DBSA-CA NEWS

Depression and Bipolar Support Alliance–California
(formerly California Depressive and Manic-Depressive Association)

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DBSA

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Redefining Practical Psychoanalysis

A Scientific Approach Brings Psychoanalysis into the 21st Century

In Dr.Owen Renik's latest book, Practical Psychoanalysis for Therapists and Patients, he attempts to dispel the myth that psychoanalysis is an impractical "science" focused only on the journey to self-discovery. In the excerpt below, he further elaborates on what he refers to as the "oxymoron of practical psychoanalysis" and paints a new picture of an often misunderstood and under-rated type of therapy. - Editor Julie Rutledge

"...No surprise...that psychoanalysis has come to be regarded by the public at large as an esoteric practice that promotes a self-involved escape from real life, rather than a treatment method that helps the patient live real life more happily. No surprise, either; that all over the world fewer and fewer patients seek psychoanalytic treatment, and that those who do are for the most part people who want to become psychoanalysts themselves or fellow travelers who have an intellectual interest in the field. Clinical psychoanalysis has become, deservedly, the stuff of *New Yorker* cartoons.

This unfortunate state of affairs is ironic, considering that psychoanalysis got its start on the basis of its therapeutic efficacy. In the course of their researches, Breuer and Freud stumbled upon a method for relieving notoriously difficult-to-treat hysterical symptoms. Though Freud was a fascinating and imaginative writer who developed far-reaching ideas about culture and society, as well as about individual psychology, the world originally paid attention to him because of the extraordinary cures he and Breuer achieved — and achieved very rapidly, too, in contrast to the expectations of contemporary psychoanalysts.

Over the years, psychoanalysis drifted away from its original orientation toward symptom relief as the desired outcome of treatment and became increasingly preoccupied with a special, specifically psychoanalytic goal: the achievement of "insight" for its own sake. In the process, psychoanalysts not only made themselves irrelevant to most people's needs, but, as many critics have pointed out, also compromised clinical psychoanalysis as a scientific investigative tool. How can the validity of insight be assessed? Insights reached by analyst and patient together about the latter's psychology are inevitably influenced by the former's theory. Therefore, unless insights are validated by correlation with symptom relief (an outcome criterion that is not theory-driven), a closed system is set up in which successful clinical analysis consists of analyst and

*Continued on page 2 (***Psychoanalysis)**

PSYCHOANALYSIS *(Continued from page 1)*

patient discovering what the analyst assumed apriori to exist. Impractical psychoanalysis is also unscientific psychoanalysis.

Clinical psychoanalysis has become impractical, but it does not have to be impractical. In order to offer patients practical psychoanalysis, however, clinicians cannot conduct treatment on the basis of received wisdom. To begin with, psychoanalysts cannot assume the virtue of any particular set of procedures — use of the couch, frequency of sessions, even the method of free association. These are techniques, and in the progressive development of any scientifically based clinical practice, techniques will alter, even alter dramatically, as empirical evidence accumulates; some prove valuable and are retained, others are discarded. Only two hundred years ago, for example, the best available medical science indicated that bleeding the patient through use of leeches or by venicotomy was part of the responsible standard of care for most illnesses. Almost every patient who consulted a physician was bled. We know now that this technique, which was practiced as a state of the art by the best physicians for centuries, was useless in almost all cases and dangerously detrimental in many.

Similarly, we have every reason to expect that the techniques of a scientifically based clinical psychoanalysis will alter over time. Therefore, it makes no sense to define clinical psychoanalysis as a particular set of techniques. Nor does it make sense to define clinical psychoanalysis as a particular set of theories, for these, too, will alter as science progresses. Even the most fundamental psychoanalytic concepts and principles should be critically reviewed at every turn, and we can anticipate that most will eventually be found obsolete. That's what happens in science. Practical psychoanalysis means remaining open-minded with regard to theory, holding nothing as axiomatic; and it means retaining an experimental approach to technique — that is, searching for whatever way of working together with a given patient seems to make progress toward the desired goals of treatment...

