MAY 2020

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FRESH START

NAMI Cobb Meeting News
NO In Person Meetings this month.

NAMI Cobb Virtual Support Groups are up and running

If you go to our website NAMICobb.org the second listing on the left side navigation column is "NAMI Cobb Virtual Support Groups" See Page 4

For security purposes the password changes each week so make sure you contact a facilitator for the updated password.

Check our website NAMICobb.org for further updates.

Don’t forget to check out NAMI Cobb on Facebook

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May President’s Letter

May is Mental Health month. This is always a busy month for NAMI Cobb and I want to make sure that you are aware of the many things happening this month virtually. We have started virtual support groups, and they will continue in May. If you go to our website NAMICobb.org the second listing on the left side navigation column is "NAMI Cobb Virtual Support Groups" click on it, and it will show you the times and contacts for joining our two weekly support groups. One group is for those with a mental health condition, and the other is for their families and friends. Please visit our website, NAMICobb.org for additional information.

The Corona Virus (COVID-19) remains the topic of the day, and information and resources are available on the subject at NAMI.org. In addition to the 21-page COVID-19 Information and Resource Guide there is a video of Dr. Ken Duckworth, Medical Director, NAMI. He makes some good points:

* Isolating is bad for people. We are social beings. You need to stay connected to people. He prefers the term physical distancing to social distancing. You need to stay in touch with people, take advantage of technology, both the telephone and the internet.
* Dr. Duckworth also reminds us that we are practicing physical distancing for the social good it is an act of collective service and altruism.

NAMI GA has started Weekly Educational Webinars. They are on Thursdays from 12-1 pm. You can join at the following link: https://zoom.us/j/462368458. This newsletter contains a listing of the topics for each webinar in May. The newsletter also contains information on the NAMI Georgia annual meeting which will be held virtually on Saturday May 16, 2020, at 2 pm.

Stay safe and keep connected.

Best regards,

Peter
JOIN US FOR the 2020 VIRTUAL ANNUAL MEETING!

Saturday, May 16, 2020 ● 2:00 PM

Join Online or By Phone
JOIN BY PHONE: Dial (929) 205-6099 and enter Meeting ID: 949 4035 8442
RSVP: Email projects@namiga.org with questions

Crisis Resources Available to You

FREE, confidential, and available to anyone who has questions about addiction and recovery or just needs to talk with someone who is also in recovery from Substance Use Disorders. Call or text 844-326-5400 from 8:30 AM - 11:00 PM, seven days per week.

A free 24/7 hotline providing mental health crisis assistance and access to mental health resources throughout the state of Georgia. 1-800-715-4225 or mygcat.com.

For emergencies in which law enforcement may be called, ask for a Crisis Intervention Team (CIT) officer. Dial 9-1-1

Reach a trained counselor by text message. Youth and teens especially welcome. Text ‘GA’ to 741-741.

Suicide Prevention Lifeline. 1-800-273-TALK or 1-800-SUICIDE
NAMI Cobb Virtual Support Groups

Although our in-person Family and Connection Support Groups are cancelled at this time, some of our support groups are meeting virtually using the Zoom platform. Get in touch with the contact listed below to find out how to connect to a virtual meeting.

Our online support groups are only open to adults living in recovery with a mental health condition (Connection Support Group) or those who are supporting a loved one with a mental health condition (Family Support Group).

For security purposes the password changes each week so make sure you contact a facilitator for the updated password.

Connection Peer Support Group

Connection Recovery Support Group is a support group for adult individuals (18+yrs) living with a mental health condition. Peers share positives and negatives led by trained facilitators who also live with a mental health condition.

Virtual meetings every Mondays from 7:45-9:15 p.m. Contact facilitator for specifics.

Text or email Paul Miner at pminer@bellsouth.net, 678-560-3058.

Family Support Group

The Family Support Group is a support group for family members, caregivers and loved ones of someone living with the everyday challenges of a mental illness. Led by trained facilitators who also have a family member with a mental health condition, families find support and learn from each other through sharing experiences.

