Faith community leaders and staff are often the first line of responding to someone with mental illness. It’s critical to know our local resources for referrals—help is available for people to live as fully as possible with mental illness. Below is a list of some of our community agencies.

This resource is organized in several sections for your use:
- Crisis Response—where to go when someone needs emergency attention.
- Treatment and Ongoing Care—organizations providing care for mental health issues; These are grouped by those that provide treatment for adults, and those for children or adolescents.
- Support—groups that provide support for people with mental illness and their loved ones.
- Education—places that those with mental health issues and the community at large can access educational opportunities.

Please note that while this compilation of mental health services represents significant resources in our community, it is not intended to be an exhaustive listing. We trust it will be helpful, though, in your work and ministry.

**Crisis Response**

**In the event of a life-threatening situation or medical emergency, call 9-1-1.** This might include situations in which thoughts of suicide are expressed or a weapon is present or a potential overdose is involved. Ask for a CIT (Crisis Intervention Trained) officer or a MAC (Mobile Acute Crisis) Team for mental health or substance use situations.

- **Community-wide Crisis Line** 520-622-6000 800-796-6762
  - Crisis clinicians are available **24 hours a day, 7 days a week** for people experiencing a crisis related to their mental health or to alcohol or other substance use.

- **Southern Arizona Mental Health Corporation (SAMHC)**  www.samhc.com
  - Persons experiencing a mental health crisis can walk-in to SAMHC **8:00 a.m. – 8:00 p.m., 7 days a week**. Trained staff will provide crisis assessment, crisis counseling, and/or referral to community providers for continuing care.
  - SAMHC’s walk-in center is located at **2502 N. Dodge Blvd.**, Suite 190  Tucson, AZ 85716.
  - SAMHC’s Mobile Acute Crisis (MAC) Teams go to wherever the person in crisis is located. They provide mental health assessment, crisis counseling, crisis de-escalation, consultation with a behavioral health provider, and/or transportation to an appropriate agency for further care.
  - Call **520-622-6000**.
Behavioral Health Pavilion 520-874-2000  Outpatient Clinic 520-874-7500
This facility provides emergency medical and mental health services as well as inpatient and outpatient service. It also includes a courtroom for patients admitted through the legal system. Located adjacent to UPH Hospital at 2802 E. District (Ajo Way and Forgeus Ave.).

Crisis Response Center 520-622-6000 (Community-wide Crisis Line)
The CRC, part of the complex including the Behavioral Health Pavilion described above, is available to triage youth and adults in a non-emergency mental health crisis and to direct them to appropriate community resources. The facility includes a sub-acute inpatient care unit.

Treatment and Ongoing Care
Community Partnership of Southern Arizona (CPSA) www.cpsa-rbha.org
CPSA is the Regional Behavioral Health Authority (RBHA) designated by the state of Arizona to manage publicly-funded mental health services for adults, children, and their families in Pima County. These services are coordinated through a provider network.
Persons seeking mental health care should call CPSA’s Member Services at 520-318-6946, 800-771-9889, or 520-318-6960 for hearing impaired. They’ll speak with a Member Services Representative who will help determine eligibility for services, explain how to become a member, and help choose a provider. Individual agencies are listed below, as well.

Adults
Behavioral Health Pavilion 520-874-2000  Outpatient Clinic 520-874-7500
This facility provides inpatient and outpatient service as well as emergency medical and mental health services. It also includes a courtroom for patients admitted through the legal system. Located adjacent to UPH Hospital at 2802 E. District (Ajo Way and Forgeus Ave.).

CODAC Behavioral Health Services 520-327-4505 (main line) www.codac.org
Other phone numbers: 520-202-1840 to enroll for treatment or make an appointment 520-343-2225 for Member Services 520-202-1950 After hours support (Safety Zone)
Part of the CPSA provider network, CODAC provides therapy and counseling for mental health issues, serious mental illness, and substance use disorders. They accept most commercial insurance plans as well as Arizona Health Care Cost Containment System (AHCCCS) plans and also have a fee-for-service option.

Compass Behavioral Health Care 520-882-5806 www.compasshc.org
Compass focuses an array of services on substance abuse treatment for adults. Their Desert Hope Detoxification Service is available by phone or walk-in 24 hours, 7 days a week: 520-622-6000 (Community-wide Crisis Line) 520-624-5272 2499 E Ajo Way
They also provide residential services, outpatient care, individual and group counseling, and family services.
COPE Community Services  
520-318-6948  800-771-9889  www.copebhs.com
Part of the CPSA provider network, COPE offers support for those dealing with serious mental illness, general mental health issues, and substance use disorders. Outpatient programs include counseling, case management, and recovery support. Residential programs are also available, as are health education and wellness programs.

Jewish Family and Children’s Services (JFCS)  
520-795-0300  www.jfcs.org
Among its array of programs, JFCS provides counseling services for people regardless of religious or ethnic background. The Counseling and Support Services therapists help with issues such as trauma, anger management, substance use and recovery (including a program for youth ages 13-18), sexual assault, domestic violence (including a program for children ages 3-18), self-harming behaviors, and other emotional/psychological issues.
These services are available at JFCS’s three offices and other community-based locations. They accept most major insurances as well as Medicare and also have a sliding fee scale.

La Frontera Arizona  
520-838-5525 (treatment services)  520-838-3804 (appointments)
www.lafronteraaz.org
La Frontera is part of the CPSA provider network. They offer outpatient counseling and outpatient services such as assessment, crisis response, therapy, and continuing care recovery. Residential treatment is available, as is the Psychiatric Health Facility, a locked facility for those in acute crisis. In addition, their housing department helps those with serious mental illness acquire affordable housing.
They accept those enrolled in AHCCCS and some other insurance plans.

LaFrontera--RAPP Project CONNECT  
520-882-8422  1101 E. Broadway Blvd. Suite 130
This program provides community-based treatment to homeless persons who have a serious mental illness. Services include a drop-in center where individuals have access to a telephone, restroom, hygiene kits, clothing, and blankets. Prescreening for mental health and/or substance use services is provided. Other services include transitional housing (Sonora House), case management for CPSA-enrolled clients, and wellness activities.

Marana Health Center  
520-682-4111  www.maranahealthcenter.org
MHC Behavioral Health Services is part of the CPSA provider network. They have programs for those dealing with general mental health issues, serious mental illness, and/or substance use disorders. Patients include adults and youth through the probation system and people enrolled in AHCCS. The facility is the major behavioral health services provider in Marana, Rillito, Picture Rocks, Avra Valley, and northwest Tucson.

Sonora Behavioral Health  
800-349-0083  www.sonorabehavioral.com
This hospital provides services for children, teens, and adults for mental health issues and addiction treatment. Services include inpatient care, intensive outpatient treatment, and assessment and referral. They accept most commercial health plans, as well as Medicare and AHCCCS.
**Children/Adolescents**

**Casa de los Ninos** 520-5600  www.casadelosninos.org
The Casa de los Ninos Behavioral Health Services is part of the CPSA provider network. They provide individual, group, and family counseling; in-home assessments; crisis care; substance abuse treatment; and case management for children and adolescents under the age of 22. Their “Great Beginnings” mental health clinic serves children under 5 years of age who have experienced or seen violence. Casa de los Ninos services are available only to those enrolled in AHCCCS.

**Jewish Family and Children’s Services** 520-795-0300  www.jfcs.org
Among its array of programs, JFCS provides counseling services for people regardless of religious or ethnic background. The Counseling and Support Services therapists help with issues such as trauma, anger management, substance use and recovery (including a program for youth ages 13-18), sexual assault, domestic violence (including a program for children ages 3-18), self-harming behaviors, and other emotional/psychological issues. These services are available at JFCS’s three offices and other community-based locations. They accept most major insurances as well as Medicare and also have a sliding fee scale.

**La Frontera Arizona** 520-838-5525 (treatment services) 520-838-3804 (appointments)  www.lafronteraaz.org
La Frontera is part of the CPSA provider network. They offer outpatient counseling and outpatient services such as assessment, crisis response, therapy, and continuing care recovery. Residential treatment is available, as is the Psychiatric Health Facility, a locked facility for those in acute crisis or those referred through Title 36 action. In addition, their housing department helps people with serious mental illness acquire affordable housing. They accept those enrolled in AHCCCS and some other insurance plans.

**Marana Health Center** 520-682-4111  www.maranahealthcenter.org
MHC Behavioral Health Services is part of the CPSA provider network. They have programs for those dealing with general mental health issues, serious mental illness, and/or substance use disorders. Patients include adults and youth through the probation system and people enrolled in AHCCS. The facility is the major behavioral health services provider in Marana, Rillito, Picture Rocks, Avra Valley, and northwest Tucson.

**Pantano Behavioral Health Services** 520-917-6485  520-318-6946 (CPSA Member Services)  www.pantanobh.org
Part of CPSA’s provider network, Pantano offer services for children, adolescents, young adults, and their families. Services include psychiatric assessment and treatment; in-home services; individual, family, and group counseling; and case management. Available only for those enrolled in AHCCCS.

**Providence Service Corporation** 520-748-7108  www.provcorp.com
Begun in Tucson, Providence is a nation-wide for-profit corporation. Their services for children, teens, and their families include therapeutic foster care (part of the CPSA provider network), home-based counseling, case management, substance abuse program, crisis intervention, and prevention services.
Sonora Behavioral Health  800-349-0083  www.sonorabehavioral.com
This hospital provides services for children, teens, and adults for mental health issues and addiction treatment. Services include inpatient care, intensive outpatient treatment, and assessment and referral. They accept most commercial health plans, as well as Medicare and AHCCCS.

Support

HOPE, Inc.  520-770-1197  www.hopetucson.org
HOPE (Helping Ourselves Pursue Excellence) is a “consumer-run, consumer-driven” agency with services for adults in the behavioral health community. Their Warm Line is available for people in a non-crisis situation who need someone to talk to:

   520-770-9909 or 520-770-9912  8:00 a.m -12:00 a.m., 365 days/year

The Nueva Luz Center offers support programs for those living with mental illness. The Center is located at 1200 N. Country Club Rd., one block north of Speedway Blvd.
They also provide recovery support and planning for adults being released from jail or the Crisis Response Center.

MIKID (Mentally Ill Kids in Distress)  520-882-0142  www.mikid.org
A state-wide organization, MIKID offers phone support for parents and caregivers of children with mental illness:  800-356-4543.
They also offer support groups for parents/caregivers and for grandparents. Their Youth Council is a place of support, service projects, and education for young people who have mental illness.

National Alliance on Mental Illness (NAMI)-Southern Arizona  520-622-5582  www.namisa.org
NAMI provides strong support and education programs for people with mental illness, their families and friends, and the community at large.
Support groups for individuals with mental illness, as well as for families and friends, are offered in various locations. Their Heart to Heart program pairs a volunteer companion with a person with serious mental illness.
See below in Education for NAMI’s educational programs.

Other Support Groups and Resources:
   Al-Anon (families of those with alcohol use issues)  520-323-2229  www.al-anon-az.org
Alcoholics Anonymous  520-624-4183 (24-hour hotline and meeting information)
   www.aatucson.org
Child and Family Resources (childcare referral, services for families)  520-881-8940
   www.childfamilyresources.org
Depression and Bipolar Support Alliance  520-531-2388  www.dbsatucson.org
Divorce Recovery  520-495-0704  www.divorcerecover.net
Emerge! Center Against Domestic Violence  888-428-0101  24 hr/7 days bilingual hotline
   520-795-8001  www.emergecenter.org
Narcotics Anonymous  520-881-8381 (24-hour helpline)  www.natucson.org
Postpartum Depression Support Group (Carondelet Health Network)  520-873-6858
Survivors of Suicide  520-861-663
Wingspan (programs for LBGT youth and adults, Anti-Violence Program)  520-624-1779
   www.wingspan.org
**Education**

Mental Health First Aid USA  
520-318-6950x3000  
www.cpsa-rbha.org

This training, begun in Australia and taught throughout the U.S., is offered in Pima County by CPSA. The 12-hour, 2-day course covers basic mental health education and response skills. The idea is to train community members how to best respond to mental health emergencies, as we do for physical health emergencies. The classes are scheduled at various times and locations and are given free of charge, though pre-registration is required.

National Alliance on Mental Illness (NAMI)-Southern Arizona  
520-622-5582  
www.namisa.org

NAMI’s education programs include Family to Family/Familia a Familia for families and friends of someone with mental illness; Peer to Peer/Persona a Persona for those who have mental illness; and NAMI Basics for caregivers of children or adolescents with mental health issues. Through their In Our Own Voice program, individuals living with mental illness are available to speak to community groups.

Community Information and Referral Services  
http://www.cir.org/

Key source of integrated information that brings people and services together to meet vital needs. It is their vision that all Arizonans are easily connected to available health and human services in their communities through this comprehensive directory of organizations.
2012 MENTAL HEALTH MINISTRY RESOURCES

Anabaptist Disabilities Network - www.adnetonline.org

Catholic Archdiocese of Chicago, Commission on Mental Illness and Faith and Fellowship for People with Mental Illness - www.miministry.org Resources include parish manual and downloadable material and reflections on Faith and Mental Illness.

Congregational Mental Health Ministry Resources – www.congregationalresources.org/mental-health-ministry-resources - over 100 annotated books and DVD’s for clergy and laypersons

Council on Mental Illness of the National Catholic Partnership on Disability (NCPD) - www.ncpd.org offers a DVD and manual entitled “Welcomed and Valued”. Also offers archived webinars and prayers services.

Jewish Community Mental Health - www.jamiuk.org


NAMI FaithNet – www.nami.org/faithnet; look for the new downloadable training materials, Reaching out to Faith Communities and Bridges of Hope

Mental Health America- www.nmha.org

Mental Health Ministries - www.mentalhealthministries.net offers DVD’s, worship resources, bulletin inserts, educational and inspirational materials,

Mennonite Media- www.mennomedia.org

Mental Illness Education Project - www.miepvideos.org

Muslim Mental Health – www.muslimmentalhealth.com

National Alliance on Mental Illness – www.nami.org


One Mind Mental Illness Ministry – www.onemindmentalillnessministry.com

Presbyterian Church Serious Mental Illness Network –look for Comfort my People, a training manual at www.pcusa.org/health/usa/programs/seriousmentalillness.htm

Pathways to Promise – www.pathways2promise.org offers bulletin inserts, worship resources and training materials

The Episcopal Mental Illness Network - www.eminnews.org/

United Church of Christ Mental Illness Network – www.min-ucc.org
NAMI Southern Arizona helps all those affected by mental illness including individuals with mental illness and their families by providing support, education and advocacy. All of our programs and services are free of charge and most programs/services are available in Spanish.

*The mission of NAMI Southern Arizona is to improve the quality of life for individuals who live with mental illness and for their family members by providing education, advocacy and support that is high quality, recovery oriented, and culturally sensitive.*

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**Our Services**

**Advocacy***
- We offer advocacy for individuals with mental illness as well as for family members. You or your loved one may ask us about patient rights, how to obtain quality mental health services, and more. Staff Advocates and Resource Specialist Advocates are available to answer your questions.

