text display was created by Family Diversity Projects of Amherst, Massachusetts. Besides striking photographs, it includes text from interviews from families in which one or more individuals have been diagnosed with a psychiatric illness.

In addition, on Sunday, May 18th at 1:00pm, the library will host an hour long presentation of Ending the Silence with Tanisha Wiggins, Joe Ridgway, and Beckie and Danae Hidy. The presentation is open to the public. Please join us or stop in and view the Nothing to Hide exhibit.

"I sometimes feel like my head is a computer with too many windows open."

~~Matt Haig
Notes on a Nervous Planet

In Memoriam

We offer our sympathy and condolences to the family of George and James Kirkpatrick on the passing of wife and mother, Muriel.

George and Muriel have been members of NAMI since 1988.

DOES DEPRESSION LEAD TO ALCOHOL & DRUG ADDICTION?

from ***rtor.org***

When we are trying to understand the roots of alcohol and drug addiction, we often must investigate brain chemistry and the history of the individual. There are many risk factors that may lead to the overindulgence of alcohol and use of drugs to self-medicate or manage moods. It is common to see depression coincide with a drug or alcohol problem, but does depression itself lead to addictions?

What Is Depression?

Depression is a result of complex changes within the brain that result in increased feelings of loneliness, a loss of pleasure or joy in life, changes in appetite, trouble sleeping or an inability to concentrate. These brain changes can be exacerbated by drug and alcohol use as the prefrontal cortex and hippocampus shrink in size due to overconsumption. But many people who are depressed may still seek relief through alcohol and drugs.

Alcoholism and Drug Addiction

Alcohol and drug abuse can develop into the serious disease of addiction. Ongoing use alters brain chemistry and makes it increasingly difficult to resist the drug. The flood of dopamine and serotonin creates an addiction cycle which requires increasingly large amounts of the substance to produce the same effect.

This makes addiction a progressive problem that tends to get worse with time. An individual suffering from depression may find instant relief when using alcohol or drugs, due to the flood of dopamine. But this sense of relief will deteriorate over time and require the user to increase the dosage, leading to the cycle of the addiction.

Coping Strategies and Behaviors

Coping behaviors are the strategies and tools we develop in order to deal with stress and trauma. Hardships are commonplace in most of our lives, but we find the strength to deal with them through healthy or unhealthy coping strategies. Sometimes coping behaviors are destructive, leading to dysfunctional behaviors, addictions, regression, and even illness. But we can also choose to seek out positive coping strategies for dealing with our pain and sadness.

Many people turn to drugs and alcohol to cope with their stress, pain, and depression. It may provide temporary relief but in exchange, there are many negative effects that accumulate over time. These behaviors can reward the brain, leading us to feel as if unhealthy alcohol or drug use is a good thing. But with time, the ability to make better decisions is degraded as the brain is damaged from the addiction abuse. A person who is depressed may struggle even more to make healthy decisions regarding resisting an addiction they developed in response to their emotional pain or suffering.

Potential Influences on Depression Leading to Addiction

Many individuals who suffer from a form of mental illness may struggle with the use of drugs or stimulants to manage the symptoms of their illness. Alcohol and drugs can provide a way to connect with others and escape from the struggles of their daily life. Depression commonly coincides with addiction and may make it even more difficult to resist utilizing drugs as a way to cope or to stop using when the addiction cycle has already begun.

Support Systems and Dysfunctional Family Patterns

When individuals face depression, the family or support circle available to them often make a significant impact in their recovery or regression. If they have friends and family who encourage them to take meaningful action towards recovery and to seek help, they may be able to learn the necessary coping skill to help them out of their depressed states.

On the other hand, dysfunctional family situations or friend groups who encourage drug or alcohol abuse may inflame the situation. Dysfunctional families may be emotionally or verbally abusive, which can further push people into depression and make them feel unsafe about reaching out for help. This can drive some people to turn to self-medicating for a sense of relief.

If the same individuals turn to friend groups who encourage the abuse of drugs and alcohol, they may find new unhealthy coping mechanisms that allow them to escape their troubles and receive the social acceptance they crave. This cycle can lead to a spiraling downward, where seeking support means being abused and feeling better is only found through drug or alcohol abuse.

Childhood Trauma

Those who suffer significant trauma may continue through life struggling with post-traumatic stress, anxiety, flashbacks, and ongoing depression. These individuals may struggle to find any relief from the after-effects of their traumatic experience. Often, in order to become free from these pains and struggles, they must go through a significant amount of counseling or therapy.

They may feel constantly plagued by their past and have trouble relaxing or feeling safe at all. For these individuals, the need to find effective coping strategies may be enormous. In order to endure intense emotional trauma, the brain has many methods to prevent mental breakdown. One mechanism is to compartmentalize the trauma so that the rest of the mind disassociates from the painful memories.

Alcohol and drugs can be a powerful tool to further enable this disassociation.

Disassociating can be a powerful urge for those who are suffering from depression that is related to a traumatic experience. In this circumstance, a serious bout of depression may be managed with the use of drugs and alcohol. These may help the person get through these tough times but may lead to an eventual addiction forming.

Conclusion

Depending on the reason for using alcohol and drugs, the level of healthy support individuals have in life, the amount of unprocessed trauma present, and their ability to deal with stress and make complex executive decisions in regard to their future will determine if depression leads to alcoholism or drug abuse.