Virtual meetings every Mondays from 6:00 -7:30 p.m. Contact facilitator for specifics.

Text or email either Jan Hemmings at janhemmings@earthlink.net, 770-354-6565. J Williams at jwilliams007@comcast.net, 404-218-1373

NAMI Support Groups help participants:

- Aim for better coping skills
- Find strength in sharing experiences
- Not judge anyone's pain
- Forgive ourselves and reject guilt
- Embrace humor as healthy
- Accept that we cannot solve every problem
- Understand that mental health conditions are no one's fault and can be traumatic Experiences

Our Group Guidelines include confidentiality, respectful dialog and empathy. Meetings begin with a review of the NAMI guidelines. Before participating in a virtual support group, each prospective participant should review and accept the security of the Zoom third-party video conferencing platform.

For tips and guidelines to using Zoom go to: https://support.zoom.us/hc/en-us/articles/206175806-Frequently-Asked-Questions
Nami Georgia COVID-19 Updates

The coronavirus outbreak and uncertainty of the future can be challenging to process emotionally. The resources below offer information on the situation and tips on dealing with mental health. If you or someone you care about feels overwhelmed with sadness, depression or anxiety, or thoughts of suicide or self-harm, call 911.

You can also contact the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Disaster Distress Helpline at 800-985-5990, the National Suicide Prevention Lifeline at 800-273-8255, or text the Crisis Text Line at 741741 to talk to a free counselor.

NAMI Georgia Program Closures Policy During COVID-19 Outbreak

- **Classes**
  All NAMI Georgia Affiliate Family to Family, Peer to Peer, Youth In Crisis, Basics, Family & Friends Seminars, other classes, and presentations are cancelled through May at this time.

- **Support Groups**
  All in-person NAMI support group meetings are cancelled at this time. Some groups are meeting virtually. Others may be added to the schedule in the future.
    - NAMI Georgia Affiliate Support Groups That Are Meeting Virtually by Video, Sound, or Chat

- **Teacher, Mentor, Facilitator and Presentation Trainings**
  Most NAMI Teacher, Mentor, and Facilitator training sessions are cancelled at this time. At this time, there is only one training scheduled to meet virtually. Others may be re-added if remote access can be arranged.
    - NAMI Program Leader Trainings Meeting Virtually

Coronavirus News And Information

Information from NAMI about COVID-19

CDC COVID-19 Situation Status and Information page

World Health Organization Update on Coronavirus (COVID-19) Disease

National Council for Behavioral Health: Resources and Tools for COVID-19

Thursday Seminars

Join NAMI Georgia and partners on Thursdays to discuss Mental Health and Wellbeing During COVID-19. See Webinar Schedule and How to Join

Resources For Healthcare Providers

Clinical Considerations for Giving LAIs during the COVID-19 Health Emergency

Mental Health Resources

NAMI Georgia’s HelpLine, (770) 408-0625, is a non-crisis line providing information about resources for persons with mental illnesses and their family members in Georgia. For more information click here.

Georgia Patient Resources

4 Self-Care Tips for How to Deal with Anxiety

How to Care for Yourself While Practicing Physical Distancing

How Do I Know Someone is Experiencing Anxiety or Depression?

How to Support a Loved One Going Through a Tough Time During COVID-19

How to Ease Childrens’ Anxiety About COVID-19
Schizophrenia and the Paradoxes of Insight

Why do patients with schizophrenia often deny they are ill?

Clara Humpston Ph.D.  Hallucinating the Self

When we think of the symptoms of schizophrenia, perhaps the first examples that emerge in our minds are the chaotic thoughts, disturbing suspicions and invisible voices tormenting the sufferer. These are indeed the most striking manifestations of acute psychosis – delusions, hallucinations and thought disorder – but as I wrote a few months ago, these symptoms are not exclusive to schizophrenia and can even occur (albeit often in milder forms) in healthy people.

Contrary to popular belief, these positive symptoms (positive as in "additions" to normal experiences) are not actually the most common occurrences in a schizophrenic disorder. The most frequent symptom is, in fact, a lack of awareness into the unreality of their own psychosis: in medical terms, a "lack of insight" is thought to occur in 97% of patients compared with 74% for auditory hallucinations and 70% for ideas of reference.