**Education**
- **Family to Family***: A 12-week educational course for family members and friends who have a loved one with mental illness. This course is taught by two teachers who each have a loved one with mental illness.
- **Peer to Peer***: A 9-week course on recovery for people with a mental illness diagnosis. This course is taught by two mentors who have mental illness and are in recovery.
- **Parents and Teachers as Allies**: An in-service education program presented to school professionals or other agencies working with children and adolescents.
- **In Our Own Voice***: An interactive presentation offered to community groups; two individuals with mental illness present their stories and an educational video.
- **NAMI Basics**: A 6-week course that provides support and education to parents and caregivers of a child with a mental illness.
- **Provider Education**: A program for mental health professionals. This course presents a penetrating subjective view of family and consumer experience in serious mental illness.
- **Public presentations***: Are offered for any civic group, church or other interested party.
- **Lending Library***: Videos, books and articles help you understand the medical and emotional aspects of various mental illnesses and how to cope with them.

**Support**
- **Support groups***: the sharing of experiences, knowledge, hope and coping skills for all those affected by mental illness.
- **NAMI Connection***: a peer-run recovery support group for those with mental illness that meets once a week.
- **Heart to Heart**: A friendship program where volunteers are trained and matched with individuals who have mental illness to talk and participate in social activities.

*Program or Service Available in Spanish*
NAMI del Sur de Arizona ayuda todas las personas afectadas por alguna enfermedad mental incluyendo individuos con una enfermedad mental y sus familias por medio del apoyo, la educación y abogacía. Todos nuestros programas y servicios son gratuitos y la mayoría de los programas y servicios están disponibles en español.

La misión de NAMI del Sur de Arizona es mejorar la calidad de vida de quienes viven con enfermedades mentales y de sus familiares, mediante educación, promoción y apoyo con servicios de alta calidad, enfocados a la recuperación y adecuados a diferencias culturales.

**Nuestros Servicios**

- **Abogacía**: Ofrecemos abogacía para individuos igual que para familiares. Usted o su ser querido nos puede preguntar sobre sus derechos como paciente, como obtener servicios de salud mental de calidad y más. Nuestros Abogados (no legal) y Especialistas de Abogacía y de Recursos están disponibles para contestar sus preguntas.

- **Educación**:  
  - **De Familia a Familia**: Un curso educativo de 12 semanas para familiares y amigos que tienen un ser querido con una enfermedad mental. Este curso es enseñado por dos maestros que también tienen un ser querido con una enfermedad mental.  
  - **De Persona a Persona**: Un curso educativo de 9 semanas basado en la recuperación para personas con una diagnosis de un desorden mental. Este curso es enseñado por dos mentores que tienen una enfermedad mental y que están en la recuperación.  
  - **Padres y Maestros como Aliados**: Un taller educativo presentado a profesionales de las escuelas u otras agencias que trabajen con niños y adolescentes.  
  - **En Nuestra Propia Voz**: Una presentación interactiva ofrecida a grupos comunitarios. Dos individuos con enfermedades mentales compartan sus historias y presentan un video educativo.  
  - **NAMI Básico**: Un curso de 6 semanas que provee el apoyo y la educación a padres y cuidadores de niños con enfermedades mentales.  
  - **Educación a Proveedores de Salud Mental**: Un programa para profesionales de la salud mental. Este curso presenta vistas subjetivas a fondo de la familia e individuos con enfermedades mentales serias.  
  - **Presentaciones al público**: Son ofrecidas para cualquier grupo cívico, iglesia u otro grupo interesado.  
  - **Una librería**: Videos, libros y artículos le pueden ayudar a entender los aspectos médicos e emocionales de las varias enfermedades mentales y como sobrellevarlas.

- **Apoyo**:  
  - **Grupos de Apoyo**: El compartiendo, conocimiento, la esperanza y herramientas para sobrellevar para todos afectados por las enfermedades mentales. de experiencias, Nuestros facilitadores entrenados también tienen experiencias personales para compartir.  
  - **Conexión NAMI**: Un grupo de apoyo de recuperación facilitado por personas con un desorden mental que se reúnen una vez a la semana.  
  - **De Corazón a Corazón**: Un programa de amistad donde voluntarios son entrenados y emparejados con individuos que tienen una enfermedad mental para conversar y participar en actividades sociales.

*Programa o Servicio Disponible en Español*
What are NAMI Support Groups?
The NAMI support group model operates differently than other, more traditional “share-and-care” groups. The NAMI support group model offers a set of key structures and group processes for facilitators to use in common support group scenarios. Our support groups ensures attendees a chance to share and participate.

Are Support Groups for me?
A support group can provide relevant information, a connection to personal experiences, listening to others’ experiences, provide sympathetic understanding and establishing social networks. Knowing that there are others who have shared your same experiences may cause a sense of relief because you are not alone.

Other Support Groups
(Not facilitated by NAMI)

- DBSA (Depression and Bipolar Support Alliance)
  Sunday evenings from 6:00 p.m. - 7:30 p.m.
  University Medical Center, 1501 N. Campbell
  Southwest corner meeting room off the cafeteria
  Parking is free on Sundays.
  Thursday evenings from 6:00 p.m. - 7:30 p.m.
  St. Phillips in the Hills Episcopal Church
  4440 N Campbell Av at River Rd
  La Parroquia bldg, Mesquite Room
  For more info & directions see dbsatucson.org or
  Call (520) 531-2388
  *Family/friends are welcome to attend.

- Survivors of Suicide - (520) 861-6632
- MIKID (Mentally Ill Kids in Distress) - Groups
  for children, parents & grandparents
  (520) 882-0142

NAMI Southern Arizona is a nonprofit 501(c)(3) corporation representing those affected by serious mental illnesses. Contributions to NAMI are tax deductible. NAMI Southern Arizona is affiliated with NAMI (National Alliance on Mental Illness), which has over 220,000 members nationwide.

6122 E. 22nd St.
Tucson, AZ 85711
(520) 622-5582 office
(520) 623-2908 fax

E-mail: namisa@namisa.org
Website: http://www.namisa.org

Promoting Hope,
Encouragement, and Recovery
to all those affected.

Visit us online at www.namisa.org!
# NAMI Southern Arizona Support Groups

### For Families & Friends Who Have a Loved One with Mental Illness

<table>
<thead>
<tr>
<th>Group</th>
<th>Days/Time</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td><strong>Northwest Side Family &amp; Friends</strong></td>
<td>1st Thursday</td>
<td>Ascension Lutheran Church &amp; School</td>
</tr>
<tr>
<td></td>
<td>of every month</td>
<td>1220 W. Magee Rd.</td>
</tr>
<tr>
<td></td>
<td>6:00 p.m. - 7:30 p.m.</td>
<td><em>(Between Oracle &amp; La Canada—park in North lot)</em></td>
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<tr>
<td><strong>Oro Valley Family &amp; Friends Support Group</strong></td>
<td>2nd Saturday of every month</td>
<td>Rancho Vistoso Urgent Care</td>
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<tr>
<td></td>
<td>1:30 p.m. - 3:00 p.m.</td>
<td>13101 N. Oracle Rd.</td>
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<tr>
<td></td>
<td></td>
<td><em>(North of Rancho Vistoso Blvd.)</em></td>
</tr>
<tr>
<td><strong>East Side Family &amp; Friends Support Group</strong></td>
<td>2nd Wednesday of every month</td>
<td>NAMI Southern Arizona</td>
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<tr>
<td></td>
<td>7:00 p.m. - 8:30 p.m.</td>
<td>6122 E. 22nd St.</td>
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<tr>
<td></td>
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<td><em>(Between Craycroft &amp; Wilmot)</em></td>
</tr>
<tr>
<td><strong>West Side Family &amp; Friends</strong></td>
<td>3rd Monday of every month</td>
<td>Maranatha SDA Church</td>
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<tr>
<td></td>
<td>6:30 p.m. - 8:00 p.m.</td>
<td>934 N. Main Ave.</td>
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<td><em>(South of Speedway)</em></td>
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<tr>
<td><strong>Green Valley Family &amp; Friends Support Group</strong></td>
<td>Last Wednesday of every month</td>
<td>Friends in Deed Building</td>
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<tr>
<td></td>
<td>10:30 a.m. - 12 p.m.</td>
<td>301 W. Camino Casa Verde, Green Valley, AZ</td>
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<td></td>
<td><em>(West of La Canada Dr.)</em></td>
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</table>

### For Persons With Mental Illness

<table>
<thead>
<tr>
<th>Group</th>
<th>Days/Time</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td><strong>NAMI Connection</strong></td>
<td>Every Tuesday</td>
<td>HOPE Inc. - 1200 N. Country Club</td>
</tr>
<tr>
<td></td>
<td>6:00 p.m. - 7:30 p.m.</td>
<td><em>(Between Speedway and Grant)</em></td>
</tr>
<tr>
<td><strong>Conexión NAMI (en español)</strong></td>
<td>Every Wednesday</td>
<td>Mission Library, 3770 S. Mission Rd.</td>
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<td></td>
<td>5 p.m. - 7 p.m.</td>
<td><em>(Corner of Mission &amp; Ajo)</em></td>
</tr>
<tr>
<td><strong>Expressive Arts Group</strong></td>
<td>Every 4th Sunday</td>
<td>Main Library</td>
</tr>
<tr>
<td></td>
<td>2:00 p.m. - 4:30 p.m.</td>
<td>Contact for more information:</td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:expressivearts@namisa.org">expressivearts@namisa.org</a> or #622-5582</td>
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</tbody>
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Please call to confirm locations and times of NAMI support groups at (520) 622-5582.

*(Groups falling on holidays will be cancelled)*
The course consists of six classes, each lasting for 2 1/2 hours. Classes are offered weekly for six consecutive weeks. The NAMI Basics course is for parents and caregivers of a child or adolescent who developed the symptoms of mental illness/serious emotional disturbance. **There is no charge for our program.**

1. Recognition of mental illness as a continuing traumatic event for the child and the family.
2. Sensitivity to the subjective emotional issues faced by family caregivers and other children in the family.
3. Recognition of the need to help ameliorate the day-to-day objective burdens of care and management.
4. Gaining confidence and stamina for what can be a lifelong role of family understanding and support.
5. Empowerment of family caregivers as effective advocates for their children.

For more information, please contact us:  
Visit us online at www.namisa.org  
Address: 6122 E. 22nd St., Tucson, AZ 85711  
Phone: (520) 622-5582   E-mail: namisa@namisa.org
This educational course consists of 12 weeks, lasting for 2 1/2 hours each week for families and friends of individuals with mental illness. Many family members describe the impact of this program as life changing. Gain information, insight, understanding and empowerment. There is no charge for our program.

Course Topics:

1. Family responses to the trauma of mental illness.
2. The biology of the brain: emerging scientific discoveries.
4. Medication Overview, Communication Skills Workshop, Self-care
5. Advocacy, Fighting Stigma
6. Understanding the inner experience of having a mental illness.
Programa Educativo para Familiares y Amigos de Personas con Enfermedad Mental

El programa consiste de un curso de 12 sesiones semanales de 2 ½ horas. Es dirigido a familiares y amigos de personas con enfermedades mentales. La mayoría de quienes toman el curso manifiestan que las clases les cambió la vida positivamente. Obtenga información, conocimiento, comprensión y capacidad. *El curso es gratuito.*

Temas del curso:

1. Respuesta de la familia al trauma de la enfermedad mental.
3. Enfermedades mentales: Depresión Severa, Trastorno Bipolar, Esquizofrenia, Trastornos de Ansiedad/Pánico, Trastorno de Estrés Postraumático, Trastorno Obsesivo Compulsivo, Trastorno de Personalidad Fronterizo, Trastornos simultáneos de abuso de sustancias y enfermedades mentales.
4. Información sobre Medicamentos, Talleres sobre Empatía, Habilidades de Comunicación y de Cuidado de Uno Mismo.
5. Combate al Estigma, Defensa y Promoción.
6. Comprender la Experiencia Interna de Vivir con una Enfermedad Mental.

Para mayor información:
Visite nuestra página web: [www.namisa.org](http://www.namisa.org)
Dirección: 6122 E. 22nd St., Tucson, AZ 85711
Tel.: (520) 622-5582  E-mail: namisa@namisa.org
Recovery Oriented Program for Individuals Living with a Mental Illness

This interactive, educational course consists of 10 weeks, each lasting for 2 hours. This course focuses on recovery for any person with a serious mental illness. This program offers support, education, and the tools needed for those wanting to learn to live well. There is no charge for our program.

Course Topics:

1. Creating a Relapse Prevention Plan and practicing Mindfulness
2. Mental illness and stigma, discrimination
3. Mental Illnesses: Major Depression, Bipolar Disorder, Schizophrenia, Panic Disorder, Post-Traumatic Disorder, Obsessive Compulsive Disorder, Borderline Personality Disorder
4. Sharing your story, Language, Emotions
5. Addictions, Medications, Physical Health
6. Coping Strategies, Cultural Questions, Empowerment, Advocacy

For more information, please contact us:
Visit us online at www.namisa.org
Address: 6122 E. 22nd St., Tucson, AZ 85711
Phone: (520) 622-5582 E-mail: namisa@namisa.org
Programa orientado a la recuperación de individuos que viven con una enfermedad mental

Este es un curso educativo e interactivo que consiste en 10 clases, cada una por dos horas. Este curso se enfoca en la recuperación para cualquier persona con una enfermedad mental seria. El programa ofrece apoyo, educación y las herramientas necesarias para aquellos que quieren aprender a vivir mejor. El curso es totalmente gratuito.

Temas del curso:

1. Crear un plan de prevención de recaídas y prácticas de concienciación.
2. Combatir el estigma y la discriminación sobre las enfermedades mentales.
3. Enfermedades Mentales: Depresión Severa, Trastorno Bipolar, Esquizofrenia, Trastorno de pánico, Estrés Post Traumático, Trastorno Obsesivo Compulsivo, Trastorno de Personalidad Fronterizo
4. Adicciones, Medicamentos, Salud Física
5. Aprendiendo estrategias para afrontar la enfermedad, Cuestiones Culturales, Autonomía, Abogacía.
Program for Recovery and Public Education

This education program consists of a 90-minute presentation given by presenters who have mental illness. Audiences include people living with mental illness, students, professionals, educators, providers, faith community members and any interested civic group. Audiences benefit from this program by learning how people with mental illness can live their lives successfully in spite of serious mental illness. **There is no charge for our program.**

**Presentation Topics:**

1. A short video takes you into the lives of several living with mental illness. The video demonstrates their personal experiences on five topics of importance in dealing with mental illness.

2. Presenters briefly relate their personal experience with each topic and then open discussion on the topic to the audience.

3. Appropriate discussion questions are raised and encouraged regarding each topic.

4. Topics Covered: Dark Days, Acceptance, Treatment, Coping Mechanisms and Successes, Hopes and Dreams.

5. A Take-Home packet is provided with fact sheets and additional resource materials.

For more information, please contact us:
Visit us online at [www.namisa.org](http://www.namisa.org)

Address: 6122 E. 22nd St., Tucson, AZ 85711
Phone: (520) 622-5582  E-mail: namisa@namisa.org
This mental health education program consists of a 90-minute in-service to help participants understand the early warning signs of mental illnesses in children and adolescents. It also covers the lived experience of mental illnesses and how schools can best communicate with families about mental health related concerns. There is no charge for our program.

1. **Welcome and Introductions** - An education professional welcomes the school professionals and introduces the topics to be covered, often with a personal story.

2. **Early Warning Signs of Mental Illnesses** - A facilitator walks the audience through the early warning signs of mental illnesses, closely following the PTasA publication.

3. **Family Response** - A parent or caregiver of a child with mental illness covers the predictable stages of emotional reactions among family members dealing with the challenges of mental illness. The lived experience of raising a child with a mental illness is explained.