Unfortunately, practical psychoanalysts tend not to publicize what they do with patients; instead, they quietly set many traditional psychoanalytic theories and techniques aside and go about doing what works. Good for practical psychoanalysts and for their patients! But not good for the field. .

This is an excerpt from Practical Psychoanalysis for Therapists and Patients, written by Owen Renik, M.D., and published in September 2006 by Other Press.

By Owen Renik, MD., Training & Supervising Analyst, San Francisco Psychoanalytic Society

For more information contact: Owen Renik, MD., Training & Supervising Analyst, San Francisco Psychoanalytic Society, 2420 Sutter Street, San Francisco, California 94115; 415-563-5815; Fax: 415-563-8406; Web site: www.sfpis.org/

Source: OPEN MINDS, December, 2006

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Common genetic factors may underlie bipolarity and anxiety comorbidity

Study findings suggest that bipolarity shares common genetic factors with comorbidity for panic disorder, obsessive-compulsive disorder, and social phobia.

Steven Dilsaver (Rio Grande City Community Mental Health Mental Retardation Clinic, Texas, USA) and colleagues found that adolescents with bipolar disorder were more likely to have anxiety disorders than their peers with major depressive disorders, and the presence of one anxiety disorder increased the odds of having another.

Moreover, a dose-response relationship was detected between the number of anxiety disorders and measures of illness severity and familial loading for affective illness.

Dilsaver and co-workers interviewed 313 Latino adolescents using the clinician version of the Structured Clinical Interview for DSM-IV. Information on the participants' family histories was also collected.

In all, 36.7% of individuals had bipolar disorder and 44.7% had major depressive disorder (MDD) while 18.5% had no affective illness and served as controls.

Patients with bipolar disorder were 4.4 times more likely to have panic disorder than individuals with MDD, and 5.1 times and 3.3 times more likely to have OCD and social phobia, respectively.

In turn, MDD patients were more likely to have these disorders than controls, with respective odds ratios of 4.2, 11.1, and 14.3.

The presence of any anxiety disorder increased the chances of having another one. For example, OCD and social phobia increased the odds of having panic disorder 10- and five-fold, respectively.

Among the patients with bipolar disorder, but not those with MDD, the presence of panic disorder and social phobia comorbidity increased the risk of suicidal thoughts. Social phobia also increased the risk of suicide attempts.

For both bipolar and MDD patients, the risk of psychosis was increased if patients had all three anxiety disorders.

Furthermore, having a first-degree relative with bipolar disorder almost tripled the likelihood of panic disorder developing, and increased the risk of social phobia 3.7-fold. The risk of developing these anxiety disorders also increased among those who had a first-degree relative with any mood disorder, but to a lesser extent. In contrast, a family history of bipolar disorder or any mood disorder was not associated with OCD.

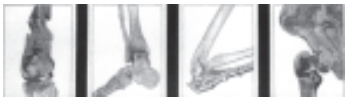
"The results are compatible with the hypothesis that heavy familial-genetic loading for affective illness in juveniles is associated with bipolarity, cumulative anxiety disorder comorbidity, suicidality, and psychosis," say Dilsaver, et.al. in the *Journal of Affective Disorders.*

They condude: "Anxiety comorbidity patterns in both adolescent and adult bipolar disorder might provide a future avenue for understanding the underlying genetic factors in the development of affective spectrum disorders."

Source: 3 Affect Disord 2006; 96: 249-258
http://www.psychiatrymatters.md/International/News/2007/Week_01/Day_1/Common_gen...
As seen in: PsychiatryMatters.MD/News Watch

Antidepressant use doubles risk of bone fracture, study says in adults 50 and older

Jan Ravensbergen
CanWest News Service



Tuesday, January 23, 2007

MONTREAL - Daily use of a widely prescribed class of antidepressants more than doubles the risk of low-trauma bone fractures for adults aged 50 and over, according to a study led by McGill University Health Centre researchers.