Explanations for this lack of insight range from ego-defence mechanisms to abnormalities in the cortical midline structures (a group of brain regions considered key in differentiating self and other); either way, it is widely accepted that lack of insight contributes significantly to treatment non-adherence and sometimes eventual relapse, simply because many patients do not believe their experiences are not real and are symptoms of mental illness.

From the patients’ perspective, these symptoms create their own reality even though such a reality is often extremely frightening and unwelcomed. It is also indisputable, however, that these symptoms have no factual bases in external reality. Hence a permanent paradox is evident: which of these two realities is to be adopted by the patient?

A mind afflicted with schizophrenia is constantly bombarded by internal mental events disguised as external stimuli, which manifest as conflicting realities. To me, nothing challenges our so-called normal sense of self and reality more than schizophrenia does. Is reality nothing but a representation of our senses and beliefs? If so, who are we to decide that patients with schizophrenia have suffered a break from reality? This, of course, is a very philosophical question, with neuroscientific and social roots.

Moreover, a schizophrenic reality does not even have to be "adopted" – it can enter one’s awareness and take hold as if it was the only position from where one experiences the world. Imbued with significance, salience, and meaning, the patient is simply unable to take on another perspective. A delusional elaboration "fits well" with the structure of their consciousness and feels right. Here, another paradox is apparent: to adopt a "false" reality implies a volitional act, but in order to do so, one has to give up the same volition.

To have an integrated understanding of the world, one must first possess an undisrupted core of awareness. Symptoms of schizophrenia are very effective in destroying this very basic sense of self, upon which one constructs identities and personal narratives. Without this minimal layer of self, it should not be surprising that one will become unable to tell apart the multitude of internal and external worlds. This is why I view schizophrenia fundamentally as a disorder of the self.

Given that the disturbance lies in the most basic level of the self, the paradoxes schizophrenia creates have the ability to carry on without solutions. Even insight itself is intrinsically just another
unsolvable paradox: the desperate efforts to keep one’s "sanity" intact pushes one deeper into the abyss of simply being aware

Indeed, if one was completely unaware, one would not experience any pain or suffering either. In other words, patients with schizophrenia suffer immensely not always because they are unaware of external or everyday reality, but because they are too aware of another kind of reality – namely the reality created by their own minds.

If there is anything of which the patient with schizophrenia is truly unaware, it will be their own self and not the factual, "rational" reality. It may be controversial, but to say that lacking insight is a sign of losing touch with reality is like saying a colour-blind person is unable to see anything at all. Schizophrenia is like colour-blindness in this way; it taints and distorts everything one sees but does not cause one to lose eyesight altogether.

Here is a scary thought: would the world truly become black-and-white if absolutely everyone became colour-blind simultaneously? Many might think the answer is no, because surely people would still remember seeing colours. But one could also argue that remembering is a mental event, therefore a ‘reality’ residing in our minds. How is this different from a schizophrenic reality?

Schizophrenia is defined as an illness because it leads to severe distress, functional decline and disability. Even though the causes of such suffering may well be neural or physical, their consequences cannot be easily disregarded as "unreality" or "lack of insight." Insight, after all, is only determined by another agent’s observation and judgment, who has their own interpretation of the world around them.

Perhaps the discrepancy in all the different realities is one of degree rather than of nature, and one only crosses the line of "normality" if one deviates too much from the consensus. But this should not make one "ill" if there is no distress or impairment to functioning. What is normality without the other end of the spectrum? The paradox of reality is one we all struggle with, and not just one faced by patients with schizophrenia.

