National Alliance on Mental Illness

PA, CUMBERLAND and PERRY COUNTIES NEWS

June 2015 **Volume XVIII, Issue 6**

NAMI is the largest nationwide, grassroots membership organization devoted to improving the lives of those affected, directly and indirectly, by serious mental illness. NAMI is comprised of family members, friends and consumers.

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Calendar:

June 18th—Support Mtg in Carlisle
June 20th—Family to Family continues
June 21st—NAMI Connections
June 28th—NAMI Connections
July 2nd—Support Mtg West Shore
July 5th—NAMI Connections
July 12th—NAMI Connections
July 16th—Support Mtg in Carlisle
July 19th—NAMI Connections
July 20th—Support Mtg in Hsbg
July 25th—Youth MHFA in M'Burg

Contact Us:

P.O. Box 527
Carlisle, PA 17013
http://www.namipacp.org
findhope@namipacp.org
Message line number:
240-8715

NATIONAL ALLIANCE ON MENTAL ILLNESS PA
OF CUMBERLAND & PERRY COUNTIES
(NAMI PA CP) PRESENTS:

HEARTS & MINDS:
A ROADMAP TO WELLNESS
FOR INDIVIDUALS LIVING WITH MENTAL ILLNESS

The NAMI Hearts & Minds program is a free educational wellness initiative promoting the idea of wellness in both mind and body. Generally, wellness is an ongoing process of learning about and making choices toward a successful life. Wellness is about the individual; you can decide what parts of your life you would like to change and you determine your own level of success.

People who live with a mental illness are often at higher risk for heart illness and much of that risk is preventable: knowledge is power.

MAJOR PREVENTABLE RISKS
FOR PEOPLE LIVING WITH MENTAL ILLNESS

*SMOKING *ELEVATED CHOLESTERAL
*OBESITY *DIABETES
*HIGH BLOOD PRESSURE (ALSO CALLED HYPERTENSION)

WHAT IS COVERED:

*MENTAL ILLNESS & SMOKING *SUBSTANCE ABUSE & ALCOHOLISM
*METABOLIC SYNDROME & TYPE 2 DIABETES *HEALTHY EATING
*MENTAL ILLNESS & EXERCISE *GOAL SETTING *COMMON BARRIERS TO HEALTHY HABITS *MY HEALTHY PLATE

PROGRAM IS FOR: PEOPLE WITH THE LIVED EXPERIENCE OF MENTAL ILLNESS WHO LIVE IN CUMBERLAND & PERRY COUNTIES.

WHEN: WEDNESDAYS, AUGUST 5, 12 AND 19, 2015 FROM 6:30 PM TO 8:00 PM

WHERE: AURORA SOCIAL REHABILITATION SERVICES, 104 MAIN ST., MECHANICSBURG, PA [Across from Jo-Jo's Pizza]

TO SIGN UP: CALL THOM AT 717-697-2602

JUNE MEETING

NAMI PA of CUMBERLAND and PERRY COUNTIES

THURSDAY, JUNE 18, 2015 at S.T.A.R.

253 Penrose Place, Carlisle, Pa.

[See page 4 for directions]

7:00 —8:30 PM Support Meeting

Duplication and distribution of this Newsletter is made possible by the MH/IDD Board of Cumberland/Perry Counties

NAMI PA, Cumberland and Perry Counties

National Alliance on Mental Illness

JUNE 2015 Vol. XVIII No. 6

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NAMI Pa. Cumberland/ Perry Counties

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Carlisle, PA 17013

http://www.namipacp.org

Message line number: 240-8715

support

What: Support Group Meeting
When: Meets 3rd Thursday of each month
Location: STAR (253 Penrose Place Carlisle, PA 17013)
Time: 7:00 pm up to 9:00 pm there will occasionally be an educational program. Where there is an education program it shall run from 7:00 PM until 7:50 PM, and the support meeting shall follow at 8:00 PM.

June 18, 2015	7:30 to 8:30 PM Support Meeting
July 16, 2015	7:30 to 8:30 PM Support Meeting
Aug 20, 2015	7:30 to 8:30 PM Support Meeting

WEST SHORE SUPPORT GROUP

Meets at 6:30 PM on the 1st Thursday of each month at St. Timothy's Lutheran Church, 4200 Carlisle Pike, Camp Hill, PA. There may be an education program 1x per quarter. Call Hazel at 737-8864 for information.

July 2, 2015	6:30 to 8:00 PM—Support Meeting

NEW CUMBERLAND SUPPORT GROUP [from York County F2F Class

Meets at 6:30 on the third Thursday of the month at the New Life Baptist Church, 530 Big Springs Road, New Cumberland, PA. Contact Beverly Riggins at 717-979-0519 for more information.

	THIS GROUP SHALL NOT MEET THIS SUMMER [June, July, and August]

DAUPHIN COUNTY SUPPORT GROUP [Assoc with NAMI PA Dauphin County]

Meets at 7:00 on the 3rd Monday of each month at the Epiphany Lutheran Church at 1100 Colonial Rd., Harrisburg, PA. Contact Marge Chapman at 574-0055 for more information.