4. **Living with Mental Illness** - An individual that experienced the early onset of mental illness shares a view from the inside, including a discussion about the positive and negative impact that their school experience had on their life.

5. **Group Discussion**

6. **Closing Remarks and Evaluation**

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For more information, please contact us:
Visit us online at www.namisa.org

Address: 6122 E. 22nd St., Tucson, AZ 85711
Phone: (520) 622-5582   E-mail: namisa@namisa.org
Community Recovery Education Program

HOPE Inc.
1200 N. Country Club
(North Entrance)

Every Tuesday
6:00 p.m. - 7:30 p.m.

Bus Routes #4 (Speedway)/#5 (Country Club)

For more information, please contact us:
Visit us online at www.namisa.org
Address: 6122 E. 22nd St., Tucson, AZ 85711
Phone: (520) 622-5582  E-mail: namisa@namisa.org
Finding the right help at the right time can be something of a challenge.

When you encounter roadblocks or need special assistance, use this guide as one of your resources.

Outpatient Mental Health and Substance Use Services

Pocket Guide
Mental Health & Substance Abuse Services

Pima County 2013
**Community Resources**

**Information and Referral**
(800) 352-3792

**Need to talk?**

**Warm Line**
770-9909 or (877) 770-9912
8 a.m - 12 a.m.

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**Recovery is a Journey…**

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**Your checklist for success might include:**

- Different Treatments/Combinations of Treatment: Medication, Therapy, Groups.
- Notifying your Primary Care Physician that you are receiving behavioral health services (especially if you are taking medication).
- Checking to see if any of your medications might conflict against other medications/natural remedies you are taking OR if those medications should not be used with alcohol or other over the counter drugs.

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**EDUCATION PROGRAMS**

**Family to Family**: A 12-week educational course for family members and friends who have a loved one with mental illness.

**NAMI Basics**: A 6-week course that provides support and education to parents and caregivers of a child with a mental illness.

**Peer to Peer**: A 10-week course on recovery for people with a mental illness diagnosis.

**Parents and Teachers as Allies**: An in-service education program presented to school professionals or other agencies working with children and adolescents.

**In Our Own Voice**: An interactive presentation offered to community groups; two individuals with mental illness present their stories and an educational video.

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**SUPPORT**

**Support groups**: the sharing of experiences, knowledge, hope and coping skills for all those affected by mental illness.

**NAMI Connection**: a peer-run recovery support group for those with mental illness that meets once a week.

**Heart to Heart**: A friendship program for individuals who have mental illness to talk and participate in social activities.

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**ADVOCACY**

We offer advocacy for individuals with mental illness as well as for family members. You or your loved one may ask us about patient rights, how to obtain quality mental health services, and more. Staff Advocates and Resource Specialist Advocates are available to answer your questions.

*Disponible en español.*

**Know NAMI! We help all those impacted by mental illness, whether you are a person with a mental disorder or a family member, NAMI is here to help!**

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**OTHER IMPORTANT NUMBERS**

**Domestic Violence/Sexual Assault**
EMERGE
- Advocacy/Outreach 881-7201
- Crisis Line 428-0101
SACASA 327-7273 or (800) 400-1001

**Suicide**
Survivors of Suicide Group 861-6632
Suicide Prevention Lifeline (800) 273-8255

**Recovery/Peer Support Centers**
HOPE Inc. 770-1197
Our Place Clubhouse 884-5553

**Employment Assistance**
Direct Center (800) 342-1853
DK Advocates 790-7677

**Shelter/Temporary Housing**
Gospel Rescue Mission 740-1501
Primavera Men’s Shelter 623-4300
Salvation Army 622-5411

**GLBT (Gay, Lesbian, Bisexual, Transgender)**
Wingspan 624-0348
PFLAG 360-3795

**Tribal Resources**
Pascua Yaqui Behavioral Health 879-6060
Tohono O’odham Behavioral Hlth 383-6165

**Recovery for Substance Abuse Groups**
Al-anon Family Groups 323-2229
Alcoholics Anonymous 624-4183
Cocaine Anonymous 326-2211
Narcotics Anonymous 881-8381
SMART Recovery 838-3878

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**Programs are free of charge**
The following brochures have been created by NAMI to provide information about various disorders, characteristics and symptoms, treatment options, and how to get help.

The brochures available include:
- Anxiety Disorder
- Attention-Deficit / Hyperactivity Disorder
- Bipolar Disorder
- Borderline Personality Disorder
- Depression
- Depressive Disorders in Children & Adolescents
- Do’s & Don’t for Families of Persons with Serious Mental Illness
- Dual Diagnosis (Mental Illness and Substance Abuse)
- Obsessive-Compulsive Disorder
- Panic Disorder
- Post-Traumatic Stress Disorder
- Schizo-Affective Disorder
- Schizophrenia

Suggested uses include:
- Distribute through a health fair
- Put in packets of information used by your care ministry, health ministry, or Stephen Ministers.
- Distribute through your information desk/brochure center

To get multiple copies:
Multiple copies of these flyers are available for your congregation. Please contact NAMI of Southern Arizona at 520-622-5582, Ext. 105, or email your request to Rebecca Garfunkel at rgarfunkel@namisa.org.

Spanish Version Available:
Many of the brochures are also available in Spanish. Please contact NAMI of Southern Arizona at 520-622-5582, Ext. 105, Rebecca can provide you additional copies in Spanish for your congregants.
shell shock, was first diagnosed in war veterans, but it can result from any number of traumatic incidents. The event that triggers it may be something that threatened the person’s life or the life of someone close to him or her. Or it could be something witnessed, such as mass destruction after a plane crash.

Whatever the source of the problem, some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled.

PTSD can occur at any age, including childhood. The disorder may be accompanied by depression, substance abuse or anxiety. Symptoms may be mild or severe—people may become easily irritated or have violent outbursts. In severe cases they may have trouble working or socializing.

Ordinary events can serve as reminders of the trauma and trigger flashbacks or intrusive images. A person having a flashback, which can come in the form of images, sounds, smells, or feelings usually believes that the traumatic event is happening all over again.

**Treatment for Anxiety Disorders**

Many people with anxiety disorders can be helped with treatment. Therapy for anxiety disorders often involves medication or specific forms of psychotherapy.

Medications, although not cures, can be very effective at relieving anxiety symptoms. Today, thanks to research by scientists at NIMH and other research institutions, there are more medications available than ever before to treat anxiety disorders. So if one drug is not successful, there are usually others to try. In addition, medications to treat anxiety symptoms are in development.

For most of the medications that are prescribed to treat anxiety disorders, the doctor usually starts the patient on a low dose and gradually increases it to the full dose. Every medication has side effects, but they usually become tolerated or diminish with time. If side effects become a problem, the doctor may advise the patient to stop taking the medication and to wait a week—or longer for certain drugs—before trying another one. When treatment is near an end, the doctor will taper the dosage gradually.

Research has also shown that behavioral therapy and cognitive-behavioral therapy can be effective for treating several of the anxiety disorders.

Behavioral therapy focuses on changing specific actions and uses several techniques to decrease or stop unwanted behavior. For example, one technique trains patients in diaphragmatic breathing, a special breathing exercise involving slow, deep breaths to reduce anxiety. This is necessary because people who are anxious often hyperventilate; taking rapid shallow breaths that can trigger rapid heartbeat, lightheadedness, and other symptoms. Another technique—exposure therapy—gradually exposes patients to what frightens them and helps them cope with their fears.

Like behavioral therapy, cognitive-behavioral therapy teaches patients to react differently to the situations and bodily sensations that trigger panic attacks and other anxiety symptoms. However, patients also learn to understand how their thinking patterns contribute to their symptoms and how to change their thoughts so that symptoms are less likely to occur. This awareness of thinking patterns is combined with exposure and other behavioral techniques to help people confront their feared situations.

**How to Get Help for Anxiety Disorders**

If you, or someone you know, have symptoms of anxiety, a visit to the family physician is usually the best place to start. A physician can help you determine if the symptoms are due to an anxiety disorder, some other medical condition, or both. Most often, the next step to getting treatment is referral to a mental health professional.

Among the professionals who can help are psychiatrists, psychologists, social workers, and counselors. However it’s best to look for a professional who has specialized training in cognitive-behavioral therapy and who is open to the use of medications, should they be needed. For some people, group therapy or self-help groups are helpful. Many do best with a combination of these therapies.

Many individuals with GAD startle more easily than they did before. They tend to feel tired, have trouble concentrating, and sometimes suffer depression, too.

Usually the impairment associated with GAD is mild and people with the disorder don’t feel too restricted in social settings or on the job. Unlike many other anxiety disorders, people with GAD don’t characteristically avoid certain situations as a result of their disorder. However, if severe, GAD can be very debilitating, making it difficult to carry out even the most ordinary daily activities.

GAD comes on gradually and more often hits people in childhood or adolescence, but can begin in adulthood, too. It’s more common in women than in men and often occurs in relatives of affected persons. It’s diagnosed when someone spends at least 6 months worried excessively about a number of everyday problems.

In general, the symptoms of GAD seem to diminish with age. Successful treatment may include a medication called buspirone. Research into the effectiveness of other medications, such as benzodiazepines and antidepressants, is ongoing. Also useful are cognitive-behavioral therapy, relaxation techniques, and biofeedback to control muscle tension.

Phobias occur in several forms. A specific phobia is a fear of a particular object or situation. Social phobia is a fear of being painfully embarrassed in a social setting. And agoraphobia, which often accompanies panic disorder, is a fear of being in any situation that might provoke a panic attack, or from which escape might be difficult if one occurred.

Specific Phobias—Many people experience specific phobias, intense, irrational fears of certain things or situations—dogs, closed-in places, heights, escalators, tunnels, water, flying—are a few of the more common ones. Phobias aren’t just extreme fear, they are irrational fear. You may be able to ski the world’s tallest mountains with ease but panic going above the 10th floor of an office building. Adults with phobias realize their fears are irrational, but often facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety. Specific phobias strike more than 1 in 10 people. No one knows just what causes phobias, though they seem to run in families and are a little more prevalent in women. Phobias usually appear in adolescence or adulthood. They start suddenly and tend to be more persistent than childhood phobias; only about 20 percent of adult phobias vanish on their own. When children have specific phobias, those fears usually disappear over time, though they may continue into adulthood. No one knows why they hang on in some people and disappear in others.

When phobias interfere with a person’s life treatment can help. Successful treatment usually involves a kind of cognitive-behavioral therapy called desensitization or exposure therapy. Three-fourths of patients benefit significantly from this type of treatment. Relaxation and breathing exercises also help reduce anxiety symptoms.

There is currently no proven drug treatment for specific phobias, but sometimes certain medications may help reduce anxiety symptoms before someone faces a phobic situation.

Social Phobia - Social phobia is an intense fear of becoming humiliated in social situations, specifically of embarrassing yourself in front of other people. It often runs in families and may be accompanied by depression or alcoholism. Social phobia often begins around early adolescence or even younger.

If you suffer from social phobia, you tend to think that other people are very competent in public and that you are not. Small mistakes you make may seem to you much more exaggerated than they really are.

Although this disorder is often thought of as shyness, the two are not the same. Shy people can be very uneasy around others, but they don’t experience the extreme anxiety in anticipating a social situation. In contrast, people with social phobia aren’t necessarily shy at all. They can be completely at ease with people most of the time, but particular situations, such as walking down an aisle in public or making a speech, can give them intense anxiety. Social phobia disrupts normal life, interfering with career or social relationships. The dread of a social event can begin weeks in advance, and symptoms can be quite debilitating.

People with social phobia are aware that their feelings are irrational. Still, they experience a great deal of dread before facing the feared situation, and they may go out of their way to avoid it. Even if they manage to confront what they fear, they usually feel very anxious beforehand and are intensely uncomfortable throughout. Afterward, the unpleasant feelings may linger, as they worry about how they have been judged or what others may have thought or observed about them.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD, once referred to as
Attention deficit/hyperactivity disorder (ADHD/ADD) is a condition that affects an estimated 4-5% of school-age children. It is characterized by symptoms of inattention, hyperactivity, and impulsivity. The disorder often results from an imbalance in the neurotransmitters that control attention and behavior, leading to difficulty concentrating, restlessness, and impulsive actions.

Many treatments -- some with good scientific basis, some without -- have been recommended for individuals with ADHD. The most proven treatments are medication and behavioral therapy.

Medication

Stimulants are the most widely used drugs for treating attention-deficit/hyperactivity disorder. The four most commonly used stimulants are methylphenidate (Ritalin), dextroamphetamine (Dexedrine, Desoxyn), amphetamine and dextroampheta- mine (Adderall), and pemoline (Cylert). These drugs increase activity in parts of the brain that are underactive in those with ADHD, improving attention and reducing impulsiveness, hyperactivity, and/or aggressive behavior. Antidepressants, major tranquilizers, and the antihypertensive clonidine (Catapres) have also proven helpful in some cases. Most recently, the FDA has approved a non-stimulant medication, Atomoxetine (Strattera), a selective norepinephrine reuptake inhibitor for the treatment of ADHD.

Every person reacts to treatment differently, so it is important to work closely and communicate openly with your physician. Some common side effects of stimulant medications include weight loss, decreased appetite, trouble sleeping, and, in children, a temporary slowing in growth; however, these reactions can often be controlled by dosage adjustments. Medication has proven effective in the short-term treatment of more than 76 percent of individuals with ADHD.

Behavioral Therapy

Treatment strategies such as rewarding positive behavior changes and communicating clear expectations of those with ADHD have also proven effective. Additionally, it is extremely important for family members and teachers or employers to remain patient and understanding.

Children with ADHD can additionally benefit from caregivers paying close attention to their progress, adapting classroom environments to accommodate their needs, and using positive reinforcers. Where appropriate, parents should work with the school district to plan an individualized education program (IEP).

Other Treatments

There are a variety of other treatment options offered (some rather dubious) for those with ADHD. Those treatments not scientifically proven to work include biofeedback, special diets, allergy treatment, megavitamins, chiropractic adjustment, and special-colored glasses.

For information contact:
CHADD, Children & Adults with Attention-Deficit/Hyperactivity Disorder
8181 Professional Place, Suite 150
Landover, MD 20785
1-800-233-4050
www.chadd.org

Suggested Reading

Attention Deficit Hyperactivity Disorder, by the National Institutes of Mental Health, 1998.
Answers to Distraction by Edward Hallowell, M.D. and John J. Ratey, M.D., 1996.
Coping With Mental Illness in the Family; A Family Guide, by Agnes B. Hatfield, Ph.D., Rev. Ed. 1998.
Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood by Edward Hallowell, M.D. and John J. Ratey, M.D., 1995.


The Bipolar Child, by Demitri F. Papalos, M.D., Janice Papalos, 1999.
The Hyperactive Child, Adolescent, and Adult: Attention Disorder through the Lifespan, by Paul H. Wender, 1987.
Teaching the Tiger: A Handbook for Individuals Involved in the Education of Students with Attention Deficit Disorder or Tourette Syndrome by Marilyn Dornbush and Sheryl Pruitt, 1999.

The Hyperactive Child, Adolescent, and Adult: Attention Deficit Disorder Through the Lifespan by Paul Wender, M.D., 1987.
Troubled Journey: Coming to Terms with the Mental Illness of a Sibling or Parent, by Diane T. Marsh, Ph.D., Rex M. Dickens, 1997.

What Is Attention Deficit Hyperactivity Disorder (ADHD)?