This post first appeared on the Cardiff University Mental Health Blog.
How to Help Someone With Bipolar Disorder

Being empathetic and encouraging is key when someone in your life is diagnosed with a mental illness.
By Marisa Cohen

Nearly one in 25 American adults has serious mental illness, which means odds are someone in your life is coping with anxiety, depression, OCD, bipolar disorder or another debilitating condition. Still, shame about mental illness — likely a holdover from when people wrongly believed such conditions were character flaws or a mother’s fault — can make it hard to seek help or even know what to say to those who struggle. To shine a light on the daily realities of mental illness, Good Housekeeping and the National Alliance on Mental Illness (NAMI) surveyed more than 4,000 people, and found that over a third had a close friend or relative with mental illness. In our special package on how to support loved ones with mental illness, women who live with these widely misunderstood psychological issues share what it feels like, and how you can make a difference.

People with bipolar disorder experience dramatic changes in emotion, mood and energy, sometimes all in the same day. “It’s like a roller coaster ride — I’m different day to day and hour to hour,” says Nicole, 30, of Denver, CO who was diagnosed with bipolar disorder six years ago. “I have periods when I’m very creative and outgoing — people describe me as being more attractive and alluring. I have a higher sex drive, and I do a lot of writing and artwork. But then I slip into a depressive state, and it feels like being in wet cement. I just want to curl up in the fetal position and sleep all day.”

Though the mania stage can seem exhilarating, all that energy may have negative consequences, says Mauricio Tohen, M.D., DrPH, chairman of psychiatry and behavioral sciences at the University of New Mexico Health Sciences Center. “There is a lot of impulsivity, which can lead to spending money you don’t have, taking risks like driving too fast and becoming sexually involved with strangers.”

30% of people surveyed said they or someone they know have symptoms of bipolar disorder.

For Clisver, 27, of Jackson, TN, manic episodes, before she stabilized on medication, were unpredictable and scary. “I didn’t know what each day was going to be like,” she says. “When I had manic episodes, I’d sometimes see and feel things that weren’t there. Once, when I was young, I went off my medication. I was crossing the street and heard the screeching sound of a car and thought I’d been hit. It was like an out-of-body experience — I didn’t know what was real and what wasn’t.”

The depressive phase, says Clisver, usually started out with feelings of distraction, leading her to procrastinate a lot. It then would take a darker turn: Clisver lost interest in things she loved, like hanging out with friends and family, and gave up even on looking nice. “I’d get to the point of feeling worthless, like there was no point in even getting out of bed each day,” she says.

The most dangerous phase of bipolar disorder is when patients have a mix of depression and impulsivity, Dr. Tohen adds, as that can often lead to thoughts or behaviors involving self-harm or even the desire to stop living. “In the past, I’ve thought about suicide,” says Nicole.

If you're thinking about suicide or are worried about a friend or loved one, call the National Suicide Prevention Lifeline at 1-800-273-8255.
Bipolar disorder affects about 6 million American adults, and it usually shows up in the late teens or early 20s. Medications, including the mood stabilizer lithium, can even out the highs and lows. “It’s not perfect and it doesn’t cure the condition, but it can improve the symptoms,” says Dr. Tohen. Antipsychotics, anticonvulsants, and antidepressants may also be prescribed; cognitive behavioral therapy has been found to be helpful in reducing the severity of symptoms. In cases that don’t respond to therapy or meds, electroconvulsive therapy (ECT) — electrical shocks that stimulate the brain while the patient is under anesthesia — can help some people find relief from symptoms.

Having a support system is extremely important, too. If a family member or loved one has been diagnosed with bipolar disorder, here’s how you can be an ally to them:

- **Encourage a healthy lifestyle:** Along with medication and therapy, keeping a regular sleep schedule, exercising, and forgoing alcohol and recreational drugs can help a person with bipolar disorder remain on an even keel. “Going for walks and getting sunlight — or using sunlamps during the winter — helped me when I was in a depressive state,” says Nicole, who adds that resisting junk food and eating plenty of fruits and vegetables also did her good.

- **Be flexible with plans:** When you’re scheduling something with a friend who is struggling, “give him the choice to participate or not,” says Katrina Gay of the National Alliance on Mental Illness. Understand that if he does come with you, he may have to leave early, and that it might be really hard for him to make any long-term commitments.

