From the Executive Director

Summer is winding down and we’re preparing to send kids back to school and back to college. The landscape has changed due to Covid-19 and for many people anxiety is high. How can we (the community) help? Through space figuratively AND literally. We do not know exactly what our neighbors are going through or what they have gone through during the last 18 months, so a little grace could go a long way. Simple actions such as masking up and distancing for those that are immunocompromised and for those that are too young for the vaccine can help keep everyone safe and ease anxieties around changes and returning to school. Remember that NAMI NKY is here for you, we are all in this together. Best of luck to everyone returning to school, and remember to please contact us if you need anything.

Dogs, Vets, and PTSD

Approximately 20 veterans per day die by suicide; In 2019, the VA reported that the suicide rate for veterans was 1.5 times the rate of non-veterans, often spurred by symptoms of PTSD. Standard therapy and medications may not be enough to manage the symptoms PTSD, but service dogs may help alleviate them. K9s for Warriors, the nation’s largest veteran service organization providing highly skilled service dogs to disabled veterans, has already rescued 653 veterans and 1278 dogs as of February 2021. The Puppies Assisting Wounded Servicemembers (PAWS) Act, H.R. 1022, introduced in February by Congressman John Rutherford (R-Fla), seeks to establish a competitive grant program to help organizations such as this to pair service dogs with veterans.
PTSD service dogs are trained to perform a variety of tasks intended to alleviate PTSD symptoms. Many of these tasks are related to detecting signs of anxiety or distress and intervening. For example, a service dog can sense changes in an individual prior to a panic attack and nudge or lean against the individual to encourage them to refocus on the dog and the present space, thereby minimizing or preventing the panic attack. The service dog can also wake up a veteran from a disturbing nightmare to provide comfort. In our recent study of 134 veterans with PTSD service dogs, we found that veterans reported the most important trained service dog task was to calm/comfort from anxiety. They used this task on average 5 times every day and it was reported to help with 12 of 20 PTSD symptoms.

Training these service animals can be expensive—costing almost $30,000. Therefore, despite acknowledging a national crisis exists with the alarming rate of veteran suicide, the VA has refused to take action by covering the cost-of-service dogs (a proven treatment method for PTSD) under the insurance benefits that veterans have earned through their military service. Upon introducing a service dog, veterans, along with their families/caregiver(s) experience a transformational improvement in quality of life, and the VA needs to take responsibility and remove the financial barrier that precludes more veterans from receiving this benefit.

The program has proven success. In a study of 141 veterans with PTSD, we found that those paired with service dogs showed clinically significant reductions in PTSD symptoms. The service dogs were not a cure for the disorder, but they helped make the symptoms more manageable on a daily basis. The service dogs were also associated with broader improvements in quality of life. For example, veterans with service dogs who were employed missed work less often and reported less anxiety, depression, and greater satisfaction with their lives and social relationships. On a biological level, we also studied the stress hormone cortisol and found that veterans with service dogs had a cortisol level closer to that of healthy adults without PTSD. The evidence suggests that service dogs should not replace other services, but instead that they can provide a valuable addition to current evidence-based care.

There is an extensive application and screening process to ensure that a service dog pairing would be feasible and appropriate for both the veteran and the dog. It is important for veterans to be willing and open to bringing a new partner into their lives, including dog care, maintenance, and ongoing training. If you are interested in this program and are a post 9/11 veteran, fill out an application with K9s For Warriors to be considered for their program: https://www.k9sforwarriors.org/warrior-application-survey.


Student Mass Shooter Characteristics

Students who were making plans to attack schools showed the same types of troubled histories as those who carried them out. They were badly bullied, often suffered from depression with stress at home and exhibited behavior that worried others, according to a U.S. Secret Service study released in March that examined 67 thwarted school plots nationwide. (those warning signs are also found in many of the adults who commit mass shootings). The largest number of thwarted plots, 11, came in 2017. Many of the attacks were planned for April, when the Columbine shootings occurred. Most of the schools targeted were public high schools, and they were located in 33 states, with 37% in suburban areas, and 14% in cities. The plotters were overwhelmingly male; five were female. The youngest was 11, the oldest 19. Most were motivated by grievances against them, usually peers and bullying. Many were suicidal or had depression. Eight had a desire for fame or notoriety. More than half had been impacted by adverse childhood experiences like substance abuse at home or parental mental health issues, and many had intended to kill themselves as part of the attack and used drugs and alcohol.