It is certainly a common cycle to see depression co-exist with a drug or alcohol problem, or for an individual to choose an addiction in order to cope with depression. But there are many different reasons that lead people to abuse drugs and alcohol and those with depression have a choice in how they cope.

It is up to each individual to decide how to act to handle problems. Everyone gets to decide what coping strategies to use to find peace through times of suffering.

Secret life of a manic

It's hard having ups and downs
Manic makes me feel like I should be wearing a crown
The excitement it brings
Later may put me to shame
But in the moment it feels so good
To others I'm misunderstood
In this state I may not realize
The people that are fighting by my side
I put my feet in their shoes
The pain I caused I see the bruise
You see the coming
Of the down
I'm feeling like I have drowned
The crash came unannounced
Emotions are like a ball that bounce
Through it all your love is shown
Taking on my pain you do not own
Feeling guilty of your pain
The suffering I caused has left a stain
To the people that stood by me
I hear your prayers I see your plea
Your commitment is not unseen
It's not your fault it's unforeseen
Your love and prayers is what keeps me going
You helped me through even unknowing
The outcome of your support
I know this is no resort
I recognize us not giving up
During this time of a hiccup

~~by Tanisha Wiggins

Do You Need Help Accessing Addiction or Mental Health Care?

Community Health Access to Addiction Mental Healthcare Project (CHAMP) can help you.

Call our Helpline (888) 614-5400

Monday-Friday 9am - 4pm

Services are free and confidential

HOW TO COMMUNICATE MORE EASILY WITH SOMEONE IN PSYCHOSIS

from HealthyPlace.com

Do you have someone in your life who experiences psychosis? If so, you might have discovered that communication can become very difficult. There are ways to communicate with someone having a psychotic episode that will reduce stress-both yours and the person you need to talk to.

Psychosis, which is a separation from reality involving hallucinations (sensing something that isn't there) and/or delusions (firmly believing something that isn't real), can be frightening, intimidating, confusing and overwhelming for everyone involved. Trying to talk to someone experiencing delusions or hallucinations can be challenging because you're both living in different worlds. Try these tips to improve communication when talking to someone in psychosis:

- Keep your statements short, simple, and clear
- Use a calm voice and steady tone
- Give the person physical space rather than crowding them
- Acknowledge what they're experiencing and how they might be feeling
- Don't argue with or challenge the delusions or hallucinations
- But don't pretend to believe them yourself
- Be neutral but not placating-give matter-of-fact statements acknowledging that their experience is real to them
- Ask them to help you understand what they're experiencing

Communicating with someone in psychosis this way helps them feel heard and supported while not overwhelming, arguing, or leading them to believe that their imagined reality is accurate. Your conversations can become less frustrating.

Thank you to those who have recently joined or renewed membership and/or made a donation to NAMI Syracuse!

Alice Edwards Circle, First Presbyterian Church, Casenovia
Katherine Beissner
Aida Caputo
Kakeera Clark
Crown Risk Management, LLC
Judy Donnelly
Mary Donovan
Carolyn Farney
Marie Fosia
Gerald & Deana Gugger
Thomas & Kate Hayden
Patricia Hetrick
Susan Hutko
Kathy Kennedy
Raymond & Dorothy Kimber
Michele Klock
Sheila Le Gacy & Bill Cross
James Livi
John McCrea
Lauren Melnikow
Jerry & Lydia Miner
Patricia Moore
Mark Morris
Patricia Murray
Katie Nash
Julie Pontante
Kryssy Ridgway
Patricia Schwartzlander
Jeanette Spottek
Rita Thompson
Erkki & Perkki Turkki
Kathleen Wagner
Jenna Weitzel
Mitzi Wolf
Wendy Zera

Thank you to the NAMI Syracuse members and friends who donated to the Off the Mask Fundraiser to help Madeline Canastra reach her goal of $2500!

BECOME A MEMBER OF NAMI SYRACUSE TODAY!

_____ Household Membership $60.00

_____ Individual Membership $40.00

_____ Open Door Membership $ 5.00 (for those on a limited income)

Donation $_____ In Memory/Honor of $_____ Name: _____

Name: _____

Address: _____

Tel. # _____ E-Mail: _____

Mail to: NAMI Syracuse Inc., 917 Avery Avenue, Syracuse, NY 13204

What are the benefits of NAMI membership?

- **Membership at all three levels of the organization: NAMI National, NAMI-NYS & NAMI Syracuse**
- **Eligibility to vote in all NAMI elections**
- **A subscription to The Advocate, NAMI National's quarterly magazine, as well as access to optional subscriptions to speciality newsletters and information at the national, state and local levels**
- **Discounts on publications, promotional items, and registration at NAMI's annual convention, state and local conferences**
- **Access to exclusive members-only material on NAMI National's website**

NAMI Syracuse
Family Support Group

2nd Wednesday of each month

NAMI Syracuse office
917 Avery Avenue, Syracuse

10-11:30am

Facilitated by:
Ann Canastra
Marla Byrnes

NAMI Syracuse
Family Support Group

3rd Tuesday of each month

AccessCNY
420 E. Genesee St., Syracuse
(parking & entrance in rear of building)

7:00pm

Facilitated by:
Sheila Le Gacy
Carol Notar