- **Don’t give unproven advice:** “Some people tell me to get off my medication and take cannabis,” says Clisver. “I’m not against other people using cannabis, but don’t tell me to go off my medication — it helps me.” Some say that anti-pharmaceutical sentiment can feel like judgment. For Nicole, the advice was “Just pray about it”: “I’ve had symptoms my whole life, and that’s what my parents would say. It didn’t help.”

- **Urge them to stay on their meds:** Drugs may have side effects, and during a manic episode, people may feel otherwise so good that they’re tempted to stop taking them. But staying the course is crucial, says Dr. Tohen. “When a patient asks me, ‘How long should I take this medicine?’ my answer is always ‘Until we find a cure,’ ” he says. “I hope that happens in our lifetime, but it hasn’t yet.”

The COVID-19 crisis has made life more challenging for everyone — especially those who are struggling with a mental illness. Visit NAMI’s COVID-19 Resource and Information Guide for additional advice. For additional information about Bipolar Disorder, visit the Depression and Bipolar Support Alliance.

Marisa Cohen
Marisa Cohen is a Contributing Editor in the Hearst Health Newsroom, who has covered health, nutrition, parenting, and the arts for dozens of magazines and web sites over the past two decades.

NAMI Georgia
Weekly Educational Webinars
May 2020

Equity in the Midst of COVID-19
May 7, 2020 from 12-1pm

Join us on May 7th as Dr. Dietra Hawkins from One Small Change, Inc. will host a live webinar on Equity in the Midst of COVID-19.

COVID-19 and the Recovery Community - The Inevitable Crisis and How We Respond
May 14, 2020 from 12-1pm

Expert Jeff Brodlof from the Georgia Council on Substance Abuse joins us on May 14th to host a live webinar on COVID-19 and the Recovery Community. He will discuss this inevitable crisis and how we respond.

Resilience in a Time of Unprecedented Change
May 21, 2020 from 12-1pm

Dr. Jeff Ashby from Georgia State University’s Center for Stress, Trauma, and Resilience joins us to host a live webinar on resilience in a time of unprecedented change.

Join at the following link:
https://zoom.us/j/462368458

Prevalent Mental Health Challenges in Georgia’s Youth
May 28, 2020 from 12-1pm

Angelique Hill from Behavioral Health Link (BHL) will explore prevalent mental health challenges in Georgia’s Youth.
It’s Not Alzheimer’s – It’s a New Form of Dementia

A definitive diagnosis of Alzheimer’s is hard to obtain before death because only then can brain cells be scrutinized closely under the microscope.

So in living patients, doctors have to rely on various tests. From the information gathered they believe the diagnosis will be accurate for nearly all patients.

But on April 30, that all changed.

On that day a paper was published in the neurology journal *Brain*. It describes a new form of dementia that can mimic Alzheimer’s. The scientists believe as many as one patient in every five has been misdiagnosed. They don’t have Alzheimer’s disease, they suffer with LATE.

Mainly Affects the Over 80s

Using new and costly brain scans, studies reveal about a third of patients with Alzheimer’s symptoms don’t have the hallmark buildup of amyloid plaques. In other words, they don’t have Alzheimer’s.

But if not, then what do they have?

A large international team of scientists think they’ve come up with the answer. These patients have limbic-predominant age-related TDP-43 encephalopathy. That’s quite a mouthful, so it’s shortened to LATE.

TDP-43 is a protein that’s already well known to scientists. It’s been linked to Lou Gehrig’s disease and a form of dementia called frontotemporal lobar degeneration.

Yet, as lead researcher Pete Nelson from the University of Kentucky puts it, LATE “is a disease that’s 100 times more common than either of those, and nobody knows about it.”

In people with LATE, the protein is misfolded in the hippocampus, a key memory and learning center in the brain. But while it mimics Alzheimer’s, it usually only occurs in people over the age of 80, and their decline into dementia is slower. Both forms can occur at the same time.

Dr. Nelson is very excited about these new findings, saying, “We’re really overhauling the concept of what dementia is.

“We recently performed an autopsy on an individual diagnosed during life with Alzheimer’s. It turned out he didn’t have Alzheimer’s at all – he had LATE instead.