July 20, 2015	6:30 to 8:00 PM—Support Meeting

Psyberguide: Your Go-To Guide to Mental Health Apps

(June 9, 2015) A new resource for people with mental illness will identify and review useful mental health apps.

Called "Psyberguide," the website is dedicated to providing information to consumers, not clinicians, by using nonclinical jargon to orient consumers to available apps that could help manage mental health conditions, according to the website. The website is at http://psyberguide.org/.

"Right now there are 5000 apps on the market for mental health conditions," said Dr. Mike Knable, speaking about Psyberguide at the 2015 Kennedy Forum on mental health. "This resource attempts to provide an unbiased centralized source of information about them."

Given the expertise necessary to understand some mental health apps, this resource will be an invaluable tool for people without professional or academic experience in the mental health world.

Psyberguide also publishes evidence and ranks apps on the basis of their clinical efficacy, which could be helpful in certifying that some mobile apps are not harmful and have no security or privacy issues.

"We hope that this guide will create a rich body of data to guide people with mental illness and professionals through the maze of other mental health resources," Knable said.

Buzzfeed has compiled 14 apps - many free and others of nominal cost - to help individuals who experience anxiety. Among the free apps are Pacifica, which "lets you rate and track mood over time, and provides guided deep breathing and muscle relaxation exercises, daily anti-anxiety experiments, and health goals."

Breathe2Relax, developed by the National Center for Telehealth & Technology, "guides you through diaphragmatic breathing (or 'belly breathing'), allows you to record your own stress level, and provides informative videos and graphics about the consequences of stress."

PTSD Coach, from the National Center for PSTD - designed specifically for veterans - "educates users about PTSD and its treatment, offers a self-assessment tool, links users up to support groups, and provides stress management tools."

Unlock Happiness by Taking Yourself Less Seriously

Posted to HealthyPlace Blog on May 19, 2015 by Arley Hoskin

Long ago, I discovered that the key to happiness lies in not taking myself too seriously. Taking myself less seriously has unlocked a world of bliss in my life. I want to share with you three techniques that I use to take myself less seriously.

In my early 20s, I experienced a severe episode of depression. I didn't realize at the time that I had bipolar disorder.

During that challenging season, my roommate encouraged me to dance.

Dance Like No One's Watching to Take Yourself Less Seriously

My roommate would turn on Miranda Lambert's *I Can't Be Bothered* and we would dance like no one was watching. Sometimes life is hard. During those times where I feel like just can't be bothered, I'll turn on that song and dance.

It doesn't matter how intense my problem— everything seems a little lighter when you are dancing to country music.

Country may not be your thing, but find out what is and dance. You may feel silly at first, but that's kind of the point.

Watch TV with No Regrets for Happiness

I used to deem TV as too trivial for my time but I would never say that now.

My favorite comedy sitcoms provide much needed laughter and they also remind me to look on the lighter side of life. The best way to learn how to take yourself less seriously is to observe someone who has mastered that art.

If you aren't sure where to start, I recommend watching any show with Tina Fey and Amy Poehler. *30 Rock*, *Parks and Recreation* and *Unbreakable Kimmy Schmidt* are all amazing.

Find a Hobby Even If You Fail at It to Take Yourself Less Seriously

My final advice for taking yourself less seriously might sound a little odd. I advise everyone I know to find a hobby

(Continued on page 4)

NAMI Connection

National Alliance on Mental Illness RECOVERY SUPPORT GROUP

"Talk with someone who understands… Someone just like you."

Too often, mental illness is an isolating experience, accompanied by profound anxiety. For people with any mental illness, talking with someone to share coping strategies and insights, as well as problems and concerts, can be an important link to the path to recovery. This group provides a place that offers Respect, Understanding, Encouragement and Hope. It offers a casual and relaxed approach to sharing the challenges and success of coping with mental illness

When: Each Sunday from 6:30 PM to 8:00 PM

Where: S.T.A.R., 253 Penrose Place, Carlisle, PA 17013 (see directions on this page)

Who: For Individuals Living with Any Mental Illness

Group Leaders: Joy , NAMI Nationally trained Support Facilitator

Contact: Any group related questions can be directed to Joy at (803) 409-9702.

WE'VE BEEN THERE: WE UNDERSTAND.

NAMI Support Groups are free and confidential
No preregistration is required
Find us on the Web at:
WWW.NAMI.ORG/CONNECTION and
WWW.NAMIPACP.ORG

Find us on Facebook at:
WWW.FACEBOOK.Com/NAMIPACP

JOIN US FOR 2015

$35.00 For an individual
Membership includes membership in NAMI [national] and NAMI PA, and Subscriptions to The Advocate, The Alliance, and NAMI PA C/P News.

$35.00 For a Family
Same price as an individual. A family consists of two people living at the same address. A family has one vote, and will receive one copy of subscriptions.

$3 - $35.00 For "Open Door" membership
*Anybody can opt to join as an open door member. Dues are **any amount that can be afforded.** This option is available so that membership is not denied due to financial hardship. Open door members are regular members with all the privileges and powers of membership including all subscriptions.*

$50.00 For Professional Membership
A Professional member shows support for the mission and goals of the organization. Upon request, NAMI PA C/P will provide multiple copies of our newsletter for the waiting room of Professional Members.

Make Payment to:
NAMI PA C/P
Send Payment to: NAMI PA C/P
Box 527, Carlisle, Pa 17013

JOIN NOW TO BECOME PART OF THE NAMI FAMILY

Memberships submitted now will extend to the end of 2015

DIRECTIONS TO S.T.A.R.

From I-81:
- Take Hanover St. Exit and turn towards town, [Rt. 34 North]:
- At the major intersection at Noble Blvd, turn left on Noble Blvd.
- Proceed straight ahead at the first Stop sign at West St.;
- Turn right after the gas station on Penrose Pl.;
- The Penrose Plaza is immediately on your left;
- STAR is the last store front on the right end of the Plaza.

From Downtown Carlisle:
- Take Hanover St. out of town [Rt. 34 South].
- At the major intersection at Noble Blvd, turn right on Noble Blvd.
- Proceed straight ahead at the first Stop sign at West St.
- Turn right after the gas station on your right;
- The Penrose Plaza is immediately on your left;
- STAR is the last store front on the right end of the Plaza.

(Continued from page 3)

that you enjoy even if you fail at it. Find something you're terrible at, but love to do. Enjoy it. Enjoy the freedom that comes with not having to be the best. This will help fight against this stress that comes with perfectionism.

Karaoke used to be my favorite hobby. Every Wednesday I would go to this dive bar with my co-workers and sing my heart out. I am completely tone deaf and have no rhythm whatsoever. But man, did I love those karaoke nights.

I also like to sew. My stitches are always a little off, and to be honest, so am I. But those crooked stitches remind me that life doesn't have to be perfect to be beautiful.

This week I encourage you to take time to dance, watch silly TV shows and do something you enjoy that you don't have to perfect at. I encourage you to enjoy simply being you. Take yourself a little less seriously and in doing so you will likely find a lot more bliss.

COMMENTARY: MENTAL ILLNESS MUST BE DECRIMINALIZED

By Mary Giliberti and Susan Pamerleau | May 26, 2015

There is growing consensus among conservatives and liberals alike that too many people are incarcerated and we spend too much money keeping them in jails and prisons with poor long-term outcomes. This is particularly true for inmates with mental illnesses.

The figures are staggering. At least 2 million people with mental illness are booked into local jails across the country every year, equal to the total population of Houston. Most of these people have not committed serious crimes, but are in jail because of untreated mental illness. Nearly 15 percent of men and 30 percent of women booked into jails have a serious mental illness. And at least 83 percent of these individuals did not have access to needed mental health treatment prior to their incarceration. Behind these numbers are distraught mothers, fathers, siblings and individuals with mental illnesses. At the National Alliance on Mental Illness, calls about the incarceration of someone with a mental illness outnumber all other calls.

In addition to the human costs, the fiscal costs of incarcerating people with serious mental illness are exorbitant. The conditions of these individuals generally worsen during incarceration, decreasing the prospects for successful transition back into the community. This can lead to jail becoming a "revolving door," releasing people into homelessness or emergency services.

We can do better. In some communities, we are already doing better.

A number of years ago, Bexar County, San Antonio and surrounding communities realized that inordinate amounts of money were being wasted by jailing people experiencing serious mental health crises. There was little coordination among agencies responsible for providing aid to people with serious mental illness and substance use disorders. Law enforcement officers were not trained on how to de-escalate crises. Jail was frequently the default option for people with serious mental illness in crisis. Not surprisingly, Bexar County's jail was overcrowded beyond capacity.

In 2003, the county established a program to link people with needed mental health and substance abuse services instead of arrests and jail. More than 2,600 law enforcement officers and other first responders were trained in how to recognize and de-escalate psychiatric crises. Additionally, a 24-hour, seven-day-a-week crisis center was established to receive people in need of immediate assistance.

Since this program began, more than 20,000 people with serious mental illness have been identified and diverted from jail into treatment. In the past five years, the program has saved Bexar County more than $50 million. This has been accomplished through wise investments in community mental health services and hiring more professionals to provide mental health and substance abuse treatment.

The city of Houston and Harris County have also taken positive steps to reduce unnecessary incarceration of people with mental illness. Houston police, the Harris County Sheriff's Department and the Harris County Mental Health Mental Retardation Authority have collaborated to develop more than 10 crisis intervention response teams. These teams respond to the most difficult crisis situations involving people with mental illness. Additionally, Adrian Garcia, who until recently was Harris County sheriff, regularly spoke out and elevated awareness about the need for mental health services as an alternative to incarceration. He also supported