In 75% of the attacks the plotters had access to weapons, mostly from inside their own homes, and more than half had already acquired weapons. Some had homemade explosives. More than half documented their plans through a to-do list or some kind of written justification for their actions. Many of the students showed interest in violence or
hate. One-third conducted research into previous school shootings. Nine plotters displayed an interest in Adolf Hitler, Nazism or white supremacy.

The findings most importantly demonstrate there are almost always intervention points available before a student resorts to violence. About 94% talked about their attacks and what they intended to do in some way, whether orally or electronically, and 75% were detected because the plotters talked about them. In these cases, they were arrested and faced criminal charges. But the point of the study was not to identify someone to arrest but to identify early warning signs, so that students do not end up arrested. Targeted violence is preventable if communities can identify warning signs and intervene—The earlier the better. The intention is not to introduce students to the criminal justice system, but to provide a student with help as early as possible.

The goal of the study is to take the information and use it so that schools can be better equipped to deal with the warning signs — and that doesn’t mean expelling students found to be troubled. The study found expelling students doesn’t eliminate the risk. Instead, the key is to address bullying, provide mental health support and assess the impact of stressors in the home.


Cats and Schizophrenia

We have previously reported on a possible link between cat feces and schizophrenia. Now new research is the latest to find evidence of a link between mental illness and infections caused by a group of bacteria commonly found in cats and other animals. The small study found that people with diagnosed schizophrenia and schizoaffective disorder were more likely to carry Bartonella bacteria in their bloodstream than a control group of patients. In 11 of the 17 people with schizophrenia or schizoaffective disorder, traces of Bartonella DNA could be found, while the same was only true for one of the 13 control patients. More research is needed to definitively show whether these infections can indeed contribute to mental illness, however.

Last year the research found that other people with similar neuropsychiatric symptoms to schizophrenia and schizoaffective disorder often carried these bacteria, along with physical symptoms of an ongoing infection that appeared around the same time, such as distinct skin lesions. Though cats, dogs, and even the fleas they carry can possibly be vectors for Bartonella transmission, the team didn't find any link between a higher chance of infection and reported pet ownership or flea exposure.
SMI and SA

At any given moment, an estimated one in four people with a serious mental illness also have a co-occurring substance use disorder according to SAMHSA. Co-occurring serious mental illness and substance use disorders are extremely common and make this population particularly vulnerable to negative consequences like more severe mental illness symptoms, increased risk of involvement with the criminal justice system and homelessness, and increased barriers to receiving adequate treatment for both of their illnesses.

(No offense to SAMHSA, but surveys can be misleading as you totally depend on a self-report. Most of us dealing with the SMI population on a daily basis would probably indicate the rate of co-occurring severe mental illness and substance abuse as higher, particularly among those most ill and non-compliant with treatment. According to an analysis of prevalence rates of co-occurring disorders in the United States over time (also conducted by SAMHSA!), there was a 73% increase in the prevalence of co-occurring disorders between 2009 and 2019, despite a total population increase of just 6% over the same period. Ed.)

This finding is significant. A 2018 study published in the International Journal of Law and Psychiatry found that people with a co-occurring disorder are seven times more likely to be arrested for a crime compared to those with neither illness and 16 times more likely to be arrested for a violent crime. This study mirrors findings of many others, all of which point to the overrepresentation of people with dual diagnoses at every stage in the criminal justice system. Yet only 12.7% of people with a co-occurring disorder received any treatment for both their serious mental illness and substance use disorder in 2019. This figure includes people who received any amount of treatment and does not account for the quality or duration of said treatment. This is alarming because it means that even fewer than 12.7% of people likely received quality, continuous treatment for their co-occurring disorders.


Substance Abuse and Mental Health Services Administration. (2019). National Survey on Drug Use and Health (Table 8.11A).


Substance Abuse and Mental Health Services Administration. (2019). National Survey on Drug Use and Health (Table 8.22B).