“Now that the scientific community is on the same page about LATE, further research into the ‘how’ and ‘why’ can help us develop disease-specific drugs that target the right patients.”
He thinks a third of people over 85 could have this disorder, and it also might explain the failure of drug trials for Alzheimer’s. They targeted the wrong protein — amyloid — in many of the patients that took part.

**Positive Feedback**

An observer who wasn’t involved in the study, Robert Howard, Professor of Old Age Psychiatry at the University College London, could hardly contain his enthusiasm:

“This is probably the most important paper to be published in the field of dementia in the last five years.

“LATE has clearly been an under-recognized contributor to dementia, particularly in people over the age of 80, and the paper will draw the attention of the field to this massively.

“It’s not often that I have a new and potentially useful diagnosis to share with my patients and colleagues, but I am sure that I will be introducing LATE to several of them over the next few weeks.”

Dr. James Pickett, Head of Research at Alzheimer’s Society UK, commented, “Though at an early stage, this research is taking a real step forward by proposing a new sub-type of dementia. This type of research is the first step towards more precise diagnosis and personalized treatment for dementia.”

Sandra Weintraub, a professor of neurology at Northwestern University Feinberg School of Medicine in Chicago, added, “TDP-43 likes certain parts of the brain that the Alzheimer’s pathology is less enamored of.

“This is an area that’s going to be really huge in the future. What are the individual vulnerabilities that cause the proteins to go to particular regions of the brain? It’s not just what the protein abnormality is, but where it is.”

While the feedback has been positive, it’s still a first step, as Dr Pickett points out. Dementia is diverse in character. Symptoms of different forms overlap, and multiple processes may be at work.

As one medic lamented, LATE “isn’t yet something doctors will be able to diagnose in the clinic.”

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2. https://apnews.com/791c3ea82e1a40a59d603cfc109d1ad9

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What Is Trauma, and Can Mindfulness Help Treat It?

How do mindfulness and trauma relate? Here’s what you need to know.

Posted Sep 19, 2019

The word **trauma** comes from the Latin word meaning "wound." In medicine, professionals use the word "trauma" to refer to physical damage to body parts. By contrast, psychological or emotional trauma, loosely defined, also refers to another type of wound: any past event that creates significant hardship and impairment in the present, at least one month after it occurred.

Many equivocally think trauma is about what happened to the person when in reality, it’s more about how the mind and body **register** what happened. Let me clarify from early on, however, that healing is
very possible, doesn't need to take a lot of time (many trauma therapies such as EMDR therapy are short-term and highly effective), and doesn't mean what the perpetrator(s) did was okay.

Unfortunately, much of the lay public doesn't see it this way or understand how or why psychological trauma can have a lasting negative impact on someone. Trauma treatment is still younger than 40 years old. In fact, it wasn't officially recognized as a significant emotional difficulty until 1980!

This is why there has been a movement toward "trauma-informed care" in all mental health fields recently. All this means is a sensitivity and awareness of how what happened to someone in the past affects them in the present. The ground-breaking ACE (Adverse Child Experiences) study is an example of this: children who endure adverse events such as physical abuse and neglect had higher rates of virtually any health problem later in life. In this sense, the ultimate goal of trauma-focused psychotherapy is getting past your past. Trauma psychotherapy, especially EMDR therapy, can be thought of as emotional surgery.

Those who experience traumatic events often develop post-traumatic stress disorder (PTSD) symptoms, such as stress, anxiety, and depression, although many don't. The criteria for PTSD are primarily hyper-arousal (the mind and body stay in a crisis-like state of tension and exhaustion, ready for danger), hyper-vigilance (the body and mind are constantly scanning for any signs of danger, and unfortunately often reacting to false-positives), and intrusive thoughts about the traumatic event replaying ceaselessly and uncontrollably in one's mind.

These aftereffects can last for weeks, months, and even years. Trauma also can cause difficulty focusing, racing and intrusive thoughts, and flashbacks of the traumatic experiences. It can wreak havoc on sufferers' relationships and quality of life. It can also affect sleep patterns, the immune system, diet, and other physiological processes significantly.

