BUTTE COUNTY *(National Alliance on Mental Illness)* **NEWSLETTER February 2012**

P.O. BOX 1 364 Chico, CA 95927 www.namibutteco.com

NAMI Butte County

GENERAL MEETING

AGENDA:

1. Consumer Speakers
2. Community Resources

***DATE*: Thur. February 16th**

***TIME:* 6:30 p.m.**

***PLACE:* Butte County Library**

1108 Sherman Ave., Chico

(Corner of East First Ave and Sherman Ave)

INFO? *CALL Cathy: 228-7100*
OR e-mail:
namibuttecosecretary@gmail.com

We are open to the public
Everyone is welcome

Meetings are held 3rd Thur. each month

COMING IN MARCH!

At our March15th meeting, members of BCBH Board of Directors will be speaking about the positive changes that have been made to services and what's now available. Speakers will be Ann Robbins & Betsy Gowen. Also Sheriff Andy Duchs will speak about CIT (Crisis Intervention Team).
A Q & A period will follow.

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NAMI WALK 2012 CELEBRATING BEAUTIFUL MINDS

Saturday, April 21st, 2012

This is our third annual NAMI Butte County Walk and our major source of funding and will make it possible to continue offering our education courses, support groups, community outreach, etc. This day is also an opportunity to reach out to the community in order to raise awareness and erase the stigma of mental illness.

GET INVOLVED:

JOIN A TEAM OR
START A TEAM OR
BECOME A SPONSOR!

Contact Linda at 343-8012 or
namibuttecosecretary@gmail.com

SUICIDE SUMMIT

Suicide Prevention Summit

The Butte County Department of Behavioral Health invites you to be a part of the solution.

- **Learn what local, regional and state resources are available.**
- **Hear current Butte County suicide data, trends and issues.**
- **Create Suicide Prevention Task Force goals.**
- **Join us in mobilizing Butte County.**

Friday, March 16, 2012
Enloe Conference Center in Chico
Questions?
Contact Betsy Gowan
530-891-2850

AMERICAN IDOL

American Idol: Singing Against Stigma

By Mike Fitzpatrick, NAMI Executive Director

It takes courage for a person to talk about living with a mental illness. That's especially the case if you are a teenager. Even more so when disclosure takes place in front of a television audience of millions on the hit show *American Idol.*

On January 25, 17-year-old Shelby Tweten of Mankato, Minnesota "wowed" the show's judges in an audition that featured a video about her struggle with bipolar disorder.

Shelby has lived with depression since she was in fourth grade. She was diagnosed with bipolar disorder in March 2011. Singing, she believes, has helped her to persevere.

"I want to show people that bipolar disorder doesn't define who you are," she said. In doing so, she has struck a powerful blow against stigma and discrimination.

NAMI members cheered and applauded in their living rooms. For those who were watching with their parents or teenage children, it was an emotional moment. The moment carried even greater emotion as Shelby sang

"Temporary Home" by Carrie Underwood. The refrain can serve as a metaphor in the journey toward recovery:

This is my temporary home
It's not where I belong
Windows and rooms that I'm passin' through
This is just a stop, on the way to where I'm going
I'm not afraid because I know this is my
Temporary home.

Both the video and vocal performance can be seen on many websites, including *Hollywood Life*. Talking publicly about your mental illness not only can help strike a blow against stigma, it can be part of recovery itself. It can liberate a person from feelings of stigma. It can stop a person from internalizing shame or fear. Besides being a step toward recovery taken for herself, Shelby's audition serves as an example that can inspire others. That's one of the principles on which NAMI's public education program In Our Own Voice also rests.

So what happens next? The audition judges selected Shelby to compete as a semi-finalist in Hollywood. Contestants will be eliminated until a winner is selected by the audience in the final episode in May.

I think NAMI members will know who they want to vote for.
Keep singing, Shelby.

02/07/12 NAMI blog at www.nami.org

BPD

Borderline Personality Disorder:

A Most Misunderstood and Maligned Mental Illness

Borderline personality disorder (BPD) is a devastating mental illness that centers on the inability to manage emotions effectively. Heritability of this illness is estimated to be 68%.

The symptoms include: fear of abandonment, impulsivity, rage, bodily self-harm, suicide, and chaotic relationships. While some persons with BPD are high functioning in certain settings, their private lives may be in turmoil. Others are unable to work and require financial support.

Officially recognized in 1980 by the psychiatric community, BPD is two decades behind in research, treatment options, and family psychoeducation compared to other major psychiatric disorders. BPD has historically met with widespread misunderstanding and blatant stigma.
www.borderlinepersonalitydisorder.com

BOOK CORNER

The Borderline Personality Disorder Survival Guide

Chapman, Alex and Gratz, Kim (2007) . New Harbinger Publications, Inc. Oakland, CA.

The book is organized as a series of answers to questions common to BPD sufferers: What is BPD? How long does it last? What other problems co-occur with BPD? Overviews what we currently know about BPD make up the first section of the book. Later chapters cover several common treatment approaches to BPD: dialectical behavior therapy (DBT), mentalization-based therapy (MBT), and medical treatment using psychoactive drugs. In the last sections of the book, readers learn a range of day-to-day coping skills that can help moderate the symptoms of BPD.

I Hate You, Don't Leave Me and Sometimes I Act Crazy

Support, Empathy, Truth - **SET** for Borderline Personality
When borderline personality disorder makes communication difficult, following the SET method may help. SET stands for support, empathy and truth. It was developed by Jerold J. Kreisman, MD and Hal Straus, the authors of I Hate You, Don't Leave Me and Sometimes I Act Crazy. A book written to educate friends and family of those with BPD and assist them in improving their relationships, while being heard. "AM I LOSING MY MIND?" People with Borderline Personality Disorder experience such violent and frightening mood swings that they often fear for their sanity. They can be euphoric one moment, despairing and depressed the next.

PREGNANCY & LITHIUM

Managing Pregnancy and Bipolar Disorder

Pregnancy and delivery often increase the symptoms of bipolar disorder: pregnant women or new mothers with bipolar disorder have a sevenfold higher risk of hospital admission and a twofold higher risk for a recurrent episode, compared with those who have not recently delivered a child or are not pregnant. A recent study published in the *American Journal of Psychiatry*also found substantial risks associated with discontinuing bipolar medications around the time of pregnancy: women who discontinued medication between six months prior to conception and 12 weeks after conception were more than twice as likely to suffer a recurrence of at least one episode of the illness (85.5 percent compared to 37.0 percent).[1] These same women experienced bipolar symptoms throughout 40 percent of the pregnancy, compared with only 8.8 percent of the time for women who continued medications throughout the pregnancy. Women who discontinued their medications abruptly were especially vulnerable to relapse.

For many people, lithium is a mainstay of their treatment for bipolar disorder. The decision to continue taking lithium during pregnancy can be life saving to the mother. Other women might switch to lithium because it has fewer risks to the developing fetus than their current medication. While taking lithium, it is important that women stay hydrated to prevent lithium toxicity in themselves and the fetus. Careful monitoring of lithium levels, especially during delivery and immediately after birth, can help prevent a relapse in the mother and will also show if there are high lithium levels in the infant.

Lithium is the only drug proven to reduce the rate of relapse of illness from nearly 50 percent to less than 10 percent when women continue or begin lithium treatment after giving birth. Women who choose to breast-feed should know that lithium is secreted in breast milk. Breast-fed newborns whose mothers take lithium should have their blood monitored for lithium.

Editor's note: Details on other medications and pregnancy are reported at www.nami.org

RECOVERY

Recovery Is Ideally Person-Driven But Not Always

I am a consumer who has successfully lived both medicated and not medicated during different points ....

By Amanda LaPera

While I think the idea behind most of the listed guiding principles is sound, I do take issue when it states that "Recovery is Person-Centered." Instead I think it would be more appropriate to state that "*ideally*, recovery is person-centered" since that is not always possible. I apologize for the long response, but many people on this site have called people's statements into question based on lack of evidence. There is a small but very important population being ignored throughout these various threads: those who are the most severely ill and lack the insight that they are indeed ill. This is not a made-up disease, or something cured by simple nutrition. [Anosognosia]() is real.
Most of the comments I've read from "consumers" who have bipolar or schizophrenia and have lead normal lives or from those who equate [assisted outpatient treatment]() (AOT) to torture don't understand that AOT does not apply to most people. Not all those who have a severe mental illness have anosognosia or a need for intervention. I am not here to represent any organization or to try to use propaganda to sway this discussion. I am trying to provide a more thorough understanding of the real issue. Please hear me out on this.

LIVING WITH AND WITHOUT MEDICATION

I am consumer who has successfully lived both medicated and not medicated during different points in my life. My mother has bipolar and has decided that she can't function without medication. (I completely agree with her - medication *along with* appropriate care from competent mental health care professionals is how she is able to take care of herself). My father has late-onset paranoid schizophrenia and tried to commit suicide three times, had three involuntary hospitalizations, has anosognosia, and has been

homeless for the last 10 years where he's been taken advantage of, had his nose broken after being attacked, and was treated for frostbite from sleeping on the cold streets. My sister has severe anxiety/depression and, without her medication, I would worry for the safety of her and her children. My friend has bipolar and, without medication, was completely unable to work, leave her house, or function. And my son, who has something that nobody can correctly label yet, has been misdiagnosed over a dozen times by nearly 20 different mental healthcare doctors, mistreated with medications that caused ulcers, stunted growth, and then weight gain, and is currently doing much better *without* any medications.

Not everyone needs nor responds to medication. In fact, the medications of the 1970s and 1980s did my mom more harm than good. Finally, science has advanced enough to provide her with appropriate and effective medication. I can see all sides of this issue. The issue of anosognosia and the recognition that some of the most vulnerable people need others to help them to get treatment does not apply to all individuals who have bipolar or schizophrenia, only the *most* severe, like my father. It seems to be easy for many here to dismiss this idea as a family's desperation (yes, many families don't have enough information to help their loved ones effectively, and it is a very painful position to be in when you have to watch your loved one deteriorate), or an overzealous pharmaceutical industry (yes, there are definitely abuses there), or incorrect diagnosis (yes, we need more research dollars to be spent on understanding and "mapping" the human brain's chemical functions to eventually be able to provide reliable evidence of all mental illnesses), or even torture (yes, the psychiatric hospitals have committed many deplorable abuses in the name of medicine). But do these same individuals here not recognize that *all* human beings deserve the decency to be able to live healthy, productive lives, free from a severe disabling condition?

what about the victims - and those who victimize them?

What about Andrew Goldstein and Kendra Webdale? What about Scott Harlan Thorpe and Laura Wilcox? What about Jared Loughner and Rep. Gabrielle Giffords and the six who died? What about Seung-Hui Cho and the 32 people at Virginia Tech? What about Kelly Thomas and the police department? The list goes on and on. What do all of these tragedies have in common? A person who was severely mentally ill who was not being adequately treated and whose family knew there was a mental illness that needed to be treated.

I am not saying all violence is attributed to mental illness, nor am I claiming that all those with severe mental illness will become violent. Neither could be further from the truth. However, definition of recovery aside, how in good conscience could SAMHSA ignore these people in this discussion? While they make up a very small minority, we are still talking about human life and mental illnesses that must be addressed. Money will always be an issue, but it's far less costly to provide sufficient care—be it inpatient or outpatient—than to sit by, pretend there isn't a problem, and allow things to continue as they have been, with people being incarcerated or left to fend for themselves on the streets, which only results in more money being spent and more preventable tragedies.

Let's look at the facts. According to SAMHSA, homelessness is frequently a mental health issue. Their National Mental Health Information Center lists the following statistics: over the course of 1996, 2.1 million adults were homeless; 39% of the homeless population in America report having a mental illness, and 20-25% meet the criteria for a severe mental illness. There are also several individual factors that may increase a person's risk for becoming homeless and remaining homeless for a longer period of time, one of which is an untreated mental illness that can cause individuals to become paranoid, anxious, or depressed, making it difficult or impossible to maintain employment, pay bills, or keep supportive social relationships. Homeless individuals with severe mental illness are twice as likely as other homeless people to be arrested or jailed.

SAMHSA also reports: "Homelessness among people with serious mental illnesses can be prevented. Discharge planning that helps people who are leaving institutions to access housing, mental health, and other necessary community services can prevent

homelessness during such transitions. Ideally, such planning begins upon entry into an institution, is ready to be implemented upon discharge, and involves consumer input. Providing short-term intensive support services immediately after discharge from hospitals, shelters, or jails has proven effective in further preventing recurrent homelessness during the transition back into the community." And, according to the U.S. Department of Justice, Bureau of Justice Statistics's study "Mental Health and Treatment of Inmates and Probationers" by Paula M. Ditton, BJS Statistician: "At midyear 1998 an estimated 283,800 offenders with mental illness were incarcerated in the Nation's prisons and jails."

I don't pretend to have the answer to everything, but I do know that we must recognize this subset of the population before they are incarcerated or homeless, and include them in this discussion.

www.treatmentadvocacycenter.org

DEPRESSION-OLDER ADULTS

Recognizing Depression in Older Adults

Once depression is distinguished from other diseases, like dementia, treatment can help restore quality of life for mature adults.

By Krisha McCoy, MS Medically reviewed by Pat F. Bass III, MD, MPH

It is estimated that one in five Americans 65 years of age or older have some form of depression. But since it is sometimes difficult to distinguish between depression and other illnesses that are common in older adults, such as dementia, depression often goes unrecognized.

Some people think that depression is a normal part of getting older, but it's not. It is normal to feel sad or blue when you experience life changes or loss, such as health problems or the death of a loved one. But when your depression symptoms are prolonged and interfere with your daily activities, it's an illness that should be diagnosed and treated.

Depression and Age: Why They're Related

Depression is thought to be due to imbalances in brain chemicals called neurotransmitters that aid communication between brain cells. It may be that these imbalances are more likely to occur as a person ages.

"One of the enzymes that breaks down neurotransmitters [increases] as we get older," says Gary Sachs, MD, founder and director of the Bipolar Clinic and Research Program at Massachusetts General Hospital and associate professor of psychiatry at Harvard Medical School in Boston. "It may be that you have less of that pleasure-giving neurotransmission" as you age, he says.

With lower levels of pleasure-giving neurotransmission, says Dr. Sachs, it takes more stimulation to give you pleasure.

Because participating in physical activity helps to produce various factors that help sustain neurons (nerve cells that carry messages throughout the body), Sachs believes that the decrease in physical activity common in aging may also contribute to depression. "We are actually losing some of our central nervous system" as we age, says Sachs. "Because of that, it just tips the balance more toward that vulnerability" to depression.

Depression: Signs to Look for

The following symptoms may indicate depression:

Nervousness; Feeling empty; Feeling worthless; Not enjoying things you used to; Restlessness; Irritability; Feeling unloved; Feeling that life is not worth living; Excessive sleep; Increased eating; Fatigue; Sluggishness; Headaches; Stomachaches; Persistent pain

You need to call your doctor if you've been experiencing these symptoms or feel persistently sad. Your symptoms may signal depression or another illness. Either way, it is important to talk with your doctor.

Depression: Treating Older Adults

Depending on your symptoms, your doctor may recommend medications or counseling to treat your depression. Antidepressant medications can help correct imbalances in neurotransmitters. Counseling, also known as "talk therapy," can help you learn new ways to think and behave to lessen your symptoms of depression.

Getting treated for depression is important for anyone, but especially so for older adults. Depression can put you at higher risk of committing suicide, and for older adults that risk is disproportionately high. Americans ages 65 and older made up 16 percent of all suicide deaths in 2004.

Talk of suicide needs immediate attention. If you are experiencing suicidal thoughts, you can call the toll-free, confidential National Suicide Prevention Lifeline, 1-800-273-TALK (8255), 24 hours a day to speak with a trained professional.

Regardless of the severity of your symptoms, you should get treatment and regain the quality of life that you should be enjoying.

http://www.everydayhealth.com/depression/depression-in-older-adults.aspx

ANTIPSYCHOTICS - OBESITY

How antipsychotic medications cause metabolic side effects such as obesity and diabetes

February 1, 2012

In 2008, roughly 14.3 million Americans were taking antipsychotics—typically prescribed for bipolar disorder, schizophrenia, or a number of other behavioral disorders—making them among the most prescribed drugs in the U.S. Almost all of these medications are known to cause the metabolic side effects of obesity and diabetes, leaving patients with a difficult choice between improving their mental health and damaging their physical health. In a paper published January 31 in the journal *Molecular Psychiatry*, researchers at Sanford-Burnham Medical Research Institute reveal how antipsychotic drugs interfere with normal metabolism by activating a protein called SMAD3, an important part of the transforming growth factor beta pathway.

The TGFbeta pathway plays an important role in metabolic disease in people who don't take antipsychotic medications. "It's known that people who have elevated TGFbeta levels are more prone to diabetes. So having a dysregulated TGFbeta pathway—whether caused by antipsychotics or through some other mechanism—is clearly a very bad thing," said Dr. Levine. "The fact that antipsychotics activate this pathway should be a big concern to pharmaceutical companies. We hope this new information will lead to the development of improved drugs."

Provided by Sanford-Burnham Medical Research Institute

Read the full article at **http://medicalxpress.com/news/2012-02-antipsychotic-medications-metabolic-side-effects.html**

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