NIMH Fails!
The National Institute of Mental Health (NIMH) was established by Congress in 1948 to conduct and fund research for the prevention, diagnosis and treatment of psychiatric illness. Seventy years later, only 10% of its research projects are rated as having the possibility to produce meaningful impact on the quality of life of individuals with schizophrenia in the next 20 years.

That doesn’t mean NIMH is not doing research on schizophrenia—in fact, they funded 428 schizophrenia-related research projects in 2018. But only 10% of NIMH’s schizophrenia research projects have any possibility of helping people who currently have the disease. The rest is basic research that may, or may not, have benefits at some distant future date. NIMH is publicly funded and was created to develop better treatments for mentally ill people now, not just in some distant future time. Some basic research is needed, of course—but 90% to 10% is unacceptable.

Between 2016 and 2019, NIMH (National Institute of Mental Health) decreased research projects on bipolar disorder by 25% and projects on schizophrenia by 17.5%. Between 2003 and 2019, NIMH decreased support for treatment trials on schizophrenia, bipolar disorder and major depressive disorder by a whopping 90%. The NIMH received more than 6,000 comments in response to its draft release of its 2020-2024 strategic plan. NIMH did not include a single addition to clinical research from the suggestions it received.

These appalling facts are consistent with former NIMH Director Dr. Thomas Insel’s previous admission that a mere 10% of NIMH research funds were dedicated to clinical research.

By comparison, in Europe, the United Kingdom, Australia and New Zealand, and Canada, basic research received 56% of the funds overall. This varied regionally from 46% in the UK; 49% in Australia and New Zealand; and 55% in Canada to 62% in Europe. Thus, the finding that NIMH is spending up to 90% of schizophrenia related funds on basic research is deficient by both national and international standards. Clinical research (treatment trials, management of treatment, and health services) received 27% of the funds overall. This varied regionally from 37% in Australia and New Zealand; 36% in the UK; and 33% in Canada 23% in Europe. NIMH outside of the national and international norms for this research also.

Where is the money going? Compared to Europe and the other three countries, the United States invests very heavily in research on substance abuse - 24% of its total mental health research funding. This is three times more than the average of the other four.

It is clear that the NIMH plans to continue to spend 90% or more of NIMH research funds on basic brain research which may, or may not, lead to improved treatments for mental illnesses in the distant future, ignoring the needs of those currently affected. The National Institute of Mental Health was established in 1948 to conduct research on neuropsychiatric disorders targeted to the most serious of psychiatric diseases including schizophrenia, bipolar disorder and depression. The research was expected to include both basic studies of brain function and clinical studies to help individuals currently affected by these disorders. NIMH is publicly supported with your tax dollars and has an obligation to help people currently affected by mental illness. Traditionally, NIMH has divided its research funds 50-50, half to help those currently affected and half for future research. NIMH needs to return to that balance.

In case you are wondering, this is not a partisan issue. Of the four key members of Congress overseeing the NIMH budget two are Democrats and two are Republicans, and the changes occurred under both Democrat and Republican administrations.

Torrey, E.F. et. al. (2020) Using the NIH Research, Condition and Disease Categorization Database for research advocacy: Schizophrenia research at NIMH as an example. PLOS One, November 19, 2020.
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0241062

Torrey, E.F. & Hancq, E.S. (2020). New study shows that NIMH clinical research on serious mental illness is deficient by both national and international standards. Treatment Advocacy Center, December 18, 2020.
COVID & Mental Health:

We are all tired of COVID. Tired of hearing about it. Tired of adjusting to it. Tired of following needed health protocols. Just plain tired. But it isn’t over by a long shot. Particularly this is true when dealing the mental health fallout. Here is why.

If only nine family members (a small number) are left behind to grieve each of the nation’s 608,000+ COVID-19 deaths, nearly 9 million Americans are grappling with loss on an unprecedented scale of mass bereavement. But unlike past disasters in which communities could come together to heal, this one has kept them six feet apart. People are not just grieving death, but the loss of work, school, and life as they knew it pre-pandemic. "If you think of that bereavement as grief, that’s not necessarily mental illness ... that’s just pain, emotional pain, that needs to be validated and normalized and expressed out loud," said Jessica Gold, MD, of Washington University in St. Louis. "Until we really do that, I think we’re kind of stalled in healing."