Contemporary, more are affected by trauma than ever before (Herman, 2015). The literature demarcates two central umbrella categories regarding trauma: large "T" and small "t" events (Shapiro & Forest, 2016).

Large "T" traumas are indisputably distressing, often necessitating a PTSD diagnosis. Examples are war combat, physical abuse, automobile accidents, loss of a loved one, terminal illness, or natural disasters, all of which can result in PTSD for many.

By contrast, small "t" traumas are those less conspicuous, quotidian events in which we are left feeling unloved, unsafe, or helpless. Small "t" traumas comprise failures, humiliations, and losses of many types. Examples are being a victim of bullying, falling off a skateboard, experiencing infidelity in your relationship(s), or being chosen last on a sport's team. Small "t" events can appear on the surface to be of little importance, yet can have a significant, enduring impact.

There's a catch, however. In a recent interview, Dr. Peter Levine, a trauma expert and creator of the breakthrough trauma therapy called Somatic Experiencing, shared a finding from an intriguing study. After successful trauma treatment, when therapists asked clients if they prefer to have never had gone through the trauma, or have gone and worked through it, most clients stated preferring having the trauma and working through it, instead of it never happening.

While this does not apply to everyone who has experienced significant trauma, trauma can clearly be a powerful catalyst for growth, wisdom, strength, meaning, and purpose. In therapy, the traumatized client often advances through treatment by starting as a victim, then feeling like a survivor, and ultimately, toward the end of therapy, a thriver.
Trauma can also wake us up. One way of working with and through trauma is mindfulness meditation. That said, practicing mindfulness can be triggering for many trauma survivors. Mindfulness practices aren't likely to cause trauma, but can reveal it.

I'm an EMDR therapist, which can be considered a mindfulness-based therapy. Mindfulness practices and research also have a lot to offer trauma sufferers and survivors. The essence of trauma is not emotionally and psychologically situated in the here-and-now. In other words, trauma keeps you stuck in the past or constantly and helplessly fearing the future.

By practicing mindfulness, sufferers can shift the pendulum back to their presence in the here-and-now. Trauma and presence (or mindfulness) cannot coexist. Thus, mindfulness practices can help bring trauma victims back to the present and heal from disturbing past events.

Mindfulness practices can greatly decrease the frequency, intensity, and duration (what I refer to by the acronym "FID" when measuring treatment goals with clients) of these trauma symptoms. In doing EMDR therapy with clients, I have found it important to introduce mindfulness and stabilization skills (training the mind and body to rest in a calm, peaceful, and safe state mindfully in the here-and-now) from the beginning of treatment in order to mitigate these symptoms before proceeding with the emotional surgery of EMDR.

These stabilization skills can be helpful to clients between sessions, as the features of trauma can occur at any time. Mindfulness is central to these stabilization skills and to a successful outcome in EMDR therapy.

Dr. Jon Kabat-Zinn (1994) is largely responsible for bringing mindfulness to the Western world. He defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally.” In using mindfulness exercises with clients, I've noticed that their focus improves, stress and anxiety decrease, and personal insight increases, which can all help to reduce trauma-related symptoms.

A traumatized brain is perhaps the opposite of a mindful brain. Whereas trauma symptoms pull you into the past, mindfulness can help to bring you to the present moment, the only place you can feel joy, calm, and peace. Often, when thoughts are racing in this manner, they are thoughts about what happened in the past or what will happen in the future. Mindfulness can be utilized in several different ways.

One of my favorite ways is with sound. Sound as an object of awareness articulates the ungovernability of experience and the open, spacious quality of consciousness quite well. It's often a safer way to start experimenting with meditation for trauma survivors, as opposed to the breath, which can be triggering or uncomfortable, especially if the person had trouble breathing during the traumatic event(s), for example.

I find it is important to emphasize to clients that they will still have thoughts during a mindfulness exercise. The task is not to eliminate thoughts, but to identify what thoughts are coming up and to then gently refocus attention on the chosen object of attention (whatever it is) in the here-and-now. It helps clients learn to rest their minds on sounds or other suitable objects of attention to between sessions, particularly when they begin to notice disturbing, racing, or ruminative thoughts, stress, anxiety, depression, or any other symptom.