Attention-deficit/hyperactivity disorder (ADHD) is an illness characterized by inattention, hyperactivity, and impulsivity. The most commonly diagnosed behavior disorder in young persons, ADHD affects an estimated three percent to five percent of school-age children. Although ADHD is usually diagnosed in childhood, it is not a disorder limited to children -- ADHD often persists into adolescence and adulthood and is frequently not diagnosed until later years.

What are the symptoms of ADHD?

There are actually three different types of ADHD, each with different symptoms: predominantly inattentive, predominantly hyperactive/impulsive, and combined.

Those with the predominantly inattentive type often:

- fail to pay close attention to details or make careless mistakes in schoolwork, work, or other activities
- have difficulty sustaining attention to tasks or leisure activities
- do not seem to listen when spoken to directly
- do not follow through on instructions and fail to finish schoolwork, chores, or duties in the workplace
- have difficulty organizing tasks and activities
- avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort
- lose things necessary for tasks or activities
- are easily distracted by extraneous stimuli
- are forgetful in daily activities

Those with the predominantly hyperactive/impulsive type often:

- fidget with their hands or feet or squirm in their seat
- leave their seat in situations in which remaining seated is expected
- move excessively or feel restless during situations in which such behavior is inappropriate
- have difficulty engaging in leisure activities quietly
- are "on the go" or act as if "driven by a motor"
- talk excessively
- blurt out answers before questions have been completed
- have difficulty awaiting their turn
- interrupt or intrude on others

Those with the combined type, the most common type of ADHD, have a combination of the inattentive and hyperactive/impulsive symptoms.

What is needed to make a diagnosis of ADHD?

A diagnosis of ADHD is made when an individual displays at least six symptoms from either of the above lists, with some symptoms having started before age seven. Clear impairment in at least two settings, such as home and school or work, must also exist. Additionally, there must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

How common is ADHD?

ADHD affects an estimated two million American children, an average of at least one child in every U.S. classroom. In general, boys with ADHD have been shown to outnumber girls with the disorder by a rate of about three to one. The combined type of ADHD is the most common in elementary school-aged boys; the predominantly inattentive type is found more often in adolescent girls.

While there is no specific data on the rates of ADHD in adults, the disorder is sometimes not diagnosed until adolescence or adulthood, and half of the children with ADHD retain symptoms of the disorder throughout their adult lives. (It is generally believed that older individuals diagnosed with ADHD have had elements of the disorder since childhood.)

What causes ADHD?

First of all, it is important to realize that ADHD is not caused by dysfunctional parenting, nor is it due to a lack of intelligence or discipline.

Strong scientific evidence supports the conclusion that ADHD is a biologically based disorder. Recently, National Institute of Mental Health researchers using PET scans have observed significantly lower metabolic activity in regions of the brain controlling attention, social judgment, and movement in those with ADHD than in those without the disorder. Biological studies also suggest that children with ADHD may have lower levels of the neurotransmitter dopamine in critical regions of the brain.

Other theories suggest that cigarette, alcohol, and drug use during pregnancy or exposure to environmental toxins such as lead may be linked to the development of ADHD. Research also suggests a strong genetic basis to ADHD -- the disorder tends to run in families. In addition, research has shown that certain forms of genes related to the dopamine neurotransmitter system are linked to increased likelihood of the disorder.

Is ADHD associated with other disorders?

Yes. In fact, symptoms like those of ADHD are often mistaken for or found occurring with other neurological, biological, and behavioral disorders. Nearly half of all children with ADHD (especially boys) tend to also have oppositional defiant disorder, characterized by negative, hostile, and defiant behavior. Conduct disorder (marked by aggression towards people and animals, destruction of property, deceitfulness or theft, and serious rule-breaking) is found to co-occur in an estimated 40 percent of children with ADHD. Approximately one-fourth of children with ADHD (mostly younger children and boys) also experience anxiety and depression. And, at least 25 percent of children with ADHD suffer from some type of communication/learning disability. There is additionally a correlation between Tourette’s syndrome, a neurological disorder characterized by motor and vocal tics, and ADHD-only a small percentage of those with ADHD also have Tourette’s, but at least half of those with Tourette’s also have ADHD. Research is also beginning to show that ADHD-like symptoms are sometimes actually manifestations of childhood-onset bipolar disorder.
Other Medications and Diet

Other drugs may be used with lithium in treating Bipolar disorder or other unrelated medical conditions.

- Lithium is sometimes used with Mellaril, Thorazine, Prolixin, Haldol, Navane, and Tegretol.
- Diuretics (water pills) alter the kidney excretion pattern of sodium (salt) and lithium.
- A decrease in dietary sodium intake can result in a potentially dangerous increase in the blood lithium level.
- Dietary extremes of sodium intake should be avoided.
- Low salt diets when combined with diuretics can result in lithium retention to the point of intoxication.

General medical doctors, internists, psychiatrists, patients and their families should work together to coordinate lithium treatment with other medications.

Impact on the Family

Any serious mental illness can be devastating for the patient’s family. Family members often struggle for years with unwarranted feelings of guilt and embarrassment. Other feelings can include anger, hopelessness, frustration, fear, and helplessness. Family members themselves may fall victim to burnout. They may experience a higher incidence of stress-related illnesses associated with the increased stress of accommodating an illness in the family. They may find limited community resources and face the pain of difficult situations and no-win decisions. Friction at home and work may increase.

These are things you can do to ease your struggle, and places you can turn to for help. Mental illnesses are medical problems. They strike frequently. The earlier you seek qualified help the better. It is helpful to read about specific illness to become familiar with their symptoms and treatment. Being educated about your loved one’s illness will help you better monitor the appropriateness and cost effectiveness of treatment.

You can work in your community to raise the level of support available for persons with mental illnesses. With proper treatment and support, people with Bi-Polar disorder can lead self-sufficient and productive lives; many can lead normal lives.

- Become active in your local NAMI chapter and advocate.
- Encourage elected officials and administrators to provide appropriate treatment in the least restrictive environment.
- Encourage adequate community support.
- Work to improve individual attitudes about mental illnesses.
- Advocate for increased research that will one day find the causes and the cures for all mental illnesses.

Suggested Reading


Sources:

The National Institute of Mental Health, Office of Scientific Information; 5600 Fishers Lane, Room 15105, Parklawn Bldg., Rockville, MD 20857


To receive a copy of Bi-Polar Disorder/Manic-Depressive Illness published in 1989 by the US Department of Health and Human Services: National Institute of Mental Health, write to:

Superintendent of Documents
US Government Printing Office
Washington, D.C. 20402

Information in this brochure was provided by the National Alliance on Mental Illness, the American Medical Association, the American Psychiatric Association, the National Institute of Mental Health, Demitri Papolos, M.D., and Mogens Schou, M.D.

Updated February 2008
Bipolar Disorder

Bipolar disorder occurs in attacks or episodes of differing duration and frequency. Because the disease involves mood swings from abnormal sadness and melancholia to a state of abnormal elation and hyperactivity, the disease is also known as Manic-Depressive Illness. Different people experience these mood swings in varying frequency and intensity. A mild mania is called hypomania. Bipolar disorder is a medical illness that produces emotional symptoms. Bipolar disorder occurs in about 3% of the population. While Bipolar disorder cannot be prevented or cured, it is highly manageable with treatment. It is important that the patient take as much responsibility as possible for managing this illness.

Characteristics of Depression

- extreme sadness and emptiness
- tearful for no reason
- irritable and hostile toward others
- “dried up” emotions; inability to cry
- lack of self-confidence
- low self-esteem
- fear of being with people
- slower mental speed: thoughts move slowly
- fewer ideas; poverty of thought
- impaired memory
- loss of interest in normal activities
- disappearance of courage and self-confidence
- resignation, lack of initiative and energy
- obstacles seem “insurmountable”
- sleep disturbance: either too much or too little
- low energy; chronic fatigue
- heavy feeling
- feelings of inadequacy, guilt, and self-reproach
- trouble making trivial decisions
- overwhelming anxiety
- agitation and restlessness
- muscles look slack; facial expression static
- desire to stay in bed
- slowed motions and response to environment
- changes in mood not caused by a life event
- constipation and/or cessation of menstruation
- decrease in sexual interest and activity
- reduced appetites and loss of weight
- suicidal tendencies

Characteristics of Mania

- lack of self-criticism
- failure to understand the concerns of others
- easily aroused anger and irritability
- increase mental speed
- a wealth of ideas racing through the head
- rapidly flowing, almost unbroken speech
- puns alternated with caustic repartee
- previously unknown vigor
- indefatigability
- less need for sleep
- rarely feeling tired
- increased sexual activity
- not taking time or forgetting to eat
- weight loss
- physical exhaustion

Treatment

A common-sense treatment plan involves treating the medical symptoms as well as learning one’s own patterns of illness and developing ways of coping. The help of a well-qualified psychiatrist is recommended. In addition to taking the medication, many patients find supportive counseling helpful. Treatment is directed at lessening the duration and intensity of the episodes and preventing recurrences. It is helpful to have accurate records of the intensity of past episodes and their duration to provide comparisons for current treatment.

How is Bipolar Disorder treated?

Medication is an essential part of successful treatment for people with Bipolar disorder. In addition, psychotherapy and support groups are important to help people understand the impact the illness has on their lives and their families’ lives and to learn ways to cope with the stresses that can trigger episodes. The person with Bipolar disorder and his or her family should be knowledgeable about and involved in the treatment plan during its implementation and throughout all its stages or adjustments. Changes in medications or dosages may be necessary, and treatment plans may change during different stages of illness.

Currently, only two medications are approved by the Food and Drug Administration (FDA) for such treatment of manic depression, lithium (such as Eskalith or Lithobid) and Depakote (divalproex sodium). Lithium has been the primary medication used in the treatment of mania because of its mood-stabilizing benefits. Lithium has been shown to be effective in preventing episodes from occurring and in treating an episode after it has begun. Manic and depressive episodes occur less frequently and are less severe when medication is taken regularly. Response to lithium can take approximately 14 days.

Side effects of lithium, including hand tremors, excessive thirst, excessive urination, and memory problems, often lessen as the body adjusts to the medication. In a small percentage of patients, long-term lithium use can interfere with kidney function. Patients then need to work with their physician to identify another treatment plan. Blood tests are required to determine the most effective doses of lithium for individual patients.

Some persons with manic depression do not respond to lithium or have intolerable side effects. These side effects often cause patients to cease treatment.

Depakote is the first medication in 25 years to be approved by the FDA as a treatment for manic-depressive illness. Research has shown that Depakote appears to be equally effective as lithium in the treatment of mania, with fewer side effects. Response to Depakote is typically seen 5 to 10 days after treatment begins. In addition to a favorable side effect profile and rapid onset of action, Depakote appears to be effective in all types of Bipolar disorder, including rapid cycling (the occurrence of at least four episodes of mania or depression within a given year) and mixed mania.

Known chemically as divalproex sodium, Depakote has been used as a treatment for epilepsy since 1983, and it was cleared as a treatment for the manic episodes associated with bipolar in 1995.

A third drug, Tevprotil (carbamazepine), has been used by some physicians as a treatment for those with rapidly changing cycles of mania and depression or for those who cannot take lithium. It sometimes takes from one week to few weeks to become effective.

It is recommended that patients not take any of these food stabilizers while pregnant.

Individuals with Bipolar disorder may need antidepressant medication during periods of depression. Five groups of drugs are most often prescribed for depression: tricyclic antidepressants; monoamine oxidase inhibitors (MAOs); lithium; serotonin selective re-uptake inhibitors (SSRIs); and serotonin and norepinephrine re-uptake inhibitors (SNRIs). Electroconvulsive therapy (ECT) may be used if an individual is suicidal or cannot take antidepressant medication.

Tricyclic antidepressant such as amitriptyline (Amitriptyline, Elavil, and Endep), desipramine (Peroxan, Norpramin); doxepin (Sinequan), imipramine (Tofranil), and nortriptyline (Pamelor), or prazosin (Vivaclit) are widely used medications for serious depression. Effexor is one of the newest antidepressants, and it can be used in combination with other psychiatric medications. Prozac, Zoloft, and Paxil are among the newly developed antidepressants known as SSRIs, which act selectively on serotonin. Wellbutrin is a medication that appears to be effective in the treatment of depression.
treatment. A neurological evaluation may be necessary for some individuals.

What Medications Are Prescribed for BPD?

Antidepressants, anticonvulsants, and short-term use of neuroleptics are common for BPD. Decisions about medications should be made cooperatively between the individual and the therapist. Issues to be considered include the person’s willingness to take the medication as prescribed and the possible benefits, risks, and side effects of the medication, particularly the risk of overdose.

Suggested Reading:


Suggested Websites:

Borderline Personality Disorder Research Foundation: http://www.borderlineresearch.org/

Borderline Personality Disorder Resource Center: http://www.bpdresourcecenter.org/

NIMH (National Institute of Mental Health): http://www.nimh.nih.gov/

TARA (Treatment and Research Advancements), National Association for Personality Disorders: http://www.tara4bpd.org/

The information in this brochure was provided by the National Alliance on Mental Illness (NAMI).
What Is Borderline Personality Disorder (BPD)?

Borderline Personality Disorder (BPD) is characterized by impulsivity and by instability in mood, self-image, and personal relationships. It is fairly common and is diagnosed more often in females than males. It is a disorder of emotion regulation. This instability often disrupts family and work, long-term planning, and the individual’s sense of self-identity. While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is as common, affecting between .07 to 2% of the general population.

What Are the Symptoms of BPD?

Individuals with BPD have several of the following symptoms:

- marked mood swings with periods of intense depression, irritability and/or anxiety lasting a few hours to a few days
- inappropriate, intense, or uncontrolled anger
- impulsiveness in spending, sex, substance use, shoplifting, reckless driving, or binge eating
- recurring suicidal threats or self-injurious behavior
- unstable, intense personal relationships with extreme, black and white views of people and experiences, sometimes alternating between “all good” idealization and “all bad” devaluation
- marked, persistent uncertainty about self-image, long term goals, friendships, values
- chronic boredom or feelings of emptiness
- frantic efforts to avoid abandonment, either real or imagined

What Causes BPD?

The causes of BPD are unclear, although psychological and biological factors may be involved. Originally thought to “border on” schizophrenia, BPD now appears to be more related to serious depressive illness. In some cases, neurological or attention deficit disorders play a role. Biological problems may cause mood instability and lack of impulse control, which in turn may contribute to troubled relationships. Difficulties in psychological development during childhood, perhaps associated with neglect, abuse, or inconsistent parenting, may create identity and personality problems. More research is needed to clarify the psychological and/or biological factors causing BPD.

How Is BPD Treated?

A combination of psychotherapy and medication appears to provide the best results for treatment of BPD. Medications can be useful in reducing anxiety, depression, and disruptive impulses. Relief of such symptoms may help the individual deal with harmful patterns of thinking and interacting that disrupt daily activities. However, medications do not correct ingrained character difficulties. Long-term outpatient psychotherapy and group therapy (if the individual is carefully matched to the group) can be helpful. Short-term hospitalization may be necessary during times of extreme stress, impulsive behavior, or substance abuse.

While some individuals respond dramatically, more often treatment is difficult and long term. Symptoms of the disorder are not easily changed and often interfere with therapy. Periods of improvement may alternate with periods of worsening. Fortunately, over time most individuals achieve a significant reduction in symptoms and improvement in functioning.

Can Other Disorders Be Present at the Same Time?

Yes, determining whether other psychiatric disorders may be involved is critical. BPD may be accompanied by serious depressive illness (including bipolar disorder), eating disorders, and alcohol or drug abuse. About 50 percent of people with BPD experience episodes of serious depression. At these times, the “usual” depression becomes more intense and steady, and sleep and appetite disturbances may occur or worsen. These symptoms, and the other disorders mentioned above, may require specific
Side Effects of Antidepressant Medications

Antidepressants may cause mild and usually temporary side effects in some people. Typically these are annoying, but not serious. However, unusual side effects or those that interfere with functioning should be reported to your doctor.

The most common side effects usually associated with tricyclic antidepressants and ways to deal with them are:

- **Dry mouth** - Drink lots of water; chew sugarless gum; clean teeth daily.
- **Constipation** - Eat bran cereals, prunes, and other fruits and vegetables.
- **Bladder problems** - Emptying your bladder may be troublesome and your urine stream may not be as strong as usual; call your doctor if there is any pain.
- **Sexual problems** - Sexual functioning may change; if worrisome, discuss with your doctor.
- **Blurred vision** - This will pass soon; do not get new glasses.
- **Dizziness** - Rise from bed or chair slowly.
- **Drowsiness** - This will pass soon; do not drive or operate heavy equipment if feeling drowsy or sedated.

The **newer antidepressants** have different types of side effects:

- **Headache** - This will usually go away.
- **Nausea** - Even when it occurs, it is usually transient.
- **Nervousness** - This may occur and insomnia, also, during the first few weeks; if persistent, discuss with your doctor.
- **Agitation** - If this happens for the first time after the drug is taken and is more than transient, consult your doctor.

**Psychotherapies**

There are many forms of psychotherapy used to help depressed individuals, including some short-term (10-20 weeks) therapies. "Talking" therapies help patients gain insight into and resolve their problems through verbal "give-and-take" with the therapist. "Behavioral" therapists help patients learn how to obtain more satisfaction and rewards through their own actions and how to unlearn the behavioral patterns that contribute to their depression. Two of the short-term psychotherapies that research has shown helpful for some forms of depression are Interpersonal and Cognitive/Behavioral-terapiers. Interpersonal therapists focus on the patient's disturbed personal relationships that both cause and exacerbate the depression. Cognitive/Behavioral therapists help patients change negative styles of thinking and behaving often associated with depression. Psychodynam ic therapies, sometimes used to treat depression, focus on resolving the patient's internal psychological conflicts that are typically thought to be rooted in childhood. In general, the severe depressive illnesses, particularly those that are recurrent, will require medication (or ECT under special conditions) along with psychotherapy for the best outcome.

**Helping Yourself**

Depressive illnesses make you feel exhausted, worthless, helpless, and hopeless. Such negative thoughts and feelings make some people feel like giving up. It is important to realize that these negative views are part of the depression and typically do not accurately reflect your situation. Negative thinking fades as treatment begins to take effect.

In the meantime:

- Do not set yourself difficult goals or take on a great deal of responsibility.
- Break large tasks into small ones, set some priorities, and do what you can as you can.
- Do not expect too much from yourself. This will only increase feelings of failure.
- Try to be with other people; it is usually better than being alone.
- Participate in activities that may make you feel better. You might try mild exercise, going to a movie, a ballpark game, or participating in religious or social activities. Don't overdo it or get upset if our mood is not greatly improved right away. Feeling better takes time.
- Do not make major life decisions, such as changing jobs or getting married or getting a divorce, without consulting others who know you well and who have a more objective view of your situation. In any case, it is advisable to postpone important decisions until your depression has lifted.
- Do not expect to "snap out" of your depression. People rarely do. Help yourself as much as you can, and do not blame yourself for not being up to par.
- Remember: do not accept your negative thinking. It is part of the depression and will disappear as your depression responds to treatment.

**Family and Friends Can Help**

Since depression can make you feel exhausted and helpless, you will want and probably need help from others. However, people who have never had a depressive illness may not fully understand its effect. They won't mean to hurt you, but they may say or do things that do. It may help to share this brochure with those you most care about so they can better understand and help you.

**Helping the Depressed Person**

The most important thing anyone can do for the depressed person is to help him or her get appropriate diagnosis and treatment. This may involve encouraging the individual to stay with treatment until symptoms begin to abate (several weeks), or to seek different treatment if no improvement occurs. On occasion, it may require making an appointment and accompanying the depressed person to the doctor. It may also mean monitoring whether the depressed person is taking medication. The second most important thing is to offer emotional support. This involves understanding, patience, affection, and encouragement. Engage the depressed person in conversation and listen carefully. Do not ignore remarks about suicide. Always report them to the doctor or members of the clinical team. Invite the depressed person for walks, outings to the movies, and other activities. Be gently insistent if your invitation is refused. Encourage participation in some activities that once gave pleasure, such as hobbies, sports, religious or cultural activities, but do not push the depressed person to undertake too much too soon. The depressed person needs diversion and company, but too many demands can increase feelings of failure. Do not accuse the depressed person of faking illness or of laziness, or expect him or her "to snap out of it." Eventually, with treatment, most depressed people do get better. Keep that in mind, and keep reassuring the depressed person that with time and help, he or she will feel better.
Depression: What You Need to Know

If your doctor believes you or someone close to you has a depressive illness, this brochure may be helpful to read and hold onto so that you can refer to it as often as you need. It provides important information about depressive illnesses. It may stimulate questions you may wish to discuss with your doctor or a mental health professional. You may wish to share it with a family member, friend, colleague, minister, school official, or other community helper.

What Is a Depressive Illness?

A depressive illness is a "whole-body" illness, involving your body, mood, thoughts, and behavior. It affects the way you eat and sleep, the way you feel about yourself, and the way you think about things. A depressive illness is not a passing, blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help over 80 percent of those who suffer from depression.

Symptoms of Depression and Mania

Not everyone who is depressed or manic experiences every symptom. Some people experience a few symptoms, some many. Also, severity of symptoms varies with individuals.

Symptoms of Depression

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that you once enjoyed, including sex
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue, being "slow down"
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Symptoms of Mania

- Inappropriate elation
- Inappropriate irritability
- Severe insomnia
- Grandiose notions
- Increased talking
- Disconnected and racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Inappropriate social behavior

Causes of Depression

There is a risk for developing depression when there is a family history, indicating that a biological vulnerability can be inherited. The risk may be somewhat higher for those with bipolar depression. However, not everybody with a genetic vulnerability develops the illness. Apparently additional factors, possibly a stressful environment and other psychosocial factors, are involved in the onset of depression.

Though major depression seems to occur generation after generation in some families, it can also occur in people who have no family history of depression. Whether the disorder is inherited or not, it is evident that individuals with major depressive illness often have too little or too much of certain neurochemicals.

Psychological makeup also plays a role in vulnerability to depression. People who have low self-esteem, who consistently view themselves and the world with pessimism, or who are readily overwhelmed by stress are prone to depression.

A serious loss, chronic illness, difficult relationship, financial problem, or any unWelcome change in life patterns can also trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive illness.

Types of Depression

Depressive illnesses come in different forms, just as do other illnesses, such as heart disease. This brochure briefly describes three of the most prevalent types of depressive illnesses. However, within these types there are variations in the number of symptoms, their severity, and persistence. Check with your doctor if you need more information about your type of depressive illness.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, sleep, eat, and enjoy once-pleasurable activities. These disabling episodes of depression can occur once, twice, or several times in a lifetime.

A less severe type of depression, dysthymia, involves long-term, chronic symptoms that do not disable, but keep you from functioning at "full steam" or from feeling good. Sometimes people with dysthymia also experience major depressive episodes.

Another type of depressive illness is manic-depressive illness, also called bipolar depression. Not nearly as prevalent as other forms of depressive illnesses, manic-depressive illness involves cycles of depression and elation or mania.

Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, you can have any or all of the symptoms of depressive illness. When in the manic cycle, any or all symptoms listed under mania may be experienced. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, unwise business or financial decisions may be made when in a manic phase.

Antidepressant Drugs

A variety of antidepressant medications and psychotherapies can be used to treat depressive illnesses. Some people do well with psychotherapy, some with antidepressants. Some do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn effective ways to deal with life’s problems. Depending on your diagnosis and severity of symptoms, you may be prescribed medication and/or treated with one of the several forms of psychotherapy that have proven effective for depression. It is important to note that most people can be successfully treated for depression on an outpatient basis. On rare occasions, electroconvulsive therapy (ECT) is useful, particularly for individuals whose depression is severe or life-threatening or who cannot take antidepressant medication. ECT often is effective in cases where antidepressant medications do not provide sufficient relief of symptoms.

Treatments

A variety of antidepressant medications and psychotherapies can be used to treat depressive illnesses. Some people do well with psychotherapy, some with antidepressants. Some do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn effective ways to deal with life’s problems. Depending on your diagnosis and severity of symptoms, you may be prescribed medication and/or treated with one of the several forms of psychotherapy that have proven effective for depression. It is important to note that most people can be successfully treated for depression on an outpatient basis. On rare occasions, electroconvulsive therapy (ECT) is useful, particularly for individuals whose depression is severe or life-threatening or who cannot take antidepressant medication. ECT often is effective in cases where antidepressant medications do not provide sufficient relief of symptoms.

Antidepressant Medications

Three groups of antidepressant medications have been used to treat depressive illnesses: trycyclics, monoamine oxidase inhibitors (MAOIs), and lithium. Lithium is the treatment of choice for manic-depressive illness and some forms of recurring, major depression. Sometimes your doctor will try a variety of antidepressants before finding the medication or combination of medications most effective for you. Sometimes the dosage must be increased to be effective. There are now newer antidepressants available that are neither trycyclics nor MAOIs, and which generally lack the side effects associated with these two traditional classes of drugs. One type, SSRIs (serotonin-specific reuptake inhibitors), selectively blocks the reuptake of one of the major neurotransmitters, serotonin. Another type is believed to act on the neurotransmitter, dopamine.

Patients often are tempted to stop medication too soon. It is important to keep taking medication until your doctor says to stop, even if you feel better beforehand. Some medications must be stopped gradually to avoid disabling symptoms.

Some medications must be stopped gradually to avoid disabling symptoms.
Behavior Therapy, sometimes called behavior modification, focuses on your child’s external behavior and tries to change those things that are inappropriate or produce negative results. These approaches seek to provide rewards for positive behavior and reinforce areas of strength. Families are an important part of a behavior modification strategy that carries over into the child’s entire environment.

Young children, usually under the age of eight, may also participate in Play Therapy. In this form of therapy, the child is asked to play with toys and dolls, and through them, demonstrate what may be going on inside and talk about his needs and feelings. Supportive Therapy often involves a group of youngsters with similar problems and helps them to feel less isolated in their difficulties while providing a comfortable environment to talk about fears and problems. Families are sometimes part of this type of group therapy, especially when it is focused on reducing stress at home and providing coping mechanisms.

Regardless of the form of therapy you and your supporting professionals choose, it is important that you establish a clear understanding with your child’s therapist. As parents, you need to be informed and involved in your child’s treatment. You will want to work with a therapist who respects your role and views your family not as a source of your child’s problem, but as strength.

Family Education:

Family Education helps if families know that they are not alone, and feel supported in their struggle. They can also learn coping strategies, and understand what depressive disorders in children are.

The National Alliance on Mental Illness has more than 220,000 members and a host of resources—NAMI’s Young Family Program offers support, education, and opportunities for advocacy to parents whose young children and adolescents suffer from serious, chronic neurobiological disorders such as autism and pervasive developmental disorders, obsessive compulsive disorder, schizophrenia, bipolar and major depressive disorder, Tourette’s syndrome, anxiety and panic disorders, and attention deficit hyperactive disorder.

Much of the material for this pamphlet was derived from articles by David A Brent on “Major Depressive Disorder” and Michael Strober on “Bipolar Disorder”, published in Neurobiological Disorder in Children and Adolescents. Edited by Enid Peschel, Richard Peschel, Carol W. Howe, and James W. Howe. Jossey-Bass Publishers. MHS #54; San Francisco, California; 1992.

NAMI’s Medical Information Series is a collection of brochures written to provide families and consumers with the most accurate and current information available on a wide variety of mental illnesses and treatment modalities. Each publication in this series is reviewed by a scientist who specializes in the subject covered. The sole purpose of the NAMI Medical Information Series is to provide information as a lay organization. NAMI does not endorse nor advocate any treatment form.

This material was reviewed by Peter S Jensen, M.D., Chief of the Child & Adolescent Research Branch at the National Institute of Mental Health.

The National Alliance on Mental Illness is a grassroots, self-help support and advocacy organization of people with serious mental illness and their families and friends. NAMI’s mission is to eradicate mental illness and to improve the quality of life for those who suffer from these no fault brain diseases.
What are depressive disorders in children and adolescents?

If you suspect that your child or adolescent suffers from a depressive disorder, you should know that there are two types: Major Depression (or unipolar depression) and Manic Depression (or bipolar disorder). Fifteen years ago, children and adolescents were not believed to suffer from depressive disorders. Now, however, doctors seek to recognize these disorders in both children and adolescents. For the most part, children and adolescents exhibit the same symptoms as adults. Approximately 2% of children and 5% of adolescents are affected. Correct diagnosis requires at least two weeks of nearly constant depressed mood plus four additional symptoms, or three additional symptoms for children under age six (See symptoms below.)

Major Depression

Major depression is a serious medical problem and should not be confused with normal ups and downs of children and adolescents. An untreated episode lasts an average of seven months. Forty percent of children affected experience a relapse within 2 years. About one of every three children with depression develops psychotic symptoms such as hallucinations, delusions, or paranoia. Even after recovery, most children show significant social impairment. Adolescents with depression are at significant risk for suicide, and often display antisocial behavior, drug and alcohol abuse, and difficult interpersonal relationships.

Symptoms of Depression

1. Change in appetite or weight (either increased or decreased); in children, a failure to make age-appropriate weight gain.
2. Change in sleep (insomnia or sleeping too much) nearly every day.
3. Agitated or slowed behavior
4. Loss of interest or pleasure
5. Loss of energy: fatigue nearly every day
6. Feelings of worthlessness or inappropriate guilt
7. Difficulty concentrating, indecision
8. Loud, obnoxious, anti-social behavior
9. Violent outbursts and trouble with self-control
10. Skipping school, dropping out of clubs and sports
11. Recurrent thoughts of death, suicidal thoughts or gestures

Bipolar Disorder

If a child with major depression also has manic symptoms, the correct diagnosis is bipolar or manic depressive disorder. This disorder is characterized by both (a) major depressive symptoms and (b) manic symptoms. Mania is marked by a mood of gaiety or irritability, extraordinary mental and physical energy, and boundless self-confidence. Manic activities are unfocused, impulsive and senseless, often producing great hardship and disruption. An example might be a child who consistently refuses to sleep, insists on engaging in strenuous activities late at night, talks endlessly and compulsively and grandiosely, refuses to listen or obey authority.

About 1 of every 100 individuals in the population has this disorder. Approximately 25% of affected individuals suffer their first attack as adolescents. For many, the disorder lasts a lifetime with frequently recurring episodes of mania and depression.

What are the causes of depressive disorders?

They are biological disorders characterized by a disrupted neurotransmitter system in the brain. Scientific studies show biological differences in depressed children and adolescents compared to normal groups. Genetic factors are extremely important in the development of these disorders. The most severe cases of bipolar disorder may, in fact, appear in children and adolescents of families with a strong genetic predisposition to the illness.

What treatments are useful for depressive disorders?

Depressive disorder should be treated by a child psychiatrist with substantial clinical expertise in this area. Therapy consists mainly of medication, psychotherapy and family education.

Medication

Appropriate medication can have a profound effect on the natural biological course of both disorders. Expanding research about the biological basis of childhood mental disorders has made doctors increasingly inclined to prescribe psychiatric medication. Such decisions should be made carefully by doctors in collaboration with parents. The doctor should fully explain the reasons for prescribing such medication, the benefits it should provide, possible side-effects and alternatives. Certain medications do have a good track record in managing acute and long-term symptoms of mental disorders in children.

For depression, both unipolar and the depressive phase of bipolar, recommended medications generally include the major tricyclic antidepressants, the newer serotonergic agents such fluoxetine and buproprion, lithium, and monamine oxidase (MAO) inhibitors.

For bipolar patients, lithium is often the most successful; others that may help include anticonvulsants, thyroid hormones, and calcium blockers. Neuroleptic (anti-psychotic) drugs are often used to control agitation and psychosis. The use of lithium and/or neuroleptics is effective in approximately 80% of bipolar patients. One study has shown that bipolar adolescents treated with lithium have a significantly lower risk for relapse.

Psychotherapy

There are many different approaches to helping children with serious emotional disabilities. Psychotherapy is a general term for many kinds of approaches. Usually this approach will consist of talking extensively with your child about his feelings and con-
We release all feeling of guilt concerning this mental illness for we are not to blame for the illness or its effects.

We understand and acknowledge that the mental illness has had an impact on all of our relationships.

We forgive ourselves for the mistakes that we have made and we forgive others for wrongs that we feel have been committed against us.

We choose to be happy and healthy; we choose to return to a health focus on ourselves.

We keep our expectations for ourselves and for our mentally ill loved one at realistic levels.

We believe that we have inner resources that will help us with our own growth and will sustain us through crisis.

We acknowledge the strength and value of this support system and we commit ourselves to sustaining it for our benefit and the benefit of our families.

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A Guilt Free “Bill of Rights” for Parents
Parents have:

- A right to survive.
- A right to privacy and to lead their own lives.
- A right NOT to go broke or alter their standard of living drastically.
- A right NOT to be psychologically abused.
- A right NOT to be physically abused.
- A right to be parents to their other children.
- A right to express their own emotions.
- A right for respite and vacations.
- A right to receive help for themselves.
- A right to set house rules and be treated with consideration.

-Developed by the Thresholds Parent Support Group.

ARIZONA Contact Numbers

NAMI of Southern Arizona - (520) 622-5582
NAMI Arizona - (800) 626-5022
SAMHIC (Southern Arizona Mental Health Crisis Corporation) - (520) 622-6000 or (800) 796-6762
Mental Health Association of Arizona - (480) 994-4407 or (800) 642-9277
AZ Center for Disability Law - (800) 922-1447
Magellan (Maricopa) – (800) 327-3566
CPSA (Cochise, Graham, Greenlee, Pima, Santa Cruz) - (800) 771-9889
Cenpatico (Gila, La Paz, Pinal, Yuma) - (800) 495-6738
NARBHA - (Apache, Coconino, Mohave, Navajo, Yavapai) - (800) 640-2123

Suggested Reading


Overcoming Depression, Demitri F. Papulos, M.D., and Janice Papulos, 1997.


The Hyperactive Child, Adolescent, and Adult: Attention Disorder through the Lifespan, Paul H. Wender, 1987.

The Bipolar Child, Demitri F. Papulos, M.D., and Janice Papulos, 1999.

Understanding Depression, Donald Klein, MD and Paul Wender, M.D., 1993.


Manic-Depressive Illness, 1990, by Frederick K. Goodwin, M.D., Kay Redfield Jamison, Ph.D.

Updated February 2008
DO's and DON'Ts for Families When Coping with Serious Mental Illness

- DO Focus on your own reactions and attitudes.
- DO Allow other people to accept their own responsibilities.
- DO Manage your anxieties one day at a time.
- DO Invest time reading helpful literature.
- DO Learn to be open and honest.
- DO Involve yourself in other support groups.
- DO Encourage all attempts to seek help.
- DO Seek the good in others and in yourself.
- DON’T accept guilt for another person’s acts.
- DON’T nag, argue, lecture or recall past mistakes.
- DON’T overprotect, cover up or rescue from the consequences of someone else’s behavior.
- DON’T neglect yourself or be a doormat.
- DON’T yearn for perfection.
- DON’T manipulate or make idle threats.
- DON’T overlook the growth opportunities of a crisis.
- DON’T underestimate the importance of “Release with love.”
- DON’T sit home feeling depressed when you could be attending a support group meeting, helping yourself and others.
- DON’T set aside yourself to help “cure” your loved one. There is no known "cure" for these illnesses — yet.
- KEEP yourself up for yourself and for others.

Handling a Crisis

Things Always Go Better If you Speak Softly and in Simple Sentences

Sooner or later, if a family member is afflicted with a serious mental illness, a serious crisis will occur. When this happens, there are some actions you can take to help diminish or avoid the potential for disaster. Ideally, you need to reverse any escalation of the psychotic symptoms and provide immediate protection and support to the mentally ill person.

Seldom, if ever, will a person suddenly lose total control of thoughts, feelings and behavior. Family members or close friends will generally become aware of a variety of behaviors which give rise to mounting concern: sleeplessness, ritualistic preoccupation with certain activities, suspiciousness, unpredictable outbursts, etc.

During these early stages a full blown crisis can sometimes be averted. Often the person has ceased taking medications. If you suspect this, try to encourage a visit to the physician. The more psychotic the patient, the less likely you are to succeed.

You must learn to trust your intuitive feelings. If you, too, feel frightened or panic stricken, the situation calls for immediate action. Remember, your primary task is to help the patient regain control. Do nothing to further agitate the scene.

It may help you to know that the patient is probably terrified by the subjective experience of loss of control over thoughts and feelings. Further the “voices” may be life-threatening commands: messages may be coming from the light fixtures, the room may be filled with poisonous fumes, snakes may be crawling on the window.

Accept the fact that the patient is in an “altered reality state.” In extreme situations the patient may “act out” the hallucination, e.g., shatter the window to destroy the snakes. It is imperative that you remain calm. If you are alone, contact someone to remain with you until professional help arrives. In the meantime, the following guidelines will prove helpful:

- **DON’T THREATEN.** This may be interpreted as a power play and increase fear or prompt assaultive behavior by the patient.
- **DON’T SHOUT.** If the mentally ill person seems not to be listening, it isn’t because he or she is hard of hearing. Other “voices” are probably interfering.
- **DON’T CRITICIZE.** It will only make matters worse. It can’t possibly make things better.

- **DON’T SQUABBLE** with other family members over “best strategies” or allocation of blame. This is no time to prove a point.
- **DON’T BAIT** the patient into acting out wild threats. The consequences could be tragic.
- **DON’T STAND** over the patient if he or she is seated. Instead seat yourself.
- **AVOID** direct, continuous eye contact or touching the patient.
- **COMPLY** with requests that are neither endangering nor beyond reason. This provides the patient with an opportunity to feel somewhat “in control.”
- **DON’T BLOCK THE DOORWAY.**

However, do keep yourself between the patient and an exit. If the patient has to be hospitalized, try to convince him or her to go voluntarily. Avoid patronizing or authoritative statements. If necessary, call the local crisis service and request that a mental health professional come immediately to intervene and start the involuntary treatment process. If indicated, call the police but instruct them NOT TO BRANDISH ANY WEAPON; request a C.I.T. (Crisis Intervention Team) trained officer. Explain that your relative or friend has a neurobiological brain disorder also known as a mental illness and that you have called them for help.


Principles of Support

Some or all of the following may be helpful in coping when mental illness strikes the family.

- We acknowledge and accept the fact that someone we love has a mental illness.
- We accept that we have no control over this illness or the individual with the illness.
- We only have control over our own actions and thoughts.
9. Don’t expect an immediate, 100% recovery. In any illness, there is a period of convalescence. There may be relapses and times of tension and resentment.

10. Don’t try to protect the recovering person from drinking/using. He must learn on his own to say “no” gracefully.

11. Don’t do for the alcoholic/addict that which he/she can do for himself/herself. You cannot take the medicine for him/her. Don’t remove the problem before the alcoholic/addict can face it, solve it, or suffer the consequences.

12. Do offer love, support, and understanding during recovery.

Suggested Reading


Portions of the information in this brochure were provided by the National Alliance on Mental Illness, Arlington, VA, and reviewed by Markku Linnoila, M.D., Ph.D., Scientific Director, National Institute of Alcohol Abuse and Alcoholism (NIAAA).
Dual Diagnosis: Mental Illness and Substance Abuse (MI/SA)

Many know how difficult it is to find treatment for those with mental illness who also abuse drugs or alcohol. Programs that treat people with mental illnesses usually do not treat substance abusers, and programs for substance abusers are not geared for those with mental illnesses. Individuals with both diagnoses (MI/SA) often bounce from one program to another or are refused treatment by single-diagnosis programs.

Is Dual Diagnosis Common?

The combination of mental illness and substance abuse is so common that many clinicians who work with the mentally ill now expect to find it. Studies show that fully 50% of persons with mental illness also have a substance abuse problem. And more than half the persons with a substance abuse diagnosis also have a diagnosable mental illness.

What Causes These Disorders?

Mental health and addiction counselors increasingly believe that mental illness and substance abuse are biologically and psychologically based.

What Kinds of Treatments Work?

People with such difficult problems do not respond to simplistic advice like “just say no” or “snap out of it.” Psychotherapy, medication, and electro-convulsive treatment combined with appropriate self-help and other support groups help most, but these patients are still highly prone to relapse.

Treatment programs designed only for substance abusers are not recommended for people who also have a mental illness. Heavy confrontations and intense emotional jolting without adequate support tend to compound the programs of persons with mental illnesses. Some substance abuse programs discourage the use of prescribed “drugs” (medications). Such advice causes confusion because it is counter to state of the art treatment and may produce stress levels that make symptoms worse or cause relapse.

What is a Better Approach?

Increasingly, the psychiatric and drug counseling communities agree that both disorders must be treated at the same time. Early studies show that when mental illnesses and substance abuse are treated together, suicide attempts and psychotic episodes decrease rapidly. The patient’s denial is a central part of the problem. Since dually diagnosed patients do not fit well in most Alcoholic Anonymous or Narcotics Anonymous groups, special peer groups based on AA principles should be developed. Clients who develop positive social networks have a much better change of controlling their illnesses. Healthy recreational activities and peer relationships are extremely important.

What is the First Step in Treatment?

The presence of both disorders must first be established by careful assessment. This may be difficult because the symptoms of one disorder can mimic the symptoms of the other. Clinicians experienced in working with dually diagnosed patients are able to make this determination.

Once an assessment has confirmed a dual diagnosis of mental illness and substance abuse, mental health professionals and family members should work together on a strategy for integrating case and motivating the client.

What Do Model MI/SA Programs Look Like?

There are a growing number of model programs. All have support groups similar to Alcoholics Anonymous and Narcotics Anonymous. Members support each other as they learn about the role of alcohol and drugs in their lives. They learn social skills and now to replace substance used with new thoughts and behaviors. They get help with concrete situations that arise because of mental illness. Several programs have support groups for family members and friends.

The New Hampshire Mental Health and Substance Abuse Departments sponsor a program with the Dartmouth Medical School Psychiatric Research Center for the state’s 10 mental health service regions. Teams of professionals provide intensive case management services. Dr. Robert Drake, M.D., Ph.D., has demonstrated the importance of programs and peer support at various stages of treatment. Individuals isolated in the community without intensive supports tend to experience relapse.

A New York program operates in a wide range of service settings. Treatment focuses on eliminating symptoms and developing strategies to prevent relapse. A residential rehabilitation program in a high-crime and drug-use area of the Bronx helps 45 homeless men who are both drug abusers and have a major mental illness.

In Washington D.C., a program offers case management integrated with treatment and referral to community substance abuse services.

How Does Dual Diagnosis Affect Family and Friends?

Dual diagnosis means the condition is especially complex and difficult to manage. Families with a dually diagnoses (MI/SA) member may experience twice the problems of those whose family member has only one disorder.

Families may feel angry with the person and blame him/her for being foolish and weak-willed. Families may feel hurt when the person breaks trust by lying or stealing, but it’s important for families to realize that mental illnesses and substance abuse are diseases and that the person cannot take control of the problem without help.

If Your Loved One Is Addicted to Drugs and/or Alcohol ...

1. Don’t regard it as a family disgrace. Recovery from an addiction is possible just as with other illnesses.
2. Don’t nag, preach or lecture to the addict/alcoholic. Changes are he has already heard or told himself everything you can say. You may only increase the need to lie or force him/her to make promises that cannot be kept.
3. Guard against a “holier than thou” or martyr-like attitude.
4. Don’t use the “if you loved me” approach. It is like saying, “If you loved me, you would not have tuberculosis”.
5. Avoid threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the alcoholic/addict feel you don’t mean what you say.
6. Don’t hide the alcohol/drugs or dispose of them. Usually this only pushes the addict into a state of depression.
7. Don’t let the addict/alcoholic persuade you to drink or use with him/her. When you condone the drinking/using, he/she puts off doing something to get help.
8. Don’t be jealous of the method of recovery the alcoholic/addict chooses. You may feel left out when the alcoholic/addict turns to other people for help staying sober. If someone needed medical care, you wouldn’t be jealous of the doctor.
increased rate of birth defects. But it can produce side effects, such as dry mouth, constipation, tiredness, fatigue, slight hand trembling, sexual dysfunction, and severe weight gain. There is the possibility of seizures in high dosages.

Fluoxetine (brand name: Prozac) and Sertraline (brand name: Zoloft) are effective in some OCD patients and have far fewer side effects for most patients. Fluoxetine occasionally causes nausea, weight loss, and insomnia.

Despite sensationalized reports that fluoxetine causes violent behavior, the drug has been examined on numerous occasions by the US Food and Drug Administration and is deemed safe and effective.

Sertraline is a relatively new drug that so far has shown fewer side effects than fluoxetine and is substantially cheaper.

**How long should an individual take medication before judging its effectiveness?**

Some physicians make the mistake of prescribing medication for only three or four weeks. That really isn’t long enough. Medication should be tried consistently for 10 or 12 weeks before judging its effectiveness.

**What is “behavior therapy” and can it effectively relieve symptoms of OCD?**

Behavior therapy is not traditional psychotherapy. It is “exposure and response prevention,” and has been found to be effective for many people with OCD.

Patients are deliberately exposed to a feared object or idea, either directly or by imagination, and are then discouraged or prevented from carrying out the usual compulsive response.

For example, a compulsive hand-washer may be urged to touch an object believed to be contaminated, and then may be denied the opportunity to wash for several hours.

When the treatment works well, the patient gradually experiences less anxiety from the obsessive thoughts and becomes able to refrain from the compulsive actions for extended periods of time.

Several studies suggest that medication and behavior therapy are equally effective in alleviating symptoms of OCD. About half the patients improve substantially with behavior therapy; the rest improve moderately with it.

**If my relative with OCD refuses to take medication and won’t participate in behavioral therapy, are there any other treatments?**

Your relative could be a candidate for brain surgery. Neurosurgeons in recent years have developed a finely tuned procedure with Magnetic Resonance Imaging to identify the part of the brain that may be involved in expressing OCD. A surgeon can make microscopic cuts in the brain, which often lead to a decrease in OCD.

**Will OCD symptoms go away completely with medication and behavior therapy?**

Response to treatment varies from person to person. Most people treated with effective medications find their symptoms are reduced by about 40 or 50 percent. That can often be enough to change their lives, to transform them into functioning individuals.

Some people are fortunate enough to go into total remission when treated with effective medication and/or behavior therapy. Unfortunately, some people find neither medication nor behavior therapy has positive effects.

**Suggested Reading**


**For Further Information:**

OC Foundation. OC Foundation, P.O. Box 961029, Boston, MA 02196, (617) 973-5801. (This foundation has a Newsletter).

Information in this brochure is from a 1992 NAMI Convention workshop led by Teri Pigott, MD, Medical Director, OCD Program, Georgetown University, Washington, DC, and former head of Obsessive Compulsive Disorder Research Unit, National Institute of Mental Health, Rockville, MD. Information also provided by Mary Lynn Hendrix, science writer, Office of Scientific Information, National Institute of Mental Health.

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What is Obsessive Compulsive Disorder?

Obsessions are intrusive, irrational thoughts, unwanted ideas, or impulses that repeatedly well up in the victim’s mind. Again and again, the person experiences disturbing thoughts, such as “My hands must be contaminated; I must wash them”; “I may have left the gas stove on”; or “I am going to injure my child.” On one level, the sufferer knows these obsessive thoughts are irrational, but on another level, he/she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.

Compulsions are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions, perhaps feeling momentary relief but without feeling satisfaction or a sense of completion. OCD victims feel they must perform these compulsive rituals or something bad will happen. Most people at one time or another experience obsessive thoughts or compulsive behaviors. Obsessive Compulsive Disorder occurs when an individual experiences obsessions and compulsions for more than an hour each day in a way that interferes with his/her life.

OCD is often described as “a disease of doubt.” Sufferers experience “pathological doubt,” unable to distinguish between what is possible, what is probable, and what is unlikely to happen.

Who gets OCD?

People of all ages and from all walks of life can get OCD. It strikes people of all ethnic groups, and both males and females. Symptoms typically begin during the teenage years or young adulthood.

What causes OCD?

The preponderance of scientific evidence suggests that OCD results from a chemical imbalance in the brain. For years, mental health professionals assumed OCD resulted from bad parenting or personality defects. This theory has been disproved over the last 20 years. OCD symptoms have not been relieved by psychoanalysis or other forms of “talk therapy.”

OCD patients can often articulate insight into “why” they have obsessive thoughts or why they behave compulsively. But the thoughts and the behavior continue.

People whose brains are injured often develop OCD, suggesting that it’s a physical condition. If a placebo is given to people who are depressed or who experience panic attacks, 40 percent will say they feel better. If a placebo is given to people who experience obsessive compulsive disorder, only about 2 percent say they feel better. This suggests a physical condition.

Brain scientists have identified the part of the brain that causes OCD. They have discovered a strong link between OCD and a brain chemical called serotonin. Serotonin is a neurotransmitter that helps nerve cells communicate.

Scientists have also observed that people with OCD have increased metabolism in the basal ganglia and in the frontal lobes of the brain.

This, scientists believe, causes repetitive movements, rigid thinking and a lack of spontaneity. People with OCD often have high levels of the hormone Vasopressin.

In layman’s terms, something in the brain is stuck, like a book, The Boy Who Couldn’t Stop Washing, as “grooming behaviors gone wild.”

How do people with OCD typically react to their disorder?

People with OCD generally attempt to hide their problem rather than seek help. Often they are remarkably successful in concealing their obsessive compulsive symptoms from friends and co-workers.

An unfortunate consequence of this secrecy is that people with OCD generally do not receive professional help until years after the onset of their disease. By that time, obsessive-compulsive habits may be deeply ingrained and very difficult to change.

How long does OCD last?

For years, even decades. The symptoms may become less severe from time to time, and there may be long intervals when the symptoms are mild, but generally OCD is a chronic disease.

Is age a factor in OCD?

OCD usually starts at an early age, often before adolescence. Left untreated, it usually grows worse with age. It may first manifest as autism, pervasive developmental disorder, or Tourette’s Syndrome, a compulsion to shout obscenities and insults at random. OCD can evolve into Tourette’s Syndrome, depression, and anxiety. Like depression, OCD tends to worsen with age. Scientists hope that if OCD patients are treated at an early age, their symptoms won’t worsen as they age.

What are some more examples of people who may suffer from OCD?

People who:
- repeatedly check things, perhaps dozens of times before feeling secure enough to go to sleep or to leave the house.
- fear the stove off? Is the door locked? Is the alarm set?
- fear they will harm others. A man’s car hits a pothole on a city street and he fears it was actually a body.
- feel dirty and contaminated. A woman is fearful of touching her baby because she might contaminate it.
- constantly arrange and order things. A child can’t go to sleep unless he lines up all his shoes correctly.
- are excessively concerned with body imperfections. A person who insists on numerous plastic surgeries or spends hours a day bodybuilding.
- are ruled by numbers, believing that certain numbers represent good, and other numbers represent evil.
- are excessively concerned with sin or blasphemy.

Is OCD commonly recognized by professionals?

Not nearly enough. OCD is often misdiagnosed and underdiagnosed. Many people have dual diagnoses of OCD and schizophrenia or OCD and manic depressive illness, but the OCD component is not diagnosed or treated. Researchers believe OCD, anxiety disorders and eating disorders like anorexia and bulimia can be triggered by the same chemical malfunctioning of the brain.

Is heredity a factor in OCD?

Yes, heredity appears to be a strong factor. If you have OCD, there’s a 25 percent chance that one of your immediate family members will have it. It definitely seems to run in families.

Can OCD be effectively treated?

Yes, OCD can be effectively treated with medication and behavior therapy. Medication can regulate serotonin and reduce obsessive thoughts and compulsive behavior. In the last few years several medications have been developed that relieve many of the symptoms of OCD. Three medications are particularly recommended as “serotonin selectors”: clomipramine, fluoxetine, and sertraline.

Clomipramine (brand name: Anafranil) has been used in Europe for more than 20 years and is now available in the US. There is little evidence that clomipramine has adverse, long-term, negative effects and particularly that it has an
experience panic attacks may have trouble metabolizing lactate, a substance usually produced by muscles during exercise.

**Is panic disorder treatable?**

Recovery from panic disorder appears to be most successful when a combination of treatments is used in fighting the disorder.

Most often, medication is used to block panic attacks, and when it is used in combination with cognitive or behavioral therapy, it allows people to overcome their fears and return to normal, functional living.

Sadly, although treatments can be quite successful—75 percent to 90 percent of those treated show significant improvement—only about one quarter of those who suffer this disorder ever seek appropriate treatment.

Cognitive therapy is used to help people think and behave appropriately, thus making the feared object or situation less threatening through supported exposure and hierarchical desensitization (being exposed to, and slowly getting used to, the thing that is so frightening).

Family members and friends play an important role in this process as they provide support, assistance, and encouragement.

Medication is most effective when used as part of a more comprehensive treatment plan that involves supportive therapy. Antidepressants, such as imipramine and phenelzine, and antianxiety agents, such as alprazolam, are most successful.

Beta blockers, which limit neuron activity in the brain, are helpful with social phobias. If you are seeking medical treatment, ask your doctor about these medications or others that may help you.

Psychotherapy and healthy living habits are also believed to help people overcome the burdens placed on them by panic disorder.

Exercise, a proper and balanced diet, moderate use of caffeine or alcohol, and reduced stress can help tremendously.

Peer support is a vital part of overcoming panic disorder. Family and friends can play a significant role in the treatment process and should be informed of the treatment plan and of the ways they can be most helpful.

**Resources**


Anxiety Disorders Association of America, 8730 Georgia Ave, Suite 600, Silver Spring, MD, 20910. American Psychiatric Association, 1000 Wilson Blvd, Suite 1825, Arlington VA, 22209-3901

National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892

The National Alliance on Mental Illness is a grassroots, self help support and advocacy organization of families and friends of people with serious mental illness. NAMI's mission is to eradicate mental illness and to improve the quality of life for those who suffer from these no fault brain diseases.

NAMI of Southern Arizona is a nonprofit 501(c)(3) corporation representing anyone affected by serious mental illnesses. Contributions to NAMI of Southern Arizona are tax deductible. NAMI of Southern Arizona is affiliated with NAMI (National Alliance on Mental Illness), which has over 220,000 members nationwide.

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Am I the only one?

Two to five percent of Americans are thought to suffer panic disorder, so you are not alone if you experience these symptoms. Most often, panic disorder first strikes people in their early twenties. A severe life stress, such as the death of a loved one, can precipitate panic attacks.

A 1986 study which they feel phobic. The American Psychiatric Association recognizes a category of symptoms called phobic disorders within the broader field of anxiety disorders.

Phobias are divided into three types: single, social, and agoraphobia.

Single (simple) phobia is an unreasonable fear of specific circumstances or objects, such as snakes or traffic jams.

Social phobia is extreme fear of making a spectacle of oneself in public, thus forcing one to avoid public occasions or areas.

Agoraphobia is literally (in Greek) "fear of the market place" and is an intense fear about feeling trapped in any situation, particularly in public places, combined with an overwhelming fear of having a panic attack in unfamiliar surroundings.

Phobias are usually chronic (long term) distressing and restrictive disorders. They can lead to other serious problems, such as depression.

In fact, at least half of those who suffer with phobias and panic disorders experience depression. Alcoholism, loss of productivity, feelings of shame, secrecy, and low self-esteem also occur.

Some people develop a pathologic dependency and are unable to go anywhere or do anything without the assistance of others they trust.

What are phobias?

Phobias are irrational, involuntary and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object about which they feel phobic.

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Some people develop a pathologic dependency and are unable to go anywhere or do anything without the assistance of others they trust.

What does it mean to "Fear the Fear"?

Many people with phobias or panic disorder "fear the fear" or worry about when the next attack is coming. Anticipatory anxiety, or the fear of more attacks, can be debilitating. People who are prone to panic attacks often begin to avoid the things they think triggered the panic attack, thus limiting the things they do or the places they go.

What's happening?

Imagine you've just stepped into an elevator and suddenly your heart races, your chest aches, you break out in a cold sweat and feel as if the elevator is about to crash to the ground. What's happening?

Imagine you are driving home from the grocery store and suddenly things seem to be out of control, you feel hot flashes, things around you blur, you can't tell where you are, and you feel as if you're dying. What's happening?

What's happening is a panic attack, an uncontrollable panic response to ordinary, non-threatening situations. Panic attacks are often an indication that a person has panic disorder.

What is panic disorder?

A person who experiences four or more panic attacks in a 4-week period is said to have panic disorder. Panic disorder may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack.

Doctors often try to rule out every other possible alternative before diagnosing panic disorder. To be diagnosed as having panic disorder, a person must experience at least four of the following symptoms during a panic attack: sweating; hot or cold flashes; choking or smothering sensations; racing heart; labored breathing; trembling; chest pains; faintness; disorientation; or feelings of dying, losing control, or losing one's mind.

Panic attacks can occur in anyone. Chemical or hormonal imbalances, drugs or alcohol, stress or other situational events can cause panic attacks, which are often mistaken for heart attacks, heart disease, or respiratory problems.

What do people who have panic disorder experience?

Many people with phobias or panic disorder "fear the fear" or worry about when the next attack is coming. Anticipatory anxiety, or the fear of more attacks, can be debilitating. People who are prone to panic attacks often begin to avoid the things they think triggered the panic attack, thus limiting the things they do or the places they go.

Am I the only one?

Two to five percent of Americans are thought to suffer panic disorder, so you are not alone if you experience these symptoms. Most often, panic disorder first strikes people in their early twenties. A severe life stress, such as the death of a loved one, can precipitate panic attacks.

A 1986 study by the National Institute of Mental Health showed that 51 percent to 12.5 percent of people surveyed had experienced phobias in the past 6 months. The study estimated that 24 million Americans will experience some phobias in their lifetimes.

Phobias are the leading psychiatric disorders among women of all ages. One survey showed that 49 percent of women and 18 percent of men have panic disorder, agoraphobia, or other phobias.

What causes panic disorder?

No one really knows what causes panic disorder, but several theories are being researched. Panic disorder seems to run in families, and this suggests the disorder has some genetic inheritability or predisposition.

Some theories suggest that panic disorder is part of a more generalized anxiety in the people who experience panic attacks or that severe separation anxiety can develop into panic disorder or phobias, most often agoraphobia.

Cognitive theorists believe that one's "wrong thinking" maintains an anxiety level that can trigger panic attacks.

Biological theories point to possible physical defects in a person's autonomic (or automatic) nervous system. General hypersensitivity in the nervous system, increased arousal, or a sudden chemical imbalance can trigger panic attacks.

Caffeine, alcohol, and several other agents can also trigger these symptoms. Researchers have found that sodium lactate, when injected into the blood stream of some people who are predisposed to panic attacks, will induce such attacks. This suggests that people who...
**Related links**

**Anxiety Disorders Association of America (ADAAA)**
National, non-profit membership organization dedicated to informing the public, providers, and policy-makers about anxiety disorders.
http://www.adaa.org/

**Clinicaltrials.gov**
Post-traumatic stress disorder research studies identified through the U.S. National Library of Medicine's link to federally and privately funded studies worldwide.
http://www.clinicaltrials.gov

**National Center for PTSD**
A program of the U.S. Department of Veterans Affairs to advance the clinical care and social welfare of America's veterans through research, education, and treatment.
http://www.ncptsd.va.gov

**National Institute of Mental Health**
Information from the NIH institute on post-traumatic stress disorder.
http://www.nimh.nih.gov/

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**POST-TRAUMATIC STRESS DISORDER (PTSD)**

**NAMI Southern Arizona**
National Alliance on Mental Illness

**Providing Advocacy, Education and Support to all those affected by mental illness.**

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Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after someone experiences a traumatic event that caused intense fear, helplessness, or horror. PTSD can result from personally experienced traumas (e.g., rape, war, natural disasters, abuse, serious accidents, and captivity) or from the witnessing or learning of a violent or tragic event.

While it is common to experience a brief state of anxiety or depression after such occurrences, people with PTSD continually re-experience the traumatic event; avoid individuals, thoughts, or situations associated with the event; and have symptoms of excessive emotions. People with this disorder have these symptoms for longer than one month and cannot function as well as they did before the traumatic event. PTSD symptoms usually appear within three months of the traumatic experience; however, they sometimes occur months or even years later.

### How common is PTSD?

Studies suggest that anywhere between 2 percent and 9 percent of the population has had some degree of PTSD. However, the likelihood of developing the disorder is greater when someone is exposed to multiple traumas or traumatic events early in life (or both), especially if the trauma is long term or repeated. More cases of this disorder are found among inner-city youths and people who have recently emigrated from troubled countries. And women seem to develop PTSD more often than men.

Veterans are perhaps the people most often associated with PTSD, or what was once referred to as "shell shock" or "battle fatigue." The Anxiety Disorders Association of America notes that an estimated 15 percent to 30 percent of the 3.5 million men and women who served in Vietnam have suffered from PTSD.

### Symptoms of PTSD

Although the symptoms for individuals with PTSD can vary considerably, they generally fall into three categories:

- **Re-experience** - Individuals with PTSD often experience recurrent and intrusive recollections of and/or nightmares about the stressful event. Some may experience flashbacks, hallucinations, or other vivid feelings of the event happening again. Others experience great psychological or physiological distress when certain things (objects, situations, etc.) remind them of the event.

- **Avoidance** - Many with PTSD will persistently avoid things that remind them of the traumatic event. This can result in avoiding everything from thoughts, feelings, or conversations associated with the incident to activities, places, or people that cause them to recall the event. In others there may be a general lack of responsiveness signaled by an inability to recall aspects of the trauma, a decreased interest in formerly important activities, a feeling of detachment from others, a limited range of emotion, and/or feelings of hopelessness about the future.

- **Increased arousal** - Symptoms in this area may include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, becoming very alert or watchful, and/or jumpiness or being easily startled.

It is important to note that those with PTSD often use alcohol or other drugs in an attempt to self-medicate. Individuals with this disorder may also be at an increased risk for suicide.

### Treatment

There are a variety of treatments for PTSD, and individuals respond to treatments differently. PTSD often can be treated effectively with psychotherapy or medication or both.

**Behavior therapy** focuses on learning relaxation and coping techniques. This therapy often increases the patient's exposure to a feared situation as a way of making him or her gradually less sensitive to it. **Cognitive therapy** is therapy that helps people with PTSD take a close look at their thought patterns and learn to do less negative and nonproductive thinking. **Group therapy** helps for many people with PTSD by having them get to know others who have had similar situations and learning that their fears and feelings are not uncommon.

Medication is often used along with psychotherapy. Antidepressant and anti-anxiety medications may help lessen symptoms of PTSD such as sleep problems (insomnia or nightmares), depression, and edginess.
Suggested Reading


*Recommended especially for schizo-affective disorder.

Portions of the information in this brochure were prepared by The National Alliance on Mental Illness, Arlington, VA, and reviewed by Elliot Gershon, M.D.; Chief, Neurogenetics Branch; National Institute of Mental Health; Bethesda, Maryland.

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Diagnosis

Some psychiatric disorders are very difficult to diagnose accurately. One of the most confusing conditions is schizo-affective disorder.

This relatively rare disorder is the presence of psychotic symptoms in the absence of mood changes for at least two weeks in a patient who has a mood disorder. The diagnosis is used when patients do not fit diagnostic standards for either schizophrenia or "affective" (mood) disorders such as depression and manic depression.

Patients may have symptoms of both a depressive disorder and schizophrenia at the same time, or they may have symptoms of schizophrenia without mood symptoms.

Many individuals with schizo-affective disorder were originally diagnosed with manic depression. If the patient experiences delusions or hallucinations that go away in less than two weeks when the mood is "normal," manic depression may be the proper diagnosis. A patient who is psychotic for three or four weeks while manic is not schizo-affective.

However, if delusions or hallucinations continue after the mood has stabilized and are accompanied by other symptoms of schizophrenia such as catatonia, paranoia, bizarre behavior, or thought disorder, a schizo-affective diagnosis may be appropriate. Accurate diagnosis is easier once the acute psychotic episode is under control.

Distinguishing between manic depressive illness and schizophrenia can be particularly difficult in an adolescent, since at that age psychotic features are especially common during manic periods.

Because this disorder is so complicated, misdiagnosis is common. Some patients may be misdiagnosed as schizophrenic. Others may be misdiagnosed with manic depression. And patients diagnosed as schizo-affective may actually have schizophrenia with prominent mood symptoms. Or they may have a mood disorder with schizophrenia-like symptoms.

Treatment

Psychiatrists often treat this disorder with an anti-psychotic medication and lithium, or with carbamazepine (an anticonvulsant medication) and lithium. Some patients have responded to Clozapine.

As a practical matter, differentiating between schizophrenia, manic depression, and schizoaffective disorder is not absolutely critical, since anti-psychotic medication is recommended for all three. If a mood problem is suspected, lithium or an anti-depressant should be added.

Prognosis

The prognosis (outlook) for patients diagnosed with schizo-affective disorder is generally better than those with schizophrenia, but worse than those with a mood disorder. (Schizophrenia is a chronic, progressively deteriorating illness. Bipolar disorder is a chronic illness in which patients usually return to "normal" between episodes.) Patients with schizo-affective disorder generally respond to lithium better than patients with schizophrenia but not as well as patients with mood disorders.

More research is needed to fully understand this illness and why it resists conventional treatment.

How can you help?

The best way to treat a friend or relative with schizo-affective disorder is with compassion, understanding, and support. The person should not be made to feel as if the disease is his, her, or anybody's fault. To paraphrase Dr. E. Fuller Torrey, people do not cause these illnesses; they merely blame each other for doing so. Learning about the disease and its treatment will help to avoid the temptation to blame.

Emotional Support

In addition to seeking help for the person who has this disease, loved ones often find mutual support invaluable. The National Alliance on Mental Illness is a grassroots, self-help organization of families and friends of persons with serious mental illnesses and those persons themselves. Through more than fifteen hundred local and state Alliance groups all across the country and in other nations, the AMI movement provides mutual support, education, and advocacy. Members meet regularly to share practical information and common experiences.

For more information about your local NAMI’s services and programs, call NAMI of Southern Arizona at (520) 622-5582.
case managers may be able to help you through the red tape, but you may have to contact your local Social Security office directly to find out what benefits are available in your area and how to apply for them. Then you may need to help the ill person through the application process. Individuals who depend on SSI, SSDI, or GA as their sole source of income generally qualify for treatment on a reduced-fee basis through their local community mental health center.

Handling symptoms. When you are confronted with the symptoms of schizophrenia, you can help if you have learned everything you can about the disorder. Try your best to understand what the affected person is going through and why the illness causes upsetting or difficult behavior. For example, it’s important to realize that when people with schizophrenia hear voices, the voices are real, and the images they see are very real to them. You should not argue with them, make fun of them, or act alarmed. Rather, it’s important to stay calm, acknowledge how the person is feeling, and do what you can to help him or her feel safe and more in control.

Managing crises. In some cases, behavior caused by schizophrenia can be very difficult, not only for the ill person, but also for his or her family. Being informed about the disorder, many families try to hide it from friends and deal with it on their own.

Families who deal most successfully with a relative who has schizophrenia are those that come to accept the illness and its difficult consequences, develop realistic expectations for the ill person and for themselves, and even keep a sense of humor. Developing such attitudes is a continuous process for most people, but it can be eased and hastened by the understanding support of others.

How Can Family and Friends Help?

Finding appropriate treatment and the means to pay for it. If you suspect that someone you know and love has schizophrenia, the most important thing you can do is to help that person find effective medical treatment and then encourage him or her to stay in it. To find a good doctor, you may want to ask your own physician for a referral, or contact the psychiatry department of a university medical school or the American Psychiatric Association. You can contact the National Alliance on Mental Illness to consult with others who have a family member with schizophrenia.

Paying for treatment is difficult for many people with schizophrenia and their families. Health insurance coverage for psychiatric illnesses, when available, usually includes high deductibles and co-payments, limited visits, or other restrictions that are not comparable to benefits for other medical disorders.

Public programs such as Medicaid and Medicare may be available to finance treatment. In addition, programs such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and General Assistance (GA) may be available to support income. Social workers or

How Can Families Cope with Schizophrenia?

A diagnosis of schizophrenia can be very difficult, not only for the ill person, but also for his or her family. Because so many people are afraid and uninformed about the disorder, many families try to hide it from friends and deal with it on their own.

If someone in your family has schizophrenia, you need understanding, love, and support from others. You may need help realizing that no one causes schizophrenia, just as no one causes diabetes, cancer, or heart disease. You are not to blame—and you are not alone.

To survive schizophrenia, one of the most important steps you can take is to join a family support group. More than 1,200 such groups affiliated with the National Alliance on Mental Illness (NAMI) are now active in local communities in all 50 states. Members of these groups share information and strategies for everything from coping with symptoms to finding financial, medical, and other resources.

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Schizophrenia poses undeniably great hardships, but it does not have to destroy you or your family. To deal with it in the best possible way, it's particularly important for you to take care of yourself and do things you enjoy and not to allow the illness to consume your life. Scientists believe that new discoveries and new treatments will bring hope to more people with schizophrenia someday. In the meantime, try to help the ill person live the best life he or she can today, and do the same for yourself.

The material in this brochure was supplied by the National Alliance on Mental Illness (NAMI) and the National Institute of Mental Health (NIMH).
Schizophrenia is a serious medical illness that affects about 2 million Americans. Although widely feared and misunderstood, schizophrenia is actually a highly treatable disorder of the brain, and new discoveries are continually improving the prospects of those who suffer from it. With new treatments, people with schizophrenia are increasingly able to minimize their need for hospitalization and lead more independent and productive lives in their communities. Left untreated, however, schizophrenia can devastate the lives of individuals, families, and communities. Because the disorder causes unusual, inappropriate, and sometimes dangerous behavior, people with schizophrenia are often shunned and unnecessarily stigmatized. They are particularly vulnerable to poverty, homelessness, and suicide when they fail to receive effective treatment.

As difficult as schizophrenia is, help is available. Doctors know more about the disorder today than ever before, and most persons with schizophrenia can recover either partially or completely.

**What Is Schizophrenia?**

Schizophrenia is a brain disorder that impairs a person's ability to think clearly, to manage his or her emotions, to make decisions, and to relate to others. Like cancer or diabetes, it is a complex, chronic medical illness affecting different people in different ways. It is not caused by bad parenting or personal weakness, but appears to be the result of problems with brain chemistry and structure, perhaps including brain abnormalities that are present very early in life. A person with schizophrenia does not have a "split personality," and the vast majority of those who suffer from schizophrenia are not dangerous, although their behavior can be quite unpredictable.

**What Are the Symptoms?**

No single symptom positively identifies schizophrenia; all of the signs of the disorder can be found in other brain disorders. In addition, an individual's symptoms may change over time, and many symptoms tend to be less severe in women.

*Altered* senses. People with schizophrenia have trouble making sense of everyday sights, sounds, and feelings. They may perceive distracting or frightening distortions of the world around them and may become extra sensitive to colors, shapes, and background noises. They may have difficulty distinguishing between themselves and others, or between themselves and objects around them.

*Hallucinations, delusions, and confused thinking.* Commonly, schizophrenia produces hallucinations (voices or objects that don't exist) or delusions (ideas that are obviously false, such as the belief that one is God or that one can control other people's minds). Schizophrenia is often marked by fragmented and confused thinking and speech that doesn't make sense.

*Altered or blunted emotions.* The disorder can cause a person to express inappropriate feelings, such as laughing at the death of a loved one or feeling disappointed when a favorite team wins a game. Sometimes people with schizophrenia express no feelings at all. Understandably, it's hard for people with schizophrenia to relate well to others, and those who suffer from schizophrenia generally experience intense periods of withdrawal and profound isolation.

*Other behavioral changes.* Schizophrenia can cause a person to move more slowly, to repeat rhythmic gestures or to adopt rituals--such as walking in circles. Some people with schizophrenia experience an effective loss of motivation and have trouble following through on tasks. In severe cases, the illness can cause a person to stop speaking completely, or to stop moving and hold a fixed position for long periods of time.

To accurately diagnose schizophrenia, a medical doctor must eliminate the possibility of numerous other organic illnesses. To be diagnosed with schizophrenia, a patient must have psychotic, "loss-of-reality" symptoms for at least six months and show increasing difficulty in functioning normally.

**Who Gets Schizophrenia?**

Schizophrenia can affect anyone at any age, but three-quarters of those with the disorder develop it between the ages of 16 and 25, and it affects slightly more men than women. Children also can be affected by schizophrenia. Most cases develop before age 30, and new cases are quite rare after 40.

Although the disorder runs in families, the chances of becoming ill with schizophrenia are very small for most people. If no one in your family has ever had the disease, the chances are 99 out of 100 that you won't either. If one of your parents, a brother, or a sister has it, there's still about 90 percent chance that you will never develop schizophrenia. If both of your parents have it, there is more than 60 percent chance that you will not; if you have an identical twin with schizophrenia, there is a 70 percent chance that you will not become ill.

**What Causes Schizophrenia?**

Scientists still don't know exactly what causes schizophrenia, but they do know that the brains of people with schizophrenia are different, as a group, from the brains of those who don't have the disorder. Recent research suggests schizophrenia involves problems with brain chemistry and brain structure. It is as much an organic brain disease as is multiple sclerosis, Parkinson's disease, or Alzheimer's disease. Some scientists think that schizophrenia may be the result of a viral infection affecting the brain very early in life, or of mild brain damage from complications during birth.

While heredity is clearly a factor, it is not the dominating one. Many researchers suspect that--like heart disease, cancer, diabetes, and other chronic illnesses--some people inherit a genetic predisposition to develop schizophrenia under some conditions.

**How Is Schizophrenia Treated?**

*Medsation.* Schizophrenia is a treatable disease. Like diabetes, a cure has not yet been found, but the symptoms can be controlled with medication in most people. The drugs for schizophrenia--called antipsychotics or neurolep-tics--help relieve the hallucinations, delusions, and thinking problems associated with the disorder. These drugs appear to work by correcting an imbalance in the chemicals that help brain cells communicate with each other.

Some of the most common drugs include: chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), and thiothixene (Navane). These medications, and other antipsychotics, such as trifluoperazine (Stelazine), perphenazine (Trilafon), and thi-oxidine (Mellaril), are all somewhat effective in relieving symptoms, but they differ in potency and possible side effects. Doctors can predict which drug will be best for which person, so some patients try several different medications before they find the one, or the combination of medications, that works best.

New antipsychotic drugs available in the United States offer the possibility of more effective treatments with fewer side effects in the future. Clozapine (Clozaril) holds new hope for some patients with schizophrenia, especially those who have not responded well to other medications; however, its use is somewhat limited by the need for frequent monitoring of those who take it. Olanzapine (Zyprexa) and risperidone (Risperdal) are new "atypical" antipsychotic medications that are other weapons in the fight to control this disorder. Studies with investigational drugs promise more options for those with schizophrenia in the future.

Antipsychotic drugs are usually taken daily in tablet or liquid form, although fluphenazine and haloperidol can be injected in one-to-four week intervals. These "depot neuroleptics" help to ensure that the patient stays on a regular course of treatment.

**Psychosocial rehabilitation.** While psychotherapy, by itself, is not effective in treating the symptoms of schizophrenia, individual and group counseling can provide important support, guidance, and friendships for those who suffer from the disorder and their families. Research has demonstrated that those who participate in structured psychosocial rehabilitation programs, in addition to their medical treatment, manage the illness best.

**Hospitalization.** Most people who become acutely ill with schizophrenia need to be hospitalized for a period of time when the disorder begins. Once they are on an effective course of medication, most people with schizophrenia can receive the support and treatment they need in day programs, rehabilitation centers, and other outpatient services. When patients relapse and need to be re-hospitalized, it is often because they have stopped taking their medication.

**What Are the Possible Side Effects of Drugs Used To Treat Schizophrenia?**

As a group, antipsychotic drugs are quite safe, and serious side effects are relatively rare. Some people may experience side effects that are inconvenient or unpleasant, but not serious. The most common of these include: dry mouth, constipation, blurred vision, and drowsiness. Less common side effects include: decreased sexual desire, menstrual changes, and/or stiff muscles on one side of the neck and jaw (a symptom that is quickly reversed or prevented with medications called anticholinergic drugs, such as benztropine (Cogentin) or biperiden (Akineton)). More serious side effects of antipsychotic medications include: restlessness, muscle stiffness, tremors of the hands or feet, and/or a deficiency of a type of white blood cell (when taking clozapine) that requires monitoring.

Probably the most unpleasant, serious side effect of antipsychotic drugs is a condition called tardive dyskinesia,