The study evaluated the incidence of such fractures — known as fragility fractures —among users of Zoloft, Prozac, Paxil, Celexa and Lexapro. It determined with a 95% confidence level that bone-fracture risk from simple events such as a fall from standing height increases by a factor of 2.1 when these antidepressants — known as selective serotonin reuptake inhibitors (SSRIs) — are being used on a daily basis.

"Basically what this shows is that the SSRIs produce a doubling in the risk of developing fractures than if you were not taking them, " Dr. David Goltzman, the study's senior author and director of McGill's Metabolic Bone Disease Centre, said yesterday after the report was released.

"It's still an association study, but it certainly suggests very strongly that SSRIs can pre-dispose to fractures, probably by reducing the amount of bone and possibly by altering the quality of bone as well.

The study also concluded daily SSRI use was associated with increased risk of falls and decreased bone-mineral density. SSRIs can cause a drop in blood pressure and fainting in some people.

Those 50 and older taking SSRIs should pay particular attention to lifestyle issues, Dr. Goltzman said, which include ensuring a diet rich in calcium and Vitamin D, regular physical activity, no alcohol and no smoking.

Source: canada.com
http;//www.canada.com/components/print.aspx?id=00882ab7-3d89-495b4c34ffe55e...

Current Research

Different Families, Different Characteristics — Different Kinds of Bipolar Disorder?

(Great Neck, N.Y. —January 30, 2007) — People with bipolar disorder (BPD) tend to share similarities in certain characteristics with other members of their families, according to new findings from researchers supported by the National Institute of Mental Health and NARSAD The Mental Health Research Association.

Because the levels of similarity vary among different families, the findings suggest the existence of different subtypes of BPD and may help determine if the subtypes have different causes.

The researchers reported in the December 2006 issue of the Archives of General Psychiatry that good social functioning "ran in the families" of some people with BPD, and poor social functioning ran in the families of others, with varying levels in between. In either case, the quality of social functioning was among the strongest similarity between members of each family.

The researchers also found that about 20 percent of the difference in social functioning had a genetic basis, although influence of shared family environment could not be ruled out as a contributor.

Other characteristics of the condition within families included the levels of substance abuse, alcoholism, psychosis, and suicide attempts. As with social functioning, some families tended to share high levels of these characteristics, while other families shared low levels. In either case, the level "ran in the family" of the person with BPD.

Breaking up the broad diagnosis of BPD into subtypes by including these familial characteristics can help researchers untangle the mix of genetic and environmental factors that contribute to this complex disorder, the researchers say. It will, for example, enable researchers to make better decisions about which characteristics to focus on in studies seeking genetic and other biological underpinnings of BPD. Ultimately, this may lead to better diagnosis and treatment.

Francis J. McMahon, M.D., a recipient of a 2006 NARSAD independent investigator grant, and Thothas G. Schulze, M.D., a recipient of a NARSAD Young Investigator grant from 2002, of the NIMH Mood and Anxiety Disorders Program, conducted the study with colleagues from the University of Illinois at Chicago, The Johns Hopkins

*Continued on page 5 (**Different**)*

Men and Women Have Different Risk Factors For Suicide

Findings suggest approaces that target each sex could help to prevent suicide

By Michael F. Grunebaum, M.D.

(Great Neck, NY - January 22, 2007) - Suicide is the third leading cause of death in people under 34 years old. It is more common than homicide, causing about 30,000 premature deaths each year in the United States. The vast majority of suicides are associated with psychiatric illness, most commonly depression.

Suicidal behavior tends to differ between males and females. Women make more suicide attempts, but men's attempts are more often fatal. More than half of all suicide deaths occur in a first suicide attempt. So identifying who is at greatest risk for a suicide attempt as early in treatment as possible may help to prevent suicides.

In an effort to improve understanding of risk factors for suicidal behavior, we conducted a two-year study of 314 persons suffering from depression or bipolar disorder. Our goal was to study how factors which increase the risk for suicide attempts are different for men versus women. The study was conducted in the Division of Neuroscience Research Clinic, Columbia University Medical Center/New York State Psychiatric Institute in New York City.