Americans were already sick. With mental healthcare inaccessible to many Americans and a 35% increase in annual suicide rates from 1999 to 2018 according to the CDC, an epidemic was already festering. Cigna’s 2018 study on loneliness determined that most Americans are lonely, and loneliness has increased with each subsequent generation. From March to June 2019, among adults ages 50-80, 41% reported a lack of companionship, 56% felt socially isolated, and 46% had infrequent social contact -- a significant increase since 2018. In 2018, suicide was the 10th leading cause of death overall in the U.S. and the second leading cause of death among 10-34-year-olds and fourth among 35-54-year-olds. The annual suicide rate, over time, increased by 35% from 1999 to 2018. In 2019, a reported 12 million adults seriously considered suicide; 3.5 million made plans to kill themselves, and 1.4 million adults attempted suicide. Reports have indicated that the number of individuals who have seriously considered suicide has risen since 2019. Before the pandemic, 15-19% of adults had anxiety or depression symptoms. By June of last year, that number had jumped to 31%, and nearly 11% reported seriously considering suicide, according to CDC survey data. Despite the vast majority of mental health clinicians transitioning to telehealth services during the pandemic and loosened federal guidelines that allowed virtual services to be reimbursed and controlled substances to be prescribed online., it wasn’t enough to ward off the pandemic’s mental health repercussions.

In a CDC survey, 13% of the population reported using substances to cope with the pandemic’s stressors. Alcohol consumption, specifically, increased by 14% in 2020 compared with the year prior in a RAND survey. The Substance Abuse and Mental Health Services Administration loosened regulations on prescribing medication-assisted treatment to include telemedicine providers. Although that prevented the disruption of treatment for many, an analysis published in JAMA found that fewer patients with opioid use disorder initiated treatment during the pandemic and fewer overall patients received urine tests, which are critical in preventing many patients from relapsing.
Nearly all states have anecdotally reported increased overdose deaths, and coroners and medical examiners are reporting a spike in suicides. In Maryland, one analysis found that suicides among Black Americans had doubled over the time of the pandemic. This is very frightening considering the Black community historically had a lower suicide rate than other groups. Certain populations disproportionately shoulder the burden of COVID-19 deaths and bereavement. Black and Latinx individuals, along with Native Americans, have been disproportionately killed by COVID-19. Thus we can anticipate increased mental health issues in these populations.

The mental health system was already strained pre-pandemic. In one 2017 report from the National Council for Behavioral Health, the demand for mental health services was projected to outstrip the system by 6,090 to 15,600 psychiatrists by 2025. Therapists were already working extra hours, trying to find time to add more people into their schedule before the pandemic. How is the system going to handle the increased demand???

Maybe it won’t be so bad. To everyone’s surprise, deaths from suicide either stayed the same or dropped in 21 high- and upper-middle-income countries, including a handful of American states, in the first few months of the COVID-19. In fact, in 12 countries or areas, there was statistical evidence of a decrease from what was expected based on pre-pandemic years. There were some limitations to the study. Suicide rates in low-income or lower-middle-income countries could not be captured. These account for 46% of the world’s suicides and might have been hit particularly hard by the pandemic.

https://www.medpagetoday.com/psychiatry/generalpsychiatry/90485?xid=nlp_SRPsychiatry_2021-01-08&en=g826113d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=PsychUpdate_010821&utm_term=NL_Specific_Psychiatry_Update_Active

https://www.medpagetoday.com/psychiatry/generalpsychiatry/90503?xid=nlp_SRPsychiatry_2021-01-08&en=g826113d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=PsychUpdate_010821&utm_term=NL_Specific_Psychiatry_Update_Active

https://www.medpagetoday.com/publichealthpolicy/publichealth/92072?xid=nlp_SRPsychiatry_2021-04-16&en=g826113d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=PsychUpdate_041621&utm_term=NL_Specific_Psychiatry_Update_Active

**Autism, Substance Abuse, and Prevention**

Substance abuse problems were more prevalent among those with autism spectrum disorder (ASD) than among sex- and age-matched controls, according to a Taiwanese study. The risk was driven mainly by a three-fold increased risk for drug use disorder, followed by a two-fold higher risk for alcohol use disorder. In addition, those with autism and co-morbid substance use disorder had a more than three-fold higher risk of death.

