DBSA-CA NEWS

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

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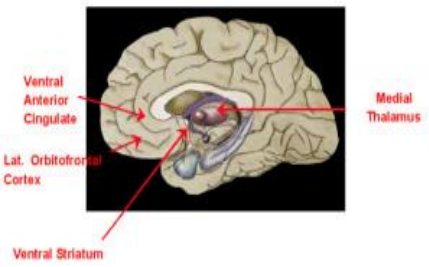
Depression saps endurance of the brain's reward circuitry

by Mel Charbonneau



A new study at UW-Madison suggests that depressed patients are unable to sustain activity in brain areas related to positive emotion.

The study challenges previous notions that individuals with depression show less brain activity in areas associated with positive emotion. Instead, the new data suggest similar initial levels of activity, but an inability to sustain them over time. The new work was reported online Dec. 21, 2009 in the Proceedings of the National Academy of Sciences.

"Anhedonia, the inability to experience pleasure in things normally rewarding, is a cardinal symptom of depression," explains UW—Madison graduate student Aaron Heller, who led the project. "Scientists have generally thought that anhedonia is associated with a general reduction of activity in brain areas thought to be important for positive emotion and reward. In fact, we found that depressed patients showed normal levels of activity early on in the experiment. However, towards the end of the experiment, those levels of activity dropped off precipitously.

"Those depressed subjects who were better able to sustain activity in brain regions related to positive emotion and reward also reported higher levels of positive emotion in their everyday experience," Heller continues.

"Being able to sustain and even enhance one's own positive emotional experience is a critical component of health and well—being," notes the study's senior author, Richard Davidson, professor of psychology and psychiatry and director of both the UW-Madison Center for Investigating Healthy Minds and the Waisman Laboratory for Brain Imaging and Behavior. "These findings may lead to therapeutic interventions that enable depressed individuals to better sustain positive emotion in their daily lives."

During the study, 27 depressed patients and 1 9 control participants were presented with visual images intended to evoke either a positive or a negative emotional response. While viewing these images, participants were instructed to use cognitive strategies to increase, decrease or maintain their emotional responses to the images by imagining themselves in similar scenarios. Heller and colleagues used functional magnetic resonance imaging (fMRl) to measure brain activity in the target areas. The scientists examined the extent to which activation in the brain's reward centers to positive pictures was sustained over time.

The work was funded by grants from the National Institute of Mental Health, Wyeth—Ayerst Pharmaceuticals, Fetzer Institute and Impact Foundation, and by gifts from the John W. Kluge Foundation, Bryant Wangard, Ralph Robinson and Keith and Arlene Bronstein.

Source: http://www.news.wisc.edu/17494
December 28, 2009

Expert Q&A

Are bipolar disorder and schizophrenia very similar?

Asked by Tony Felts, Helmetta, New Jersey

~ Are the psychoses of bipolar disorder and schizophrenia very similar? How do you tell psychotic bipolar disorder apart from schizophrenia with mood disorder? How similar are the two diseases considering that the same medicines (anti-psychotics) are beneficial to both?

Expert answer

The issues you raise, Tony, are so interesting. And apologies in advance for using a little more academic language than I normally do.

Modern psychiatry is built around diagnosing psychiatric disorders based on three primary factors: clustering of symptoms, course of symptoms over time and degree of life impairment that results from these symptoms.

Think for a moment about how different this approach is from the way most medical disorders are diagnosed and treated these days. Let's say you develop crushing chest pain and shortness of breath. You go to the ER. Do they make a diagnosis of heart attack (myocardial infarction, or Ml) based on your symptoms?

No, they order a blood test that will show whether heart muscle is dying. And they get an electrocardiogram, to measure electrical activity in the heart, which changes in very specific ways in the context of an MI. If these tests are positive, you are admitted and rushed off for other tests and interventions. If the tests are negative, you are told that you are probably having an anxiety problem and referred to a psychiatrist.

We have no blood tests in psychiatry, nothing like an electrocardiogram. All we have are symptoms we can watch over time. In this way, we are in a situation not so different from doctors in other fields of medicine 100 years ago, before organs such as the heart and lungs began yielding their secrets to technology.

I say all this as a prelude to addressing your first question about how similar schizophrenia and bipolar disorder are, and if they are similar, how they can be told apart. It turns out that this question is where modern psychiatry began.

In the 19th century, psychosis was considered to be a single condition characterized by various symptoms consistent with a person being disconnected from reality. It took a gentleman named Emil Kraepelin — who is often considered the father of biological psychiatry — to notice around the turn of the 20th century that although psychotic states looked similar to one another, people with psychosis seemed to follow one of two long-term disease courses.

One group of people developed psychosis early in life and

Continued on Page 3 **(Bipolar and Schizophrenia)**

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BIPOLAR AND SCHIZOPHRENIA*(Cont'd from pg. 2)*

had a progressive decline in their ability to think and function that was unremitting and terrible. Reflecting the degeneration that accompanied this state, Kraepelin called this condition "dementia praecox." Today we call this schizophrenia.

Another group of people who developed psychotic symptoms tended to do so a little later in life. Rather than showing a constant decline, these people circulated in and out of madness, and they were always either depressed or elated when they lost touch with reality. To this condition, Kraeplin gave the name manic depression — a term that although still in use, has been supplanted by the category of "bipolar disorder" in official psychiatric nomenclature.

So notice that the essence of the distinction between schizophrenia and bipolar disorder has nothing to do with the type of psychotic symptoms that a patient demonstrates, but rather with the course of the symptoms over time.

This insight got lost for half a century when psychoanalysis reigned supreme, but made a strong comeback in the 1960s and 1970s with the advent of new scientific techniques for studying the brain, and more importantly, the availability for the first time of medications that had profound effects on psychosis and mood disorders.

Especially relevant to the distinction between schizophrenia and manic depression was the discovery that lithium was often a miracle drug for people with bipolar disorder but was generally of little use in schizophrenics. This pharmacological truth seemed to powerfully validate Kraepelin's ideas. From the marriage of Kraepelin, new scientific techniques and new medications was born the modern psychiatric diagnostic guidelines that can be found in the DSM-IV.

So that's a little history. I can tell you that the certainties that launched modern diagnostic psychiatry have mostly vanished, and continue to fade with each new scientific discovery. So the short answer to your question is that schizophrenia and bipolar disorder are increasingly looking more similar than separate.

Source: Excerpted from CNN Health (cnn.com) February 2010

Mental Health Expert
Dr. Charles Raison
Psychiatrist,
Emory University
Medical School

Withdrawal symptoms of desvenlafaxine

A study by a U.K. group (S.A. Montgomery and colleagues, *International Clinical Psychopharmacology* 24:6:296-305, 2009) corroborates a handful of anecdotal reports suggesting that the recently approved desvenlafaxine (Pristiq) may, like its methylated parent venlafaxine (Effexor), give rise to clinically significant withdrawal symptoms when discontinued after (insufficiently slow) dosage tapering.

The authors retrospectively analyzed data from nine eight-week double-blind, placebo-controlled desvenlafaxine antidepressant trials (at daily dosages of 50, 100, 200, or 400 milligrams in 897 patients), a 12-week, open-label "relapse-prevention" study (of 373 patients receiving daily desvenlafaxine dosages of 200 or 400 milligrams), and a 24-week double-blind, placebo-controlled continuation study (of 191 patients, receiving placebo or daily desvenlafaxine dosages of 200 or 400 milligrams).

All samples of desvenlafaxine-treated patients experienced withdrawal symptoms (assessed after desvenlafaxine discontinuation following gradual dosage tapering). Somatic withdrawal symptoms that occurred in at least five percent of patients included headache, fatigue, sweating, nausea, dizziness, and diarrhea, while withdrawal symptoms resembling psychiatric symptoms that occurred in at least five percent of patients included irritability, anxiety, and "abnormal dreams."

Desvenlafaxine withdrawal symptoms were observed in patients who had been treated with as little as 50 milligrams per day for durations as brief as those of patients in the eight-week studies, as well as in those treated with higher dosages for 12 or 24 weeks.

The authors concede that desvenlafaxine may, like venlafaxine, give rise to withdrawal symptoms after discontinuation of both short- and long-term treatment. *(Obiter:* Another serotonin-norepinephrine reuptake inhibitor (SNRI), duloxetine (Cymbalta), also has been reported to cause clinically significant withdrawal symptoms after discontinuation (D.G. Perahia and colleagues, *Journal of Affective Disorders* 89 (l-3):207-212, *2005).)*

Source: CURRENTS in affective illness/literature review and commentary December 2009

Study: More of today's US youth have serious mental health issues than previous generations

BY MARTHA IRVINE

CHICAGO — A new study has found that five times as many high school and college students in the U.S. are dealing with anxiety and other mental health issues than youth of the same age who were studied in the Great Depression era.

The findings, culled from responses to a popular psychological questionnaire used as far back as 1938, confirm what counsellors on campuses nationwide have long suspected as more students struggle with the stresses of school and life in general.

"It's another piece of the puzzle - that yes, this does seem to be a problem, that there are more young people who report anxiety and depression," says Jean Twenge, a San Diego State University psychology professor and the study's lead author. "The next question is: what do we do about it?"

Though the study, released Monday, does not provide a definitive correlation, Twenge and mental health professionals speculate that a popular culture increasingly focused on the external - from wealth to looks and status - has contributed to the uptick in mental health issues.

Pulling together the data for the study was no small task. Led by Twenge, researchers at five universities analyzed the responses of 77,576 high school or college students who, from 1938 through 2007, took the Minnesota Multiphasic Personality Inventory, or MMPI. The results will be published in a future issue of the Clinical Psychology Review,

Overall, an average of five times as many students in 2007 surpassed thresholds in one or more mental health categories, compared with those who did so in 1938. A few individual categories increased at an even greater rate - with six times as many scoring high in two areas: -"hypomania," a measure of anxiety and unrealistic optimism (from 5 per cent of students in 1938 to 31 per cent in 2007) -and depression (from 1 per cent to 6 per cent).

Twenge said the most current numbers may even be low given all the students taking antidepressants and other psychotropic medications, which help alleviate symptoms the survey asks about.

The study also showed increases in "psychopathic deviation," which is loosely related to psychopathic behaviour in a much milder form and is defined as having trouble with authority and feeling as though the rules don't apply to you. The percentage of young people who scored high in that category increased from 5 per cent in 1938 to 24 per cent in 2007.

Twenge previously documented the influence of pop culture pressures on young people's mental health in her 2006 book "Generation Me: Why Today's Young Americans Are More Confident, Assertive, Entitled - and More Miserable Than Ever Before." Several studies also have captured the growing interest in being rich, with 77 per cent of those questioned for UCLA's 2008 national survey of college freshmen saying it was "essential" or "very important" to be financially well off.

Experts say such high expectations are a recipe for disappointment. Meanwhile, they also note some well-meaning but overprotective parents have left their children with few real-world coping skills, whether that means doing their own budget or confronting professors on their own.

"If you don't have these skills, then it's very normal to become anxious," says Dr. Elizabeth Alderman, an adolescent medicine specialist at Montefiore Medical Center in New York City who hopes the new study will be a wake-up call to those parents.

Students themselves point to everything from pressure to succeed - self-imposed and otherwise -to a fast-paced world that's only sped up by the technology they love so much.

Sarah Ann Slater, a 21 -year-old junior at the University of Miami, says she feels pressure to be financially successful, even when she doesn't want to.

"The unrealistic feelings that are ingrained in us from a young age - that we need to have massive amounts of money to be considered a success - not only lead us to a higher likelihood of feeling inadequate, anxious or depressed, but also make us think that the only value in getting an education is to make a lot of money, which is the wrong way to look at it," says Slater, an international studies major who plans to go to graduate school overseas.

The study is not without its skeptics, among them Richard Shadick, a psychologist who directs the counsellingcentre at Pace University in New York. He says, for instance, that the sample data weren't necessarily representative of all college students. (Many who answered the MMPI questionnaire were students in introductory psychology courses at four-year institutions.)

Continued on page 5 **(Youth)**

(YOUTH) *Continued from page 4*

Shadick says his own experience leaves little doubt more students are seeking mental health services. But he and others think that may be due in part to heightened awareness of such services. Twenge notes the MMPI isn't given only to those who seek services.

Others, meanwhile, say the research helps advance the conversation with hard numbers.

"It actually provides some support to the observations," says Scott Hunter, director of pediatric neuropsychology at the University of Chicago's Corner Children's Hospital. Before his current post, Hunter was at the University of Virginia, where his work included counselling a growing number of students with mental health concerns.

While even Twenge concedes more research is needed to pinpoint a cause, Hunter says the study "also helps us understand what some of the reasons behind it might be." He notes Twenge's inclusion of data showing that factors such as materialism among young people have had a similar upswing. She also noted that divorce rates for their parents have gone up, which may lead to less stability.

Amid it all, Hunter says this latest generation has been raised in a "you can do anything atmosphere." And that, he says, "sets up a lot of false expectation" that inevitably leads to distress for some.

It's also meant heartache for parents.

"I don't remember it being this hard," says a mother from northern New Jersey, whose 15-year-old daughter is being treated for depression. She asked not to be identified to respect her daughter's privacy.

"We all wanted to be popular, but there wasn't this emphasis on being perfect and being super skinny," she says. "In addition, it's 'How much do your parents make?'

"I'd like to think that's not relevant, but I can't imagine that doesn't play a role."

On the Net

— Twenge's site: http;//www.jeantwenge.com/

Source: The Canadian Press
January 2010

Behavioral problems could stem from nicotinic receptor deletion

November 3, 2009, Houston, Texas The loss of a gene through deletion of genetic material on chromosome 15 is associated with significant abnormalities in learning and behavior, said a consortium of researchers led by Baylor College of Medicine (BCM) in a report published online in November in the journal *Natural Genetics.*

"This research goes about 95 percent of the way to pinning these problems in a specific group of individuals to this gene," said Arthur L. Beaudet, MD, chair of molecular and human genetics at CM. He believes that the deletion will be identified in other people with behavioral problems as well as schizophrenia, developmental delay and epilepsy. The gene's role in schizophrenia has been under study for some time.

Previously, a larger deletion containing more genes had been reported in people with the same constellation of disorders. In this work, Beaudet, along with Pawel Stankiewicz, MD, PhD, assistant professor of molecular and human genetics a BCM, and colleagues found that a smaller deletion of genetic material—the whole of the gene in question, CHRNA7, and a part of another -was associated with similar problems in 10 members of four families.

"This gene encodes a subunit of a nicotinic receptor," Beaudet said. "It is a gene that mediates the response to nicotine via a receptor whose normal ligand is acetylcholine." The gene encodes a protein called an ion channel, which allows ions to flow in and out of neurons in the brain. Defects in ion channels have previously been associated with forms of epilepsy or seizure disorder.

"If insufficient expression of the nicotinic receptor causes most or all of the problems associated with deletions in this particular area of chromosome *15,* then it offers a target for drug treatment," Stankiewicz said.

One such drug mentioned in the paper is Chantix, a medicine now used in smoking cessation efforts.

Source: SZ Magazine, Winter 2010
As Seen in: NAMI Tulare County
March 2010

Violence is not a symptom of mental illness

Julian Hendy's BBC documentary investigates his father's murder by a stranger with mental illness. Here Dolly Sens who is bipolar, responds.

Contemplating losing someone I love in a random killing makes my heart shrink. I understand the fear people feel. Julian Hendy tries to confront the issue straight on. His film, Why did you kill my dad? BBC2, tonight 9pm, investigates the circumstances behind the murder of his father by a stranger with severe mental illness. He talks to other families in the same grim position. And he questions official statistics, claiming that these cases are more common than we think.

Some viewers will hear the film's message: recommendations must be implemented; families must be listened to; mental health services must improve.

Others will only see how harrowing these cases are, without registering that the documentary is referring to only a handful of people per year.

There are about a million people in the UK with bipolar disorder, schizophrenia and personality disorder. I hope viewers will remember that the vast majority of people with severe mental illness, are ordinary, law-abiding citizens.

I have a severe mental illness. I was originally diagnosed with schizophrenia, this diagnosis was recently updated and I am now considered bipolar, both are psychotic illnesses. I have never been violent, ever. I have had delusions and hallucinations; I have been gripped by paranoia. My delusions were utterly convincing. I convinced others too, like the time I went into a supermarket and preached to the needy in the headache pill aisle: " Follow me and you will be well." I acquired a congregation.

The documentary doesn't explain that violence is not a symptom of severe mental illness. Nor does it address the real problems behind some of these cases. The biggest factor that increases the risk of violence is drug and alcohol misuse. Once you take that away, people with schizophrenia are no more likely to be violent than anyone else.

The other problem is that people in crisis and their families often ask for help from mental health services and receive none. Charities like Rethink and the Sainsbury Centre for Mental Health cite cases where relatives have begged for help for their loved ones time and time again, only to be met with a resounding silence. These experiences are tragic for them too, but we don't meet these victims in Hendy's film.

Of course, every death is one too many. We must find solutions that work, such as more specialist dual diagnosis services that treat people who have both a mental illness and a drug or alcohol dependency. Our mental health services also need to be more responsive to cries for help from patients and families.

Our public debate of this issue must be balanced and consider everyone involved. If the debate is unbalanced, it will affect everyone who is unlucky enough to develop a mental illness. In my case, there was the post office clerk who hissed "Hitler had the right idea about people like you", when he learned I had a mental illness, the neighbour who repeatedly threw eggs at my door, the person who spat at me in the street.

All of them need better education on mental illness, what it means and what the real risks are. How many viewers watching this film will realise they're in more danger from their partner beside them on the sofa than from a stranger with schizophrenia in the street?

Dolly Sen is a filmmaker and mental health campaigner with severe mental illness.

Source: www.guardian.co.uk/society/joepublic/2010/mar/01/

Regulations spell out how to apply U.S. mental health parity law

February 4, 2010, ALEXANDRIA, VA---Mental Health America (MHA) praised the release of regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act earlier this year.

According to the advocacy organization, the regulations clarify a number of key issues that will help to ensure that the intent of the parity law---to prohibit discriminatory treatment of mental health and substance abuse conditions ---is fully realized and implemented.

The regulations make clear that the parity law prohibits insurance plans from discriminating against mental health and substance use treatment in areas such as medical management, prescription formulary design (that is, which drugs are covered by a plan), and so-called "fail first" policies that require someone to fail to respond to one drug before qualifying for another treatment.

Source: bp Magazine Spring 2010

New bipolar questionnaire developed

February 11, 2010, NORWALK, CT---Researchers have developed a new self-reporting questionnaire that's specific to

Continued on Page 7 **(Questionaire)**

Clip and Keep!

Educational Resources

American Psychiatric Association
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American Psychological Association
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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 (647-2642)
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National Mental Health Association
800 / 989-6642 • www.nmha.org
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http://www.usdoj.gov/crt/ada/adahom1.htm
ADA technical assistance, information line, enforcement, settlement information, regulations, mediation, and more.

QUESTIONNAIRE*(Cont'd from pg. 6)*
bipolar disorder.

The American team said until now, methods to measure impairments in functioning related to bipolar disorder were adapted from tools originally developed for use in other conditions such as major depression or schizophrenia.

The new Bipolar Functional Status Questionnaire (BFSQ) identifies eight measurements: cognitive functioning, emotional funtioning, energy/vitality, social functioning, personal management, and sexual functioning.

The researchers said the questionnaire should make it easier to track changes in functional status across changing clinical states such as mania or depression during treatment.

Source: bp Magazine Spring 2010

More workplace support for mental illnesses needed

February 17, 2010, TORONTO, ON---With mental illness costing $17.7 billion annually in los productivity in Canada, the Centre for Addiction and Mental Health (CAMH) is calling for increased workplace prevention and support programs.

New CAMH research found that while someone who had a previous workplace leave due to a physical disability is twice as likely to go out on leave again, those with a mental illness are seven times more likely to need another leave. Factors may include the chronic nature of mental illness and the lack of workplace resources.

David Goldbloom MD, CAMH's senior medical advisor, said successful mangement of mental illness requires proper follow-up care and medication, counseling, social support from loved ones and the workplace, and ongoing access to meaningful employment.

Source: bp Magazine Spring 2010

Ontario inmates get psychiatric care by teleconferencing

February 18, 2010, TORONTO, ON---Inmates in federal prisons in Ontario will soon be able to get mental health care through a new telemedicine initiative.

The Ontario Telemedicine Network (OTN) said the prison population has significantly higher rates of mental illness

than the general population, but said it can be challenging to recruit and retain psychiatric specialists.

Under the new program, inmates with mental health issues will be able to go to a private room where thay will be connected via two-way video conferencing with a psychiatrist located outside the prison.

OTN said there has been an 85 percent increase in the number of Canadian inmates identified as having a mental health disorder on arrival at prisons since 1997.

Source: bp Magazine Spring 2010

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