Beware, however, as mentioned, that while mindfulness doesn’t cause re-traumatization or stress in itself, it can increase a client’s awareness of it. In other words, it can reveal what’s already there and needing to be healed.
Mental Illness Can Be Debilitating, and It's Harmful to Pretend That's Not the Case

As someone who is clinically diagnosed with depression and anxiety, I understand the importance of normalizing mental illness and fighting back against the stigma that prevents people from getting the help and support they need. But while we've made strides in recent years, I worry it's come at the expense of downplaying the seriousness of these conditions.

I often hear folks say that people with mental illness function just like everyone else and that these conditions rarely, if ever, interfere with their lives. I've even heard these disorders compared to broken bones — and while it's true that you should be no more ashamed of having bipolar II than you would be of having a broken arm or foot, this analogy is deeply flawed.

For one thing, doctors know exactly how to fix broken bones. There are casts, crutches, slings, and surgeries — and though the treatment plan varies depending on the severity of the break, physicians can typically estimate how long it'll take for you to recover.

With mental illness, doctors have a much more difficult time finding an effective treatment. Many people find themselves shuffling through different types of therapies and medications for years before landing on a combination that works for them — and even then, you may find that you've suddenly hit a wall with a specific therapist or that your dosage needs to be adjusted. When everything falls into place, there's still no cure for mental illness. Treatment helps manage the symptoms, but there are days when you may still experience panic attacks, struggle to get out of bed, lash out at friends, bite your nails until they bleed, or lose all sense of time.

It's time we acknowledge the hardships those with mental illness face, instead of diminishing them. Some days, I struggle to find the energy to do even the simplest tasks. I'm constantly worrying and overanalyzing things I've said or done, wondering what would have happened if I had handled things differently. I'm also not good with change, and I often find it difficult to stay motivated to hang out with friends, despite feeling lonely. Worst of all, I always feel like I'm disappointing everyone, no matter what I say or do.

Of course, despite these challenges, people with mental illness can still earn a college degree, have a family, get the career they want, have a fulfilling social life, and more. But doing these things while navigating a diagnosis is difficult and exhausting in ways that those who have never struggled with their mental health may never understand. It's time we acknowledge the hardships those with mental illness face, instead of diminishing them. Because every day is a triumph.

Thank you so much for your interest in joining NAMI Cobb Affiliate! Please complete the form below, and mail this with your check made out to NAMI Cobb. (If you wish to pay by credit card, go to www.nami.org and click on “Join”. You will start receiving our monthly electronic newsletter within the month. You are also invited to attend our monthly education and support meetings, on the third Thursday of each month at 7:30pm (there is a time to look at resources and brochures at 7pm). You are not alone. Come join us.

Yes, I would like to join NAMI Cobb of Georgia!

Date:____________________

Membership is for NAMI Cobb, includes NAMI Georgia and NAMI

Annual Dues: Individual [__] $40.00  Open Door [__] $5.00
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(Please note there has been a slight increase in membership fees nationally).

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Address:_________________________________
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Phone:_________________________________
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☐ I am interested in volunteering. My skill is ____________________.

Next Monthly NAMI Cobb

NO NAMICobb In-Person Meetings are scheduled for May

Our location is:

Tommy Nobis Center
1480 Bells Ferry Road
Marietta, GA 30066

**Please mail this form along with your check to:

NAMI Cobb, P.O. Box 999
Kennesaw, GA 30156

Thank you for your membership!

NAMI Cobb
P.O. Box 999
Kennesaw, GA 30156

Informing, Educating and Supporting
people with mental illness and their families

Support Group Meetings

For families of those with a mental illness

1st Presbyterian Church
189 Church St
Marietta, GA

MONDAYS  Time: 7-8:30 PM
Family Support Group Room 048
Connections Support Group Room 046

Contact Neill Blake at 770-427-5353 or nhblake@earthlink.net with questions about either support group.

TO: