

Community Counseling of Bristol County's *Mission in Motion*

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Message from Phil Shea President/CEO

50th Anniversary of Community Mental Health Act

This year marks the 50th anniversary of President Kennedy's signing into law the Community Mental Health Act. Community Counseling plans to commemorate this anniversary with a celebration in late October.

In many respects it is fair to say that this legislation not only sought to shift the focus of care from remote institutions to places where people live and work, but also to fully integrate them into the social and economic life of the community. Looking back it seems one of the unstated assumptions was that by shifting the locus of care and providing treatment and supports in familiar settings, individuals with serious mental illness would be full participants in the institutions and make up of community life. In short, that stigma would not follow those with serious mental illness from the institutions to the community. We know today that stigma has presented and continues to present a formidable barrier to inclusion in the community life of those with serious mental illness.

Since the 1960s to many it has been obvious and self-evident that those with serious mental illness are better off when they live in and are part of the community. Today, community integration is seen as an essential part of recovery. Some researchers, however, define community integration in contrast to the illness experience, that is exclusive of a system of community-based care. As cited in an article by Bromley in July's *Psychiatric Services*, McColl writes that "community integration has been conceptualized as the opposite of handicap," and Davidson describes recovery as "minimizing, managing or overcoming the effects of being a mental patient." Bond and colleagues seem to go further – community integration "is not immersion in worlds

created and managed by mental health professionals. These settings are designed specifically to pull consumers into treatment and away from community life." To some the care and supports available to those with serious mental illness seems antithetical to community integration. Yet we know that for many what some would describe as community integration often falls short of what was envisioned and too often includes rejection by family, peers and society as a whole. This rejection expresses itself in isolation, inadequate housing or homelessness, unemployment, poor access to health care, victimization and even criminalization.

During this time little research has been done to understand the perspective of those with serious mental illness of how they define and evaluate the communities in their lives, and to the extent they obtain what they seek from these communities. Bromley and colleagues attempt to understand the meaning of community of those with serious mental illness. They conducted semi-structured interviews with those with serious mental illness who were receiving services at two public mental health clinics. Their findings are presented in this month's *Psychiatric Services*.

To summarize, they report that those with serious mental illness have their preferences for, and perceptions of, community in remarkably consistent ways. Participants describe community involvement not in terms of moving away from illness experiences and identities, but as a process substantially influenced by them. Specifically they found four experiences as central to their concept and sense of community. These included receiving help, avoiding stigma, minimizing risk and giving back. For example, most participants described public settings as risky and for many, risky to their stability and comfort, but also a risk to

Continued from Page 1

others on whom their behaviors may have an impact. These findings run counter to some of the literature on community integration. For example, "according to recovery-oriented definitions of community definitions, community integration affords engagement with the main-stream public. In contrast, study participants often named places and groups comprising persons with mental illness as useful for forging identity, developing comfortable patterns of social interaction and facilitating participation in communities. Participants most often experienced mainstream communities as stigmatizing or risky and most often described communities centered in the mental illness experience as helpful or as a source of protection from rejection."

This important research I hope marks the beginning of a shift away from philosophical and even dogmatic positions about what constitutes "normalized" settings and community integration to more careful considerations of the experiences of those with serious mental illness and what, for them, constitutes a safe, welcoming and inclusive setting in which to live, work and play.

Reference

Bromley, E. "Experiencing Community: Perspectives of Individuals Diagnosed as Having Serious Mental Illness." *Psychiatric Services* 1 July 2013: Vol. 64, no. 7, pp. 672-679.

CCBC forms Committee to Plan Celebration Honoring the Anniversary of the Signing of the Community Mental Health Act.

October 31st marks the 50th anniversary of President Kennedy's signing of the Community Mental Health Act (CMHA) on October 31, 1963. The bill marked a shift in public policy of the care for those with serious mental illness from remote institutions to the communities in which people live. The celebration will underscore the advances that have been made in treatment over the past 50 years and highlight the work that remains to be done. Andy Dawley will serve as Chair of the CCBC CMHA Celebration Committee. **More information to follow.**



Human Resources

Welcome to New Staff!

CCBC wishes to welcome our new hires for March through June, 2013.

MARCH

Sarah Farias, TCBFS
Joshua Galloway, ACBFS
Kristyn Britton, CSP
Christine Sameiro, TCBFS
Rafael Gracia, PACT
Ira Lopes, ACBFS
Vanessa Wade, CSP
Jenna Durfee, CSP
Nathan Rogers, CSP
Katherine Sorensen, CSP
Elizabeth McElroy, PACT
Rachael Berthelette, Bridge

APRIL

Adriana Guerrero-Owens, COP
Yoned Delahoz, ACBFS
Justin Araujo, CSP
Sarah Gregoire, TCBFS
Abdulfatai Abdulwahab, TCBFS
Priscilla Bernardo, IHT
Nicole Geniusz, CSP

MAY

Robert Accettullo, COP
Brittany Sands, TCBFS
Elizabeth Venuti, CSA
Meghan O'Leary, CSA
D'Anna Garrett, BPACT
Sarah Booth, CSP
Edward O'Brien, AOP
Joshua Berthiaume, TCBFS
Dawn Lezoche, ACBFS
Haylee Foley, CSP
Tess Bettencourt, PACT

JUNE

Tyler Jones, IHT
Vanessa Mendivil, IHT
Allison Meleedy, Adm

CPI: Pathway to Prevention

CCBC has taken a very active approach towards safety. The CCBC Safety Committee has sought out and addressed many staff-driven concerns. Solutions are being developed using technology, policy, practice, and training. The agency's adoption of the **Crisis Prevention Institute's (CPI) model of Nonviolent Crisis Intervention (NVC)** is one of these major initiatives. We are closing in on finishing our second year.

We are very grateful to our training staff. Matt Cianci and Alyssa Altrui are part of our founding group of instructors. Both have acted as captains. Their influence has been seen in how classes are taught, the planning of CPI-related programming, as well as in developing refresher methodology. We are sorry to say that two other founding members will not be continuing with us. Zachary Brennan has demonstrated a lot of flexibility in participating in other training sessions. He will be leaving the agency. Gregory Auger has a very engaging presentation style which is an effective vehicle for sharing his wealth of experience. He will be focusing on other agency business, including CPR training.

Our core group is very pleased to announce two new instructors; Emily Baumgart and Joseph Mone. Emily, who is a valued member of the Children's Outpatient Department, is a former CPI instructor, with diverse human services experiences, and will have an impact right away. Joe is a respected member of the Community Support Program, has a strong education background as well as many other professional and life experiences that will make him an integral member of the Team.

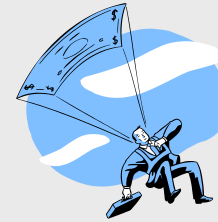
It is also important to recognize and thank Andy Dawley. Andy has led the Safety Committee with Maria Cancel. It is also through his leadership and strong advocacy that the agency has adopted CPI. This is a substantive investment.

The CPI Instructor Team has recommended that agency staff go through CPI training every two-years. After our final FY13 training session scheduled for June 5, 2013 is concluded, the Team will start focusing on

Bonus Quality Quote:

**"Minds are like parachutes.
They only function
when they are open."**

James Dewar



our FY14 training schedule. We have new staff to train as well the need to start the re-training process. Stay tuned!

Lastly, in order to support staff, we will be generating a **monthly tip series** plus a **bonus quality quote**, starting with this newsletter. Future submissions will go to all users through CCBC email. The tips are intended to be a regular reminder that we hope will be both informative and engaging. Any feedback will be welcome as we move forward.

By Tom Loftus, MS, LMHC

Quality Management and Compliance Coordinator

CPI Refresher Tip: Rational Detachment

Keep your balance –

Stay in control of your own behavior and don't take acting-out behavior personally.



- Develop a plan.
- Recognize your own limits.
- Use a Team approach.
- Use positive self-talk.
- Debrief.

What It's Like to Have Schizophrenia

Ladies' Home Journal, May 15, 2013

By Lisa Halpern



Here are four things you've probably heard about people who have schizophrenia. Since I've struggled with the disease for almost my entire life, I'm more than qualified to tell you if they're true or false.

- **They hear voices.** *Yep, I hear them. Those are real, at least to me.*
- **They're paranoid.** *True. For years I was pretty sure people were out to get me.*
- **They commit violent crimes.** *No, that's not a symptom. Those of us with schizophrenia tend to be secretive and avoid human contact. We're more likely to hurt ourselves.*
- **They commit suicide.** *Unfortunately, true. About 40 percent of us try it, and 10 to 13 percent succeed. The voices I heard told me to kill myself, and I came pretty close to doing it – until I finally got help.*

People are talking about mental health issues these days, and that's a good thing. But it's so important to separate the myths from the realities. That's why I want to tell my story.

Looking back, I think I had symptoms of schizophrenia as early as kindergarten. Remember those "stranger danger" films when you were little, where a man gets out of his car, offers you candy, and then kidnaps you? Well, I became terrified of those men and started having nightmares about them trying to capture me. When I'd get off the bus after school, I'd run home as fast as I could. If I saw a car coming, I'd hide in the bushes so the men couldn't get me. And I figured out right away that I should keep this a secret and not tell my parents or friends. These were early versions of the delusions, paranoia, and secrecy that became part of my pattern for years.

I grew up in Seattle and had a relatively happy childhood, but in junior high we moved to California. I had a harder time making friends there. I looked like I belonged. I played soccer and was on the track team. I was thin and fit and wore the coolest jeans. But I became convinced that other kids were watching me and talking about me behind my back. I was sure they hated me, and I was scared of them. I hid it well, though: *My parents just thought I was a little insecure.*

I was in high school when I started hearing the voices. I was picked to give a graduation speech, but I thought I heard people talking about how they didn't want me to give the speech. They weren't, of course, but here's the thing: It wasn't like a figment of my imagination. Those voices seemed absolutely real to me – like having hallucinations that you hear.

I was a high achiever, yet I was convinced I was a total failure. I was so good at covering up what was going on inside my head that I was even voted "most likely to succeed." To make things worse, I developed anorexia because a voice kept telling me that I was fat and ugly. My mom became concerned about my health. But most of the time my parents and teachers had no idea that anything was wrong.

I got accepted to Duke University, where I majored in economics and public policy. At first I made friends, joined a sorority, participated in the triathlon club, and even had a boyfriend for a few months. But by my sophomore year I thought that people were talking about me and laughing at me. I was so afraid of everyone that I quit the clubs and started isolating myself. I'd hide in my single dorm room with black paper over the peephole in my door. If someone knocked, I'd be so terrified that I wouldn't open the door. On weekends I'd pack up a bag of food and hide in an empty classroom to avoid people. Still, I continued to keep up appearances. I participated in class discussions, got good grades, and dressed well. To others I looked pretty normal, but that's not how I felt.

Lost in My Own Reality. Around this time I saw a doctor who diagnosed me with depression. My parents were worried; they could tell I didn't have any friends. Of course they had no idea that when the slightest thing went wrong, like if I got a bad grade on a test or my car had a flat tire, I thought about killing myself. I was an expert at hiding my feelings.

My life really fell apart when I started graduate school at Harvard. I was hearing voices all the time. They were feeding on my vulnerabilities, telling me "You're ugly, you're worthless, you deserve to die..." usually in this particular male, robotic-sounding monotone.

My mental abilities were slipping, too. Experts don't really understand why it happens, but cognitive decline is a part of this disease. When I got to the Harvard campus in the fall of 1998, I was completely disoriented. I'd get lost trying to find a classroom. I couldn't listen and take notes anymore. One day at the Laundromat I looked at the coins in my hand and they all looked the same; I couldn't count them. I had intense hallucinations, too. For example, my mom's parents were Holocaust survivors. One day at a subway station near the campus I thought the trains were going to concentration camps. I was convinced that if I got on a train I would die. So I stopped taking public transportation.

Soon I could no longer do the most basic things, like read and write, or take a shower. When I did go out, I wore a scarf around my mouth to keep random words from escaping. Some days all I could do was watch reruns of *Laverne & Shirley*. And I thought my landlord was trying to kill me. I felt like I was losing my mind, and I finally had to quit school. I still didn't know what was wrong with me, though. I thought maybe I had a brain tumor. I saw a neurologist, but the MRI showed nothing. And of course I didn't tell him about the voices or hallucinations.

Despite my secrecy, my parents were deeply worried. One day when I was talking to my mother on the phone, I told her I couldn't understand a word she was saying and I broke down crying. She panicked at first, but then she went online and got me an appointment with a psychiatrist. He thought I had borderline personality disorder (because he specialized in borderline personality disorder). Then I went to a specialist in bipolar disorder, and guess what? He thought I had bipolar disorder. But two months later, I finally found a doctor at McLean Hospital who really helped me.

I'd only been seeing him for a couple of weeks when I hit rock bottom: My voices told me to kill myself. "Seattle is where you were born and where you were meant to die," they said. I decided to do it. Despite my cognitive decline, I was able to plan my trip using the same determination that helped me fool everyone all those years. I unplugged my phone and fax machine in Cambridge and paid cash for my airline ticket so no one could track me. I didn't tell anyone. When I arrived in Seattle I checked into a hotel, where the voices seemed to emanate from the walls of my room. They told me to jump out the window. I tried to gather my courage to do it, with the voices egging me on. But then I thought about the physical pain of jumping, how much it would hurt, and something deep inside me, some long-buried sense of self-preservation, made me call my doctor. Luckily someone paged him and he called me right back. I told him where I was and that I just needed to talk. I didn't tell him I was planning to kill myself, though. His calm, reassuring voice was so different from the voices in my head and somehow, despite my foggy brain, it gave me the perspective I needed to postpone my suicide. That was my turning point.

Dealing with the Diagnosis. Getting a diagnosis of schizophrenia is very complicated. You have to have symptoms for at least six months. And, of course, you have to actually share what your symptoms are. After the Seattle incident, I was given a bunch of tests over several days. It was exhausting because I was convinced that the people doing the tests were out to get me. I thought everything had hidden meanings and I was terrified. My doctor gave me an IQ test, too, and my once high number had dropped to 70, a level nearly low enough to classify me as mentally retarded. I was in such bad shape I had to be hospitalized twice. All this told the doctor what he needed to know. I felt both devastated and hopeful to finally have a diagnosis - **Schizophrenia**.

I needed a lot of cognitive behavioral therapy to sort out my distorted thoughts. And we had to rebuild my brain from the bottom up, just like a broken body after a car accident. It was a relief when I finally told my parents. They flew across the country and were there for me every step of the way. My mom started by reading children's books to me -- old favorites like *Babar*, *Curious George*, and *Make Way for Ducklings*, to trigger my memory. We did word searches and played simple card games to stimulate my mathematical aptitude. For creativity, we played with Play-Doh and colored in coloring books. Little by little my brain got stronger. When I could read again, I started with juvenile books like *Deenie* by Judy Blume, which I had read as a tween. I practiced memorizing by starting with college basketball rankings and eventually worked my way up to Shakespeare. We slowly nursed my brain back to health.

Yes, I needed medications, too. I took antidepressants and I tried many antipsychotic drugs -- Haldol, Seroquel, Clozaril, Zyprexa (the one I'm on now). My doctor always believed, even when I couldn't read or write, that I would go back to Harvard. His faith in my future made all the difference. When I finally did go back I was able to get my master's degree.

I still hear the voices at times: "You're going to fail, you're going to get fired." "You're ugly, you deserve to die." It happens when I'm stressed out and tired. My doctor gave me techniques to help me cope. One I call "the hand." I count on each finger the people who agree with what the voices say, and there's only one: the voice itself. Then on the other hand I count the people who disagree with what the voices say: my doctor, my family, my friends, my coworkers -- and then that hand covers the other and overwhelms it.

I learned so much, I decided I wanted to help others who'd been through a similar nightmare. Now I have a full-time job working with people who have mental health issues. I teach, arrange events, speak to groups, and mentor patients. I want them to know that recovery is possible.

My life is so different now, and I'm sad I missed out on all kinds of normal relationships for so long. Sure, dating is difficult. Seriously, when do you tell a potential partner that you have schizophrenia? It's not something you want to say on a first date. Seeing my brother's loving family makes me think of how much I want kids. I recently turned 39, and I know that my medications can cause problems with pregnancy, so I doubt I can have a baby. Sometimes I mourn the fact that I'm not married and don't have children.

Schizophrenia is relentless, that's for sure. There's no cure, and you have to fight it every day. But I'm doing the best I've ever done. I have terrific support from my family, my friends, and my doctors. It's really challenging. And it takes guts to tell this story. But it's about the fight -- a fight I'm winning.

Suicide Rates Rise Sharply in U.S.

The New York Times

By Tara Parker-Pope, May 24, 2013

Suicide rates among middle-aged Americans have risen sharply in the past decade, prompting concern that a generation of baby boomers who have faced years of economic worry and easy access to prescription painkillers may be particularly vulnerable to self-inflicted harm.

More people now die of suicide than in car accidents, according to the Centers for Disease Control and Prevention, which published the findings in Friday's issue of its Morbidity and Mortality Weekly Report. In 2010 there were 33,687 deaths from motor vehicle crashes and 38,364 suicides.

From 1999 to 2010, the suicide rate among Americans age 35 to 64 rose by nearly 30 percent, to 17.6 deaths per 100,000 people, up from 13.7. Although suicide rates are growing among both middle-aged men and women, far more men take their own lives. The suicide rate for middle-aged men was 27.3 deaths per 100,000, while for women it was 8.1 deaths per 100,000.

The most pronounced increases were seen among men in their 50s, a group in which suicide rates jumped by nearly 50 percent, to about 30 per 100,000. For women, the largest increase was seen in those ages 60 to 64, among whom rates increased by nearly 60 percent, to 7.0 per 100,000.

Suicide rates can be difficult to interpret because of variations in the way local officials report causes of death. But C.D.C. and academic researchers said they were confident that the data documented an actual increase in deaths by suicide and not a statistical anomaly. While reporting of suicides is not always consistent around the country, the current numbers are, if anything, too low.

"It's vastly underreported," said Julie Phillips, an associate professor of sociology at Rutgers University who has published research on rising suicide rates. "We know we're not counting all suicides."

The reasons for suicide are often complex, and officials and researchers acknowledge that no one can explain with certainty what is behind the rise. But C.D.C. officials cited a number of possible explanations, including that as adolescents, people in this generation also posted higher rates of suicide compared with their cohorts.

"It is the baby boomer group where we see the highest rates of suicide," said the C.D.C.'s deputy director, Ileana Arias. "There may be something about that group, and how they think about life issues and their life choices that may make a difference."

The rise in suicides may also stem from the economic downturn over the past decade. Historically, suicide rates rise during times of financial stress and economic setbacks. "The increase does coincide with a decrease in financial standing for a lot of families over the same time period," Dr. Arias said.

Another factor may be the widespread availability of opioid drugs like OxyContin and oxycodone, which can be particularly deadly in large doses.

Although most suicides are still committed using firearms, officials said there was a marked increase in poisoning deaths, which include intentional overdoses of prescription drugs, and hangings. Poisoning deaths were up 24 percent during the 10-year period and hangings were up 81 percent.

Dr. Arias noted that the higher suicide rates might be due to a series of life and financial circumstances that are unique to the baby boomer generation. Men and women in that age group are often coping with the stress of caring for aging parents while still providing financial and emotional support to adult children.

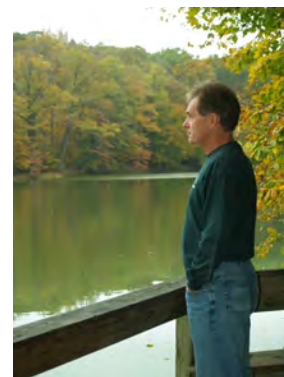
"Their lives are configured a little differently than it has been in the past for that age group," Dr. Arias said. "It may not be that they are more sensitive or that they have a predisposition to suicide, but that they may be dealing with more."

Preliminary research at Rutgers suggests that the risk for suicide is unlikely to abate for future generations. Changes in marriage, social isolation and family roles mean many of the pressures faced by baby boomers will continue in the next generation," Dr. Phillips said.

"The boomers had great expectations for what their life might look like, but I think perhaps it hasn't panned out that way," she said. "All these conditions the boomers are facing, future cohorts are going to be facing many of these conditions as well."

Nancy Berliner, a Boston historian, lost her 58-year old husband to suicide two years ago. She said that while the reasons for his suicide were complex, she would like to see more attention paid to prevention and support for family members who lose someone to suicide.

"One suicide can inspire other people, unfortunately, to view suicide as an option," Ms. Berliner said. "It's important that society becomes more comfortable with discussing it. Then the people left behind will not have this stigma."

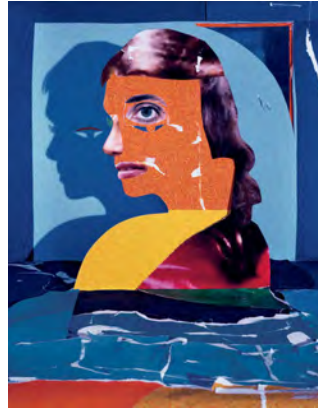


The Problem With How We Treat Bipolar Disorder

The New York Times

April 26, 2013, By Linda Logan

The last time I saw my old self, I was 27 years old and living in Boston. I was doing well in graduate school, had a tight circle of friends and was a prolific creative writer. Married to my high-school sweet-heart, I had just had my first child. Back then, my best times were twirling my baby girl under the gloaming sky on a Florida beach and flopping on the bed with my husband - feet propped against the wall - and talking. The future seemed wide open.



I don't think there is a particular point at which I can say I became depressed. My illness was insidious, gradual and inexorable. I had a preview of depression in high school, when I spent a couple of years wearing all black, rimming my eyes in kohl and sliding against the walls in the hallways, hoping that no one would notice me. But back then I didn't think it was a very serious problem.

The hormonal chaos of having three children in five years, the pressure of working on a Ph.D. dissertation and a genetic predisposition for a mood disorder took me to a place of darkness I hadn't experienced before. Of course, I didn't recognize that right away. Denial is a gauze; willful denial, an opiate. Everyone seemed in league with my delusion. I was just overwhelmed, my family would say. I should get more help with the kids, put off my Ph.D.

When I told other young mothers about my bone-wearying fatigue, they rolled their eyes knowingly and mumbled, "Right." But what they didn't realize was that I could scarcely push the stroller to the park, barely summon the breath to ask the store clerk, "Where are the Pampers?" I went from doctor to doctor, looking for the cause. Lab tests for anemia, low blood sugar and hypothyroidism were all negative.

Any joy I derived from my children was now conjoined with grief. I couldn't breathe the perfume of their freshly shampooed hair without being seized by the realization that they would not always be under my roof. While stroking their backs, I would mentally fast-forward their lives — noses elongating, tongues sharpening — until I came to their leave-taking, until I reached my death and, ultimately, theirs.

I lost my sense of competence. If a colleague remarked on my intelligence, I mentally derided him as being too stupid to know how dumb I was. If someone asked what I did for a living,

I would say, "Nothing" — a remarkably effective conversation stopper. I couldn't bear the thought of socializing; one night I jumped out of the car as my husband and I were driving to a party.

Despite having these feelings in my mid-30s I was thriving professionally: I had recently completed my Ph.D. in geography, had just finished co-teaching a semester at M.I.T. and was revising my dissertation for a respected university press. Yet several nights a week, I drove to the reservoir near my home, sat under a tree and, as joggers ran past, thought about ending it all. There was a gun shop on the way to my poetry group; I knew exactly where to go when the time came.

My day, once broken by naps, gradually turned into lengthy stretches of sleep, punctuated by moments of wakefulness. My husband and I didn't explain to the kids that I was depressed. "Mommy's a little tired today," we would say. A year or so earlier, a therapist told us to tell the children. "But they're just kids," we said. "What do they know?" "They know," she said. When we eventually spoke to them, my oldest daughter came to me and asked: "Why did you keep it a secret? I thought all mothers were like you."

Gradually suicide eclipsed all other thoughts.

I finally told my husband about my worsening psychic pain. The next day I was hospitalized. It was June 1989. Even though we were living in Boston, we decided I should go to Chicago to work with the psychopharmacologist who, 15 years earlier, restored the health of my father, who had also been hospitalized for depression. As the cab pulled away from our house, I turned and saw three children's hands pressed against the screen of an upstairs window. This is the way the world breaks.

The moment the psych-unit doors locked behind me, I was stripped of my identity as wife, mother, teacher and writer and transformed into patient, room number and diagnosis. I was told when to sleep and when to wake, when to eat and when to go to group. My routine revolved around the clattering sounds of the food trays being brought three times each day from the service elevators into our unit. With my husband and children nearly 1,000 miles away, I was severed from my fixed stars. I missed my children's smells, the way they used to wrap their bodies around my legs when I was on the phone. I brought my son's comforter to the hospital for my bed. I remembered him with one leg thrown across the covers, a foot peeking out from his pajamas.

When my children visited, I had to resuscitate my maternal self, if only for an hour. I dragged myself to the shower, pulled on a pair of clean sweat pants and a

fresh T-shirt and ran a streak of lipstick across my lips, hoping to look like a facsimile of a mother.

My doctor used my first hospitalization as a “washout,” a period during which he planned to take me off the medication I was on and introduce several drugs in different combinations. The prospect of poly-pharmacy — taking many drugs at once — seemed foreboding. I read about Prozac’s giving some people entirely new personalities: happier, lighter, even buoyant. “Who are you going to turn me into?” I asked my doctor.

“I’m not turning you into anyone,” he said. “You’ll be yourself, only happier.”

“I don’t think I have a self anymore.”

“We’ll find your self.”

I was wary. “Just don’t turn me into Sandy Duncan.”

How much insult to the self is done by the symptoms of the disorder and how much by the drugs used to treat it? Paradoxically, psychotropic drugs can induce anxiety, nervousness, impaired judgment, mania, hypomania, hallucinations, feelings of depersonalization, psychosis and suicidal thoughts, while being used to treat the same symptoms. Before getting to the hospital, my daily moods ranged from bad to worse, each state accompanied by a profound depth of feeling. The first drug I was given was amitriptyline (Elavil), which, in the process of reducing my despair, blunted all my other emotions. I no longer felt anything.

While some medications affected my mood, others — especially mood stabilizers — turned my formerly agile mind into mush, leaving me so stupefied that if my brain could have drooled, it would have. Word retrieval was difficult and slow. It was as if the door to whatever part of the brain that housed creativity had locked. Clarity of thought, memory and concentration had all left me. I was slowly fading away.

I would try to talk to my doctors about my vanishing self, but they didn’t have much to say on the subject. Instead they focused on whether I could make eye contact or how much expression I showed in my face. They monitored my lithium and cortisol levels; they took an M.R.I. of my head. I received an EKG, was exposed to full-spectrum lighting and kept awake all night for sleep-deprivation therapy. Nurses jotted down their observations; my scribbled lines in art therapy were inspected. Everything was scrutinized — except the transformation of my self and my experience of its loss.



My current psychiatrist, William Scheftner at Rush University Medical Center, says this is typical when treating patients with acute mental disorders. The primary goal at the height of a mental-health crisis is symptom reduction. That means monitoring patients’ sleep patterns, appetites and responses to medications — not worrying about philosophical questions like who they are and who they will become. “The issue of self just isn’t there,” he told me, “because you’re pre-occupied with whether someone is actually improving or not.”

By August 1989, I was back in Boston with my husband and kids, having been discharged from the hospital almost three months after I was admitted. My children, like many people, mistook “discharge” for “recovery.” “Why did they let you out if you’re not better?” my daughter asked. I didn’t know how to explain the welter of factors that go into discharge: poses no threat to self or others; is functioning at a high-enough level to participate — however minimally — in the tasks of daily living. Recovery was not an end, I told her, but a process.

The trees were starting to change colors. Acorns dropped and exploded like tiny bombs. My car was in the driveway; my clothes were in my closet. But things felt ill fitting and unfamiliar. Nowhere was my otherness more keenly experienced than at the driveway at the grammar school. Everyone knew that I had been “away,” and why. I tried to imitate the other mothers, their relaxed camaraderie, their confidence, the way they threw their heads back when they laughed.

Around Halloween I had my first hypomanic episode. This was how my doctors confirmed that my depression wasn’t just depression — I had bipolar II disorder, like my father. With bipolar II, unlike bipolar I, the upward swing from depression stops at hypomania, not mania. Mania is having five grand pianos delivered to your house; trying to buy the Sears company; sleeping with the local baseball team. Hypomania is mania with a tether, and, while it might avert some of the financial and interpersonal disasters that unchecked mania may engender, it can still feel like a runaway train.

By that point my vestigial self had grown used to my depressed self, with her somber mood and tenuous hold on life. Now a newcomer arrived. I seemed to have split into three: my shell-shocked self, my depressed self and a brazen hypomanic self. We could practically hear the new girl sizing us up, cackling. Under her reign, we slept two hours a night. We ate half a sandwich and two potato chips a day. We packed the children’s lunchboxes at 3 a.m. We began to study for the MCATs (the fact that we had never taken a biology or chem class seemed irrelevant). The hypomanic self’s activities, from relentless lunch dates and impulsive spending sprees, left my

tattered and depressed selves saying, “That’s not us” and “We don’t do that.”

I no longer went to bed with my husband. Instead I stayed awake, scribbling in my notebooks. My wakefulness worried my son. “I had a bad dream,” he said. “You were downstairs working, and while everyone else in the house was sleeping, the house fell down on you.” “Oh,” I said, pulling him close. “That is a bad dream. Did anybody get hurt?”

“No, but the cats almost died.”

Hypomania was consuming me. My doctor, in an effort to quash the hypomania, upped my lithium dose and catapulted me back into depression, back to a locked psych unit, after New Year’s Day in 1990. A few weeks later, my kids came to visit. I met them in the lobby. The chair I was sitting in felt insubstantial; the walls seemed to bend. My son was excited. “I made a scientific discovery!” he said. “There can’t be a shadow in the darkness.” He understood depression better than my doctors, I thought. “Mommy?” he said a few moments later. He sounded far away. I leaned back and fell asleep. I didn’t see them again for 4 months.

My medical records showed that by the spring, I thought I was in a Canadian train station and that it was 1976. I lugged a suitcase stuffed with towels around the unit, looking for the departure platform. If my self had been assailed by depression, then psychosis was the final blow. My sense of boundedness — where I stopped and other people or the environment began — was sloppy, like a toddler scribbling outside the lines. I didn’t envision myself as human; I pictured myself as black vermicelli on an asphalt driveway. For a brief time, I could neither write nor speak. My journals show a perseverating pencil — a long string of Ts or entries in hypergraphic writing, alternating between conventional and unconventional language.

I hallucinated. The world was suddenly up for grabs; reality, an option. Rectangular rainbows streamed through the day-room windows. Peasants from a Jean-François Millet poster walked out of the frame and marched across the wall.

Some researchers say that in psychosis, the self persists, however tenuously. Sue Estroff, a professor of social medicine at the University of North Carolina, described it as “more of a foreground, background thing. During psychosis, the self recedes.” But, she told me, “you’re still in there.”

By early summer, the psychosis had run its course, and I returned to lucidity. Later that summer, after I became well enough to be discharged once again, we decided to move to the Chicago area so that I could continue working with my father’s doctor, whom I trusted, and be near our families. But seven months after moving into our new house, I was back in the hospital. I would be readmitted and discharged two more

times over the next half-year. When I left the hospital for the last time in August 1991, I was 38, and while no longer intent on self-destruction, I was more accurately rescued, not restored.

Taking care of children and running a household seemed like a herculean task. My husband and I realized we needed a housekeeper. We found a wonderful woman who knew just what needed to be done: cook, clean and be a surrogate mother. While appreciative of her help, I felt as if my role had been usurped.

I continued to see my doctor every week as an outpatient. But I was demoralized and failed to see much of a change. I asked him how he healed my father, maintaining him on only three lithium tablets a day, whereas I had experimented with about 100 different combinations and dosages of medications (including antidepressants like monoamine oxidase inhibitors, tricyclics and, later, S.S.R.I.’s). “*Because,*” he said, “*your dad was a Ford. You are a Ferrari.*” I didn’t know if this was a compliment or an insult.

The first few years after my last hospitalization, I spent a lot of time on the shore of Lake Michigan, near my home. I collected beach stones and organized them by size, color, shape and heft. Soon I had dozens of shoe boxes full of them. Sometimes I talked to the Russian fishermen looking for smelt on the pier; other times I walked alongside older women and helped them look for sea glass. I took three-hour naps every afternoon, trying to remember to set the alarm clock, so I would be awake when the kids came home from school. Many times they met a closed bedroom door.

By 1995, I started to feel small changes. The medications were the same. I was still seeing my father’s doctor. I had the same support from my family and from my husband, who once, when I came home on a day pass, had pansies — my favorite flowers — planted along the path from the driveway to the house. The protective cocoon he made for me, along with time, allowed my self to regrow. I could feel my self filling in. Gradually, I was able to fulfill more of my maternal role: helping with homework, driving to piano lessons, making the worst Rice Krispies Treats in the school. Our housekeeper, while still a tremendous support, was becoming more of a safety net than a primary caregiver.

With confidence easing its way back to my self, I volunteered at an anorexia foundation near my house. Writing was getting easier, words were unlocking. One day I was on the porch with the kids, who were doodling with crayons, when I wrote down the word “pain.” Without thinking, I picked up a crayon and added the letter T to the end of the word. A half-hour later, we were at an art-supply store, buying brushes, paint and a canvas.

We converted the unused third floor of our house into a studio. Passion had returned and, along with it, creativity.

One day, about eight years ago, it struck me that bipolar disorder was the hand I was dealt. I remembered what my father said to me when I moved from Boston: ***“Don’t look at what your disorder has taken away from you, try to find what it has given you.”*** I began speaking to family-education classes at a mental-health organization. I presented a paper at a conference. The more often I spoke, the less traumatic my experience seemed, the less sad, and, somehow, the less personal.

Over the years, I’ve talked to clinicians about why the self is rarely mentioned in treating patients who suffer from mental illnesses that damage their sense of who they are. If anything, it seems that psychiatry is moving away from a model in which the self could be discussed. For many psychiatrists, mental disorders are medical problems to be treated with medications, and a patient’s crisis of self is not very likely to come up in a 15-minute session with a psychopharmacologist.

Philip Yanos, an associate professor of psychology at John Jay College of Criminal Justice, in New York, studies the ways that a sense of self is affected by mental illness. He told me that when his work was under grant review, it was initially met with skepticism. Some thought that what he calls “illness identity,” which manifests in some patients as over-identifying with their mental disorder, was a topic of lesser importance in the face of other serious symptoms that patients experience, like cognitive impairment and thoughts of suicide.

Yanos told me that reshaping your identity from “patient” to “person” takes time. For me, going from patient to person wasn’t so arduous. Once I understood I was not vermicelli, part of my personhood was restored. Reconstructing my self took longer.

One reason that may have been the case, as Amy Barnhorst, a psychiatrist at the University of California, Davis, told me, is the unique set of challenges facing people who have experienced mania and hypomania. “The parts of the selves that may come out” in mania and hypomania, which can be horrifying, “are very real,” she said, making it difficult for patients “to reconcile those behaviors with their self as they have come to know it.” In mania and hypomania, the sick self has no accountability; the improved self has a lot of explaining, and often apologizing, to do.

For many people with mental disorders, the transformation of the self is one of the most disturbing things about being ill. And their despair is heightened when doctors don’t engage with the issue, don’t ask about what parts of the self have vanished and don’t help figure out strategies to deal with that loss.

Janina Fisher, the assistant director of the Sensorimotor Psychotherapy Institute in Broomfield, CO, told me that there has been a change in the role the self plays in the therapeutic dialogue since the decades when I was sick. New therapies and

treatment philosophies, founded mostly by clinical psychologists and other practitioners who are not medical doctors, recognize the role of the self in people with mental illness. Patients tell her, *“I just want to be that person I used to be.”* Fisher encourages her patients to recognize that their mental trauma is a part of their life, but shouldn’t dominate it.

In my own experience with Scheftner, whom I began seeing after my father’s doctor moved away, we talk about the self but only when I bring it up. That’s why I have enjoyed helping to run a support group for people with mental disorders, something I’ve been doing for the last three years. There are usually 8 to 12 of us. We sit in the basement of a library every Wednesday afternoon. Though we know one another’s innermost thoughts, we are intimate strangers, not friends. Like A.A. and other self-help groups, we’re peer-led: run by and for people with mental disorders. We talk one by one about the past week — achievements, setbacks, conflicts. While the self is not always an explicit topic, the loss of self, or for those doing better, the reconstruction of the self — is a hovering presence in the group.