During the two-year study, results from which were published in the January issue of the *American Journal of Psychiatry*, we found that 17 percent of the patients attempted or committed suicide. In men, fami1y history of suicidal acts, past drug use, cigarette smoking, borderline personality disorder, and early parental separation each more than tripled the risk of future suicidal acts.

For women, each past suicide attempt increased future risk threefold. Suicidal ideation, seriousness of past attempts, hostility, subjective depressive symptoms, fewer reasons for living, borderline personality disorder, and cigarette smoking also increased the risk of future suicidal acts for women, but not to the same degree as a past attempt.

The results highlight some important facts. As with what we found with the women in this study, other research has shown that people who have made a past suicide attempt are at highest risk for future attempts. As with men in this study, \other research has shown that suicidal behavior is likely to

*Continued on page 5 (**Suicide**)*

SUICIDE *(Continued from page 4)*

have genetic components since it tends to cluster in families. Having borderline personality disorder in addition to a mood disorder increased the risk of suicidal acts for both men and women in this study, as did cigarette smoking. The role of cigarette smoking requires further research, but may involve its effects on brain chemicals involved in the biology of mood disorders.

Reasons for living had a stronger effect among women, possibly related to aspects of having children. Early parental separation had a stronger effect among men, raising intriguing questions about males' ability to form attachments to caregivers. Hostile-aggressive traits and substance abuse are other factors that prior research has found raise the risk of suicidal behavior.

This study raises questions for further research on how suicide risk factors may differ between males and females. Ultimately, understanding these factors may allow psychiatrists to provide more targeted interventions for men and women to prevent suicide. In the meantime, for persons at risk for suicide, their families and healthcare providers, it highlights the necessity of close follow-up and effective treatment of mood disorders, borderline personality traits and substance abuse with appropriate combinations of medication and/or counseling. The Division of Neuroscience, Columbia University Medical Center/New York State Psychiatric Institute is currently enrolling patients in additional studies of mood disorders and suicidal behavior.

Michael Grunebaum, M.D., an assistant professor of clinical psychiatry at Columbia University College of Physicians & Surgeons (P&S) and the New York State Psychiatric Institute (NYSPI), is supported by NARSAD: The Mental Health Research Association and the National Institute of Mental Health. J. John Mann, M.D., Ph.D., professor of psychiatry and translational neuroscience at P&S and chief of neuroscience at NYSPI, was senior author on the paper cited above and is a member of NARSAD's Scientific Council.

Source: NAMI Tulare County
March 2007

DIFFERENT *(Continued from page 4)*

University, and the University of Heidelberg. The scientists credited NARSAD with supporting Dr. Schulze for his work in this paper.

Source: Schulze T.G., Hedeker D., Rietschel M., McMahon J. What is Familial About Familial Bipolar Disorder? Archives of General Psychiatry, 63:1368-1376, December 2006. The National Institute of Mental Health gave NARSAD, The Mental Health Research Association permission to reprint the above press release.
As seen in: NAMI Tulare County
March 2007

Neurostimulation Among Top Ten Medical Innovations Expected to Shape Health Care in 2007

The Cleveland Clinic identified neurostimulation devices, used to relieve treatment-resistant depression (TRD) and obsessive-compulsive disorder, among the top ten medical innovations expected to influence health care in 2007. Four firms: Cyberonics, Medtronic, Neuronetics, and Northstar Neuroscience are developing neurostimulation therapy devices to treat psychiatric disorders. The Cyberonics Vagus Nerve Stimulation Therapy device received approval from the U.S. Food and Drug Administration (FDA) in July 2005, as a treatment for TRD. The Neuronetics device is scheduled for consideration by an FDA panel of outside experts in early 2007. Medtronic is working with the FDA to design a TRD clinical trial with patient enrollment scheduled to begin in 2007 and Northstar Neuroscience is conducting a clinical feasibility study of its cortical stimulation therapy system for the treatment of depression. Also topping the list of leading medical innovations are targeted cancer therapies, convection-enhanced delivery of drugs, and several techniques being used to treat cardiovascular disease.

The top ten medical innovations identified by the Cleveland Clinic were announced at the Cleveland Clinic Medical Innovation Summit held November 6-8, 2006. Selection criteria for the innovations included the technology's potential for short-term clinical impact; probability of successful treatment outcomes, market adoption, payer acceptance; proximity to market launch; and the bulk of efficacy documentation data.

Other emerging technologies selected in the top ten include the following: 1) Left Ventricular Assist System, an implantable device that senses when to increase or decrease the rate of blood flow to the heart; 2) Targeted cancer therapies; 3) Endografting, a technique now being used to treat vascular disease; 4) Ranibizumab, a drug therapy treating the cause of age-related macular degeneration; *5)* Bronchial Thermoplasty, a therapy to improve pulmonary function and curb asthma symptoms; 6) Optical Coherence Tomography, noninvasive imaging tech-nology used to treat and diagnose eye diseases; 7) Designer therapeutics using se1ective receptor antagonists; and 8) Cancer vaccines.

Source: OPEN MINDS
February 2007

Depression at Menopause

Two new studies find that the transition to menopause is linked to depression and imply that the depression is at least partly the result of hormonal changes.

In one study, 231 Philadelphia women, ages 35 - 47, were followed for eight years. All were premenopausal (had regular menstrual cycles) and none had ever been clinically depressed. During the study, 43% went into the menopausal transition, also called perimenopause: They began to have skipped and irregular periods and changes in menstrual blood flow. Women were four times more likely to report a high number of depressive symptoms during perimenopause than before, and twice as likely to develop clinical depression.

After correcting for possible effects of smoking, body mass index (a measure of weight-height ratio), premenstrual syndrome, hot flashes, and insomnia, as well as general health, marital and employment status, and age, the researchers found that depressive symptoms were correlated with changes in hormone production. The strongest risk factor for depression was a fluctuating level of the female hormone estradiol.

A 6-year study based on telephone interviews and questionnaires answered by 460 Boston women ages 36—45, none of whom had been depressed before, found that those who entered perimenopause (70%) were nearly twice as likely to develop serious depressive symptoms and clinical depression, regardless of age and stressful events such as divorce and death in the family.

The increased risk was greatest for women who had hot flashes. The researchers say that hot flashes can raise the risk of depression or that depression may result from the same hormonal changes that cause hot flashes. In this study, hormone replacement had no effect on depressive symptoms in general but did provide some relief for severe depression. The authors believe that by suppressing hot flashes, hormone replacement might at least temporarily improve depression in women undergoing menopause.

Cohen LS, et al. "Risk for New Onset of Depression during the Menopausal Transition: the Harvard Study of Moods and Cycles", *Archives of General Psychiatry* (April 2006): Vol. 63, No. 4, pp. 385—90.

Freeman EW, et al. "Associations of Hormones and Menopausal Status with Depressed Mood in Women with No History of Depression," *Archives of General Psychiatry* (April 2006): Vol. 63, No. 4, pp. 375—82.

Source: HARVARD MENTAL HEALTH LETTER
April 2007

Names will often hurt you

The children's rhyme denies it, but it may be true. Words are weapons that can cause lasting wounds, especially when wielded by parents against children. The damage is sometimes more serious and lasting than injuries that result from beatings, say Harvard researchers reporting on a survey of young adults.

More than 500 people aged 18 - 22 who responded to an advertisement were asked whether their parents had ever yelled at them, swore at them, insulted, threatened, or ridiculed them. Among those who reported no physical or sexual abuse, the researchers chose the 10% most often subject to this verbal abuse and compared them with controls.

All the participants answered a series of questionnaires about symptoms of depression, anxiety, anger, and especially dissociative experiences-split consciousness, out-of-body sensations, a sense of unreality. They were also asked about symptoms typical of temporal lobe epilepsy, including transient hallucinations and automatic actions, as well as dissociative experiences.

All types of abuse—sexual, physical, and emotional (including verbal abuse and witnessing domestic violence)—raised the risk of depression, anxiety, dissociation, and epilepsy-like symptoms. Emotional abuse had as great an effect as the other kinds, and verbal abuse was a particularly strong risk factor for dissociative episodes and epilepsy-like symptoms.