People who were taking psychotropic agents for the treatment of their autism had a reduced risk of developing substance use disorders (SUD). Those receiving one agent saw a 40% reduced risk for SUD, while those taking multiple agents had a 63% reduced risk. While several psychiatric comorbidities were more prevalent among individuals with ASD, including intellectual disability, attention deficit hyperactivity disorder, tic disorder, epilepsy,
obessive-compulsive disorder, mood disorder, anxiety disorder, and impulse control disorder, people with autism still had a higher risk of having SUD compared with matched controls with the same comorbidities. So, the presence of more than one diagnosis does not explain the findings; they are unique to the autism.

Future research is needed to see if there is a similar risk reduction with non-pharmacotherapies for autism such as behavioral therapy, family therapy, or psychotherapy.


ECT: The Good, The Bad, The Stigma

Electroconvulsive Therapy (ECT) has been used since 1938. We have decades of data on its use and effects. Yet it remains controversial. Stigma is an important part of this controversy. ECT can still sound frightening and conjure up images out of a horror movie. Patients contend with negative opinions and perceptions from the general public, acquaintances, friends and even health care professionals, whether they be pharmacists, physicians in other specialties, or indeed, even psychiatrists. (Indeed, in the 70’s Thomas Eagleton was forced to withdraw from the race for Vice President when the press revealed he had received ECT treatments. Ed.)

No treatment in medicine is completely appropriate for all individuals. The trick is to find the right treatment for the right person at the right time. It is a mistake to generalize experiences of one person to others. It may be that some peoples benefit more from ECT than others. In addition to ECT we have similar situations with transcranial magnetic stimulation, vagal nerve stimulation, deep brain stimulation, and intravenous ketamine. Will these face the same stigma?

(ECT is generally considered safe and effective for treatment resistant and/or severe depression. It is NOT as Hollywood presents it! Use for other disorders is more controversial. The primary negative associated with its use is memory loss for what occurred 1-3 days prior to the treatment. Editor.)


Benzodiazepine Use in Geriatrics

Benzodiazepines (also called anti-anxiety drugs) are things like Librium, Valium, and Xanax among many others. They are commonly used to treat various disorders including anxiety, insomnia, agitation, alcohol withdrawal, and seizures. The prevalence of benzodiazepine use among older adults in the United States is approximately 8.7%; meaning more than 1 out of 12 older adults is taking one of these. This is not appropriate. It has been found that approximately 44% of the prescriptions for benzodiazepine among older adults are potentially inappropriate. The 2019 American Geriatrics Society Beers Criteria identifies benzodiazepines as potentially inappropriate medications
for use among older adults. Factors associated with long-term use of benzodiazepines include the following: female sex, a diagnosis of Alzheimer disease (AD), schizophrenia, bipolar disorder, depression, coronary artery disease, and asthma/chronic obstructive pulmonary disease. None of these conditions justify the use of these drugs. In addition, benzodiazepine use was associated with greater risk for hospitalizations, emergency department visits, outpatient visits, and higher health care costs. The overdose death rate increased due to benzodiazepine use from 0.58 to 3.07 per 100,000 adults between 1996 and 2013. Benzodiazepine’s use is also associated with an increased risk of falls among older adults. Additionally, the use of benzodiazepines is associated with a 60% to 80% increase in the risk of traffic accidents. If you mix them with alcohol there is a 7.7-fold increased risk for traffic accidents.

Now, there is also emerging evidence that the use of benzodiazepines may increase the risk for developing dementia among older adults. Perhaps you have heard this in the news. And actually, this is a good case study of how you must be careful in interpreting research.

Of the 15 studies done on this relationship, 8 showed a positive association between benzodiazepine use and the development of dementia. That is only slightly over half. Four studies found benzodiazepines were not associated with the development of dementia. Two studies showed mixed results. One study found that previously using benzodiazepines was associated with the development of dementia, but current use was not. The other study found that short-term use of benzodiazepines was associated with the development of dementia, but long-term use was not (which makes no sense whatsoever). The final study found that the use of benzodiazepines had a protective effect against the development of dementia!

In other words, we still do not know about these drugs and dementia. But we DO know they are not wise to use in the geriatric population for many other reasons.


**FAMILY SUPPORT WANTED**

We here at NAMI know that families provide important support to individuals living with severe mental illness. Not only do families play a vital role in recognizing early signs and symptoms but research indicates that higher levels of family support can improve outcomes for individuals with schizophrenia and bipolar disorder.

A recent study found that the ill individual prefers this also. The majority of individuals enrolled in an early psychosis care program preferred to have their families involved in their treatment. At enrollment, 59% of individuals requested that their family be involved in their treatment, 35% requested that their family be involved on some conditions. Only 6% requested no family involvement. People who preferred no family involvement were more likely to be older, experience homelessness or live alone. A higher proportion of early discharges from the program were of individuals who requested no family involvement. Family members of Black participants, those who were uninsured or those receiving public insurance had lower family contact rates as well as. The results suggest that there are potential racial and socioeconomic inequities in the capacity of families to be involved in service.
WHY WE MAKE POOR DECISIONS
(And what to do about it)

Why don't we keep our doctor appointments?

Why do we skip doses of our meds?

Why don't we do better for ourselves?

Some reports show rates of "non-adherence" to preventive regimens—things that would improve our health—to be over 80%. Why, despite knowing what is needed for better health, do most of us have such a hard time following through? And when we don't either we are blamed by our healthcare provider or we blame ourselves. Is blame the best we can do when things go wrong?

Let's look for a moment at economics. Until relatively recently, economic models focused on rational choice theory—that is, human behavior is the result of rational decision-making that weighs the pros and cons of a given choice before making a selection. In the second half of the twentieth century, psychologists and economists started to challenge this framework, arguing that psychological, cognitive, emotional, and environmental factors, among others, significantly influenced the way real humans make choices. This alternative perspective became known as behavioral economics, and proposes that the rationality of humans is bounded. Human decisions can be biased or otherwise influenced by mental shortcuts, cognitive biases, and environmental cues. As a result, humans display consistent errors in "rational" conscious thinking.

So we do not do the rational thing and take care of ourselves. In fact, we are creatures of habit—actions that are automatic, and not subject to the higher-level reflective thinking we think of as rational. Research from research psychologist Wendy Wood and her colleagues has demonstrated that around 40% of our daily actions can be classified as habit-driven. This finding was a major hit for the idea of the conscious decision-maker as the only determinant in our outcomes.

Research in the fields of immunology, endocrinology, and neuroscience has convincingly demonstrated that our choices are biological. For example, levels of the hormone ghrelin correlate with appetite, and giving ghrelin to humans significantly increases food intake. Changes in estrogen levels during the menstrual cycle predict impulsive thinking, and testosterone and cortisol are thought to affect financial decisions in men. The state of our immune function has also been found to affect our thoughts and actions. Higher levels of inflammation, for example, are associated with more present-focused thinking as opposed to future-orientation, and induction of inflammation in volunteers predicts more impulsive thinking. Clearly this is not rational!

It isn't just hormones, either. Decision-making patterns can also be linked to patterns of brain activation and structure. In imaging studies, the quality of our decisions reflects activation and interactions between parts of the brain including the prefrontal cortex and the basal ganglia, and when researchers activate the lateral prefrontal cortex
using magnetic stimulation, impulsive thinking decreases. This research makes it readily apparent that the quality of our decisions reflects the state of our brains.

Reconceptualizing choices as an outgrowth of our biological systems invites empathy and curiosity in place of blame. Biological variables like hormones, immune markers, and activation states of the brain help us understand why we do what we do, instead of simply chalk ing poor decisions up to an unhelpful character trait or personal defects like “lack of willpower”.

How can we improve our decision making?

1) Connect with nature. One study showed that compared to photos of buildings, even short exposures to nature photographs could help decrease impulsive thinking.

2) Get enough sleep. Getting restful sleep may help us to make healthier food choices, while poor sleep may predispose us to eating more food, especially foods that lead to weight gain.

3) Exercise may strengthen executive functions, the brain functions needed for good decision-making.

4) Meditation and mindfulness similarly may affect the parts of the brain most implicated in healthy choices and enhance executive functions.

5) Consumption of more fruits and vegetables correlated with improved executive functions.

The blame-based model just perpetuates poor choices by increasing stress. It's not working in healthcare or in the general public. It's high time we take a deeper look at the biological substrate that underlies our thinking and move away from snap judgments based on limited and faulty data.

And quit playing the blame game.


SOCIAL MEDIA PRECAUTIONS

Anyone who has spent any time on Facebook, Twitter and other social media platforms has probably gotten into a conversation with a total stranger which turned cruel and nasty. Online anger like this is summoned only when the other person has been depersonalized -- just a face dissociated from a person. More an object than a human being. For some, this growing hostility drives them away. Every time they said anything, they felt mobbed by a sea of increasingly angry voices. They didn't need the stress.

In the best of times, social media is a double-edged sword. It is a great way to get a message to many people, but it is de-personal, and driven by the economy of attention. Anger, disgust, and outrage are the emotions that engage and addict the users. People, good people, can become disinhibited and say things they don't truly mean, or would never say in real life. Of course, this is during the best of times. We most definitely are not in the best of times. People have been cut off from friends, family, and co-workers, and many are still living in isolation. In fact, this has
been the loneliest period in human history. The largest number of people in history (billions) have deprived
themselves of, at least some, social interactions. Mental health is suffering, and when we are tired and angry we are
not our best selves, and paired with the algorithms of social media, it is a recipe for disaster.

The anger gets out of control when we invent motivations for others. Folks who share our point of view are always
good people who want to save lives, and folks who disagree with us are people indifferent to human beings.
Despicable, even. But, if one steps back, how can that possibly be? Surely people on all sides of an issue --
whether that be school reopening or best vaccination practices or politics -- have varied reasons for holding their
view. A tiny fraction may have some ulterior motive, but surely the vast majority hold their view for the same reason
folks who disagree hold their view -- an alternative interpretation of facts and values.

How can you help yourself--and others--cope with this?

1. **Get offline.** Each of us has to decide if social media serves our purposes and makes us better informed or
happier, but probably all of us should use it less. Read it less, and post less.

2. **Mute all notifications.** Say what you have to say, and let it go. No need to reply to anyone, and the easiest way
is to set the accounts to never disturb you again.

3. **Don't reply to others.** If you read a point of view you disagree with, what value is there in replying to the other
person? Just state your point of view in your terms on your feed. No need to pick a fight. Just make your point on
your terms.

4. **If you are having a hard time at home or work, don't use social media.** It is hard enough to manage when you
wake up in a good mood, but when you are feeling tired, scared, afraid or sick, it is too much. If you love someone,
and they are hurting, suggest they do the same.

5. **Meet or call someone every day.** Social media thrives from our loneliness -- it's a cheap way to feel less lonely in
the loneliest period of human history. But it is a poor way to connect. Call someone. And if you are vaccinated, visit
someone. Interact more in real life.

6. **Tell someone you don't know you appreciate their thoughts.** Perhaps the best thing we can do to combat
negative emotions is to give some positive feedback to folks we appreciate.


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**Genes and Depression, Anxiety**

Children as young as 9 years old have an increased risk of major depressive disorder and other psychopathologies if
one or more generations in their family were also affected.

A recent study found the prevalence of depressive disorder in children ages 9 to 11 years was 3.8% for those with no
family history of depression, 5.5% for children who had a depressed grandparent but no depressed parent, and
10.4% for those who only had an affected parent. The prevalence jumped to 13.3% for children who came from two
prior affected generations. In other words, the more relatives with depression and the closer the relationship, the
more likely is the child to develop depression. Furthermore, his trend was similar for a range of other psychiatric
disorders, including all anxiety-related disorders. The prevalence of depressive disorders among children remained relatively similar across race, ethnicity, sex, and socioeconomic status.

This study underlines just how profound family history is as a risk factor for depression. The important message is that depression begins early, has an effect on all life functions, and treatment and intervention need to come as early as possible, before it becomes chronic or recurrent.