One day a middle-aged man came to our group. He told us that he spent the past year attending different grief groups, but none of them were right. “Why not?” someone asked. The man said: ***“Because everyone there was grieving the loss of another person. I was grieving for myself. For who I used to be before I got sick and who I am now.”***

During the 20-odd years since my hospitalizations, many parts of my old self have been straggling home. But not everything made the return trip. While I no longer jump from moving cars on the way to parties, I still find social events uncomfortable. And, although I don’t have to battle to stay awake during the day, I still don’t have full days — I’m only functional mornings to mid-afternoons. I haven’t been able to return to teaching. How many employers would welcome a request for a cot, a soft pillow and half the day off?

Five years ago, my husband and I were talking on the family-room sofa. I was still wearing my pajamas and had wool hiking socks on. As he rubbed my feet, he told me he was leaving. It was, at once, a scene of tenderness and savagery. A little later, he threw some clothes into a suitcase and moved out. But my self — devastated, grieving, angry — remained intact.

Today, my mind is nimble. Creative writing has crept back into my life. I’ve made a couple of close friends in Chicago. My greatest pleasure is still my children — they’re starting careers, marrying, on the brinks of their lives. This June, I’m turning 60. I’m having a small party to celebrate my ingathering of selves. My old self was first to R.S.V.P.



Delivering Quality & Innovation in patient care

National Nurses Week is celebrated annually from May 6, also known as National Nurses Day, through May 12. The National Nurses Week logo was developed by the American Nurses Association (ANA) to help celebrate nurses and all that they do.

CCBC's Inaugural Nurses Meeting

On May 6, 2013, CCBC nurses attended the inaugural CCBC Nurses Meeting at 1 Washington Street for a combined luncheon in honor of National Nurses Day and business meeting. Attendees included Jean Ann Helger, Abe Rodriques, Marcia Miller, Beth Fitzgerald, Liz McElroy, Gregory Auger, and Louise Preti. This grass roots gathering proved productive in terms of forming the function and charge for the CCBC Nurses Committee.

The nurses shared ideas and prioritized nursing needs for the agency, including recruitment of additional Infection Control Subcommittee members. Nurses Committee members agreed to meet quarterly to network and collaborate, discuss challenging case studies, review pertinent nursing issues affecting clinical practice, recognize peer professional accomplishments, and present topics for updated evidence-based trainings to further inform clinical nursing practice.

The CCBC Nurses Committee proudly announces that one of our members, **Gregory Auger, has achieved National Certification in Addictions Nursing, CARN.** We congratulate Gregory on this prestigious accomplishment!

The CCBC Nurses Committee is committed to the delivery of quality care to all clients consistent with CCBC's purpose and mission. The CCBC Nurses Committee is also committed to the support of all agency employees. As nurses we look forward to continuing in our daily work to deliver our best nursing care for all!

Coping with Mental Illness - A Narrative of Hope

by Russell D. Pierce, J.D.

Russell Pierce is the Department of Mental Health's new Director of Recovery and Empowerment. In his narrative "[Coping with Mental Illness - A Narrative of Hope](#)" he presents an insightful and compelling look at living with mental illness. Here are several excerpts:

"I was initially reluctant to write a short note about "coping" with mental illness, because for me I have not been coping with a disease, I have been very much celebrating a struggle and not mourning a death. Coping connotes an unwanted interference, something that is very bothersome, but I welcome this challenge as an opportunity to grow - a pain that nurtures."

"Peer support programs at their very best are non-pathologizing, non-hierarchical, non-infantilizing, and very much "bottom-up" rather than "top-down" - and of immense personal value and satisfaction. Peers are persons with whom I feel comfortable - so much so that I can share - strong enough to reveal hurts, scars and wounds, disappointments, pains and pleasures. So linked do peers become that we share not only our common medical histories or psychological profiles, but delve ever more deeply into what makes us really human - gradually removing the veil of all difference, and becoming in the process "durable companions" even."

To read the article in its entirety, please click on the link below. (*ctrl + click to follow link*):

<http://comcounseling.org/documents/narrative-of-hope.pdf>



This is a reminder to staff that suggestions for articles to submit for the Fall 2013 Newsletter are welcome!

Please email Becky Roberts @broberts@comcounseling.org.

Did you know...

Statistics provided from the National Council of Behavioral Health.



The 10th Annual NAMI Walk was held in Boston on Saturday, May 11, 2013. Starting at Artesani Park in Brighton, the walk is 3 miles (5k) and makes a nice loop around the Charles River. As always, CCBC had an enthusiastic group of NAMI walk volunteers this year. Our team was comprised of prescribers, managers, clinicians, and clients: both walkers and cheerleaders. People pulled together in a most encouraging and uplifting way, preparing, arranging, making lunches, cheer-leading and soliciting donations. *Great weather, great music, great energy, a great success!*

MISSION STATEMENT

THE PURPOSE AND MISSION OF COMMUNITY COUNSELING OF BRISTOL COUNTY, INC. (CCBC) IS TO DEVELOP AND DELIVER COMPASSIONATE, RESPONSIVE, CULTURALLY COMPETENT, AND QUALITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES TO MEET THE PREVENTION, EDUCATION, TREATMENT, REHABILITATION AND RECOVERY NEEDS OF THOSE IN OUR COMMUNITY. THESE SERVICES ARE BASED ON THE LATEST EVIDENCE-BASED APPROACHES TO RESPOND TO THE COMPLEX NEEDS OF CHILDREN, ADOLESCENTS, ADULTS, ELDERLY AND FAMILIES AS PART OF A LOCALLY INTEGRATED HEALTHCARE DELIVERY SYSTEM LINKED TO REGIONAL AND STATEWIDE DELIVERY SYSTEMS.



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