The authors speculate that name-calling and threats cause stress that affects the development of vulnerable brain regions or serve as an unfortunate model for adult communication. The effects can be severe, they suspect, partly because verbal abuse may be more continuous and relentless than sexual or physical abuse.

The symptoms found in adults subject to childhood verbal abuse could also have genetic roots, as the authors acknowledge. Abuse of all kinds, including verbal, is more likely when a parent suffers from mental illness, and most psychiatric disorders have a genetic component. Furthermore, people with current psychiatric symptoms are more likely than others to report childhood maltreatment, but their memories are not necessarily reliable or objective. That means the association discovered in the study could be influenced by heredity and biased recall as well as the abuse itself.

The authors point out that in surveys, 63% of American parents admit that they have sworn at or insulted a child at some time. The authors note that physical child abuse and witnessing domestic violence are regarded as traumatic experiences that create a risk of post-traumatic stress disorder. The study suggests that when verbal abuse is constant and severe, it too creates that risk --- although parents should not be concerned that children will be traumatized by an occasional harsh or angry word.

Teicher M H, et al. "Sticks, Stones, and Hurtful Words: Relative Effects of Various Forms of Childhood Maltreatmen, *American Journal of Psychiatry* (June 2006): Vol. 163, No. 6, PP.993-1000.

Source: HARVARD MENTAL HEALTH LETTER
April 2007

Video by DBSA "State of Depression in America," Wins Three Awards

October 17, 2006, Chicago, IL

The State of Depression in America, a landmark mental health video report released by the Depression and Bipolar Support Alliance (DBSA), earned three honors in the field of television and broadcast: a Telly Award, a Creative Excellence award by the U.S. International Film and Video Festival, and an Award of Distinction by the Videographer Awards.

Hosted by veteran CBS journalist and patient advocate Mike Wallace, the groundbreaking video is a comprehensive analysis of depression.

The State of Depression in America examines the economic, social and individual burdens of this illness and explores opportunities to improve the availability and quality of care while working toward recovery and better lives for all Americans.

Source: bp Magazine, Winier 2007
As seen in: NAMI Tulare County
April 2007

Mark Your Calendar for the 2007 NAMI Convention

June 20 to 24 at the Town and Country Resort in San Diego, California

The Child and Adolescent Action Center will be hosting valuable sessions at the conference on evidence-based practices and other critical topics related to children's mental health.

Dr. Barbara Burns, national leading expert on children's evidence-based practices, and Dr. Mary Fristad, who are currently working on establishing evidence-based practices for children living with bipolar disorder, will speak at our children's symposium on evidence-based practices. We will also have additional child-focused workshops and ask the doctor sessions that will cover a wide array of important child and adolescent mental health concerns. We hope that you can join us in sunny California for this wonderful opportunity to learn more about the mental health issues affecting our children.

For more information about the 2007 NAMI Convention and to register for this exciting event visit www.nami.org/convention today. CEU's are available.

Source: NAMI Tulare County
April 2007

Act, Don't Think, to Relieve Depression

That's the conclusion of a study comparing standard cognitive behavioral therapy with an expanded version of behavioral therapy called behavioral activation therapy.

Cognitive therapy targets persistent self-defeating thoughts. Cognitive behavioral therapy, a version that includes behavioral training and homework, has become one of the most widely used treatments for depression. But some researchers have questioned how much work the cognitive part of the therapy realty does.

Behavioral activation therapy, the alternative used in the new study, is based on the idea that depressed people withdraw from the routine activities and demands of daily life to avoid emotional pain. As a result, they receive fewer rewards and become more depressed. For example, a depressed person in the midst of a conflict with a coworker stays home for several days. Withdrawing from feeling as well as action, she avoids immediate conflict but deprives herself of the satisfying knowledge that she is completing tasks and earning money, while doing nothing to address the original problem. What would help her in the long run is temporarily difficult and unpleasant. As depression progresses and deepens, that may come to include getting out of bed in the morning.

In behavioral activation therapy, the therapist is interested in the function of negative thinking—the way it promotes withdrawal—rather than its rightness or wrongness, as in conventional cognitive behavioral therapy. Patients are shown how to find out and record what gives them a feeling of accomplishment, then do it more. They are taught to maintain regular routines and schedules while exploring alternative behavior by role-playing. They also learn to avoid pessimism and gloomy rumination by directing their attention to the immediate experience of their senses. In this respect, the authors point out, behavioral activation therapy resembles the newer mindfuIness based cognitive therapies. In a study at the University of Washington, nearly 250 people with major depression were divided into four groups that received either behavioral activation therapy, cognitive behavioral therapy, an antidepressant medication, or a sugar pill (placebo). Treatment continued for 24 sessions over four months while standard questionnaires measured changes in the symptoms. Results were tracked separately for mildly depressed and severely depressed patients.

Patients in all four groups improved, and all treatments were equally effective for the mildly depressed patients. For the severely depressed, behavioral activation and the antidepressant drug were equal, and both were superior to cognitive behavioral therapy and the placebo. But patients taking the medication or placebo were much more likely to drop out than those receiving psychotherapy. So, over all, behavioral activation therapy was the most successful treatment. When depressed people were prodded into action, it seemed, their thoughts took care of themselves.

Source: Harvard Mental Health Letter, February 2007
As seen in: THE ROLLERCOASTER TIMES, Spring 2007

Parity: the legislative landscape

by John B. MiIigan

March 6, 2007, WASHINGTON, DC—The 110th Congress offers the best prospects in a decade for advances in the campaign for better medical insurance coverage of mental illness.

The cause is known in political short-hand as "mental health parity," but the term implies simpler and more sweeping mandates than are actually spelled out in the bills under consideration on both sides of Capitol Hill. Nevertheless, mental health advocates are cautiously optimistic that major legislation worthy of the parity label could land on President George W. Bush's desk later this year.

Under Republican majorities of recent years, parity has prospered in the Senate but stalled in the House. The pattern may change, however, with the Democrats now ruling both houses. The president is on record as favoring mental health insurance parity.

A look at the current state of affairs may clarify the status of mental health coverage in the medical marketplace. From the patient's point of view, there are really two distinct marketplaces: the vast private arena that encompasses even the publicly financed coverage of Medicare and Medicaid; and the health insurance system for federal workers—smaller, but still covering millions of American families. The new legislation aims to equalize mental health coverage with regular medical coverage in the realm of cost, such as co-payments, and in the administrative mechanics of managed care.

Although its beneficiaries assert that inequities persist, the rules of the federal employees system seek to treat mentally ill individuals on an equal footing with victims of physical illness or injury. The parity rules in the private market—though toughened in 1996 are still much weaker.

Generally, the 1996 law forbade those medical plans that covered mental health to cap annual or lifetime benefits at a lower level than the plan's benefits in policies for physical illness. The law did not require insurance companies to offer mental health coverage, nor did it enter the complex field of co-payments, premiums, and managed care systems.

The new legislation would effectively extend the reach of the 1996 law—to co-payments and to the nuts-and-bolts of care networks, for example—forbidding insurers to cover the victims of physical ailments more comprehensively or cheaply than they cover their mental health patients.

Rep. Patrick Kennedy, D-RI, speaks about the Paul Wellstone Mental Health Equitable Treatment Act during a press conference on Capitol Hill in September of last year.

In February, the key Senate health committee cleared its parity bill for early debate by the full Senate. The chief authors of the Senate bill, Sen. Edward M. Kennedy, D-MA, Sen. Pete V. Domenici, R-NM, and Sen. Mike Enzi, R-WY, negotiated compromises between the insurance lobby and the mental health lobby to get broad political support.

The chief House sponsors, Rep. Patrick J. Kennedy, D-RI, and Rep. Jim Ramstad, R-MN, also sought swift action on their version of the bill. They have vowed to try to ensure that certain highly stigmatized illnesses— such as eating disorders—do not get second-class treatment in the general advance toward parity.

John E. Mulligan is Washington bureau chief of the Providence Journal.

Source: bp Magazine
Spring 2007

Publication promotes accurate portrayals in TV & movies

February 2, 2007, WASHINGTON, DC— The U.S. Entertainment Industries Council (EIC) has published a comprehensive new publication, *Picture This: Bipolar Disorder* designed to increase understanding and awareness about bipolar among the entertainment industry and the public at large.

The EIC, a nonprofit organization, promotes accurate depictions of health and social issues in movies, television, music, and music videos.

The new 24-page publication covers such topics as signs, symptoms, and types of bipolar; misconceptions and inaccuracies; stigma; recovery; and suggested depictions for writers and producers. The publication is downloadable for free at the Web site **www.eiconline.org.**

Source: bp Magazine
Spring 2007

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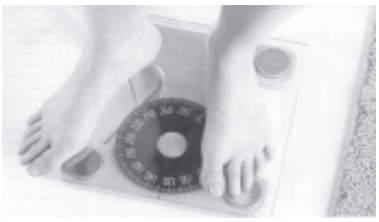
Educational Resources

American Psychiatric Association
202 / 682-6220 • www.psych.org
American Psychological Association
800 / 374-2721 • www.apa.org
Advocacy Center
800 / 342-0823 • www.advocacycenter.com
Child & Adolescent Bipolar Foundation
847 / 256-8525 • www.bpkids.org
DBSA-California
(909) 780-3366
National Alliance for the Mentally Ill (NAMI)
800/ 950-6264 • www.nami.org
National Association for the Dually Diagnosed
800/ 331-5362
National Depression and Bipolar Support Alliance
800 / 826-3632 • DBSAlliance.org
National Family Caregivers Association
301 / 942-6430
National Foundation for Depressive Illnesses
800 / 248-4344
National Institute of Mental Health
800 / 421-4211 • www.nimh.nih.gov
Panic Disorder Line:
800 / 64PANIC
800 / 647-2642
Anxiety Disorder Line:
888 / 826-9438
National Mental Health Association
800 / 989-6642 • www.nmha.org
Confidential depression screening:
www.depression-screening.org

Scientists may have solved the antipsychotic weight gain riddle



February 12, 2007, BALTIMORE, MD --- Scientists at the Johns Hopkins School of Medicine believe they have uncovered how and why some powerful medications used to treat mental disorders cause people to gain so much weight that they can develop life-threatening complications, such as heart disease and diabetes.

The findings could have important ramifications for people taking atypical antipsychotics and doctors prescribing the medications, because they create hope for identifying a newer generation of drugs without the weight-gain side effecs, Solomon H. Snyder, MD, professor of neuroscience at Johns Hopkins, said in a news release.

Previous research already had fingered increased levels and actions of one particular enzyme, AMPK, in brain cells as a control lever for appetite in mice and, presumably, humans. In the new study, the researchers, injected mice with atypical antipsychotics commonly used to treat bipolar disorder and schizophrenia. Mice given the drug clozapine, used for people who do not respond well to other atypicals, showed quadrupled AMPK activity.

The researchers then gave the mice leptin, a hormone that suppresses appetite, and as suspected, saw lowered AMPK levels.

The researchers then connected the link between histamine, a protein involved in cell-to-cell communication and a substance well known as a trigger in allergies, with AMPK and appetite.

Snyder said the study's connection between histamine, AMPK, and appetite control may open new avenues for research on weight control, possibly including drugs that safely suppress appetite.

The study, funded by the U.S. Public Health Service, Canadian Institute of Health Research, National Institutes of Health, and National Multiple Sclerosis Society, appeared in an online version of the Proceedings of the National Academy of Sciences in late February.

Source: bp Magazine Spring 2007

ATTENTION! ATTENTION!

DBSA CONFERENCE 2007 PLANNING COMMITTEE

We did not have our ususal planning committee at the end of our Conference in San Mateo last August. If you would like to be a part of the planning comittee for our conference in 2007, please contact Jo Ann at: 951/780-3366 or by e-mail at joannmartin1@ aol.com.. We will start our conference calls after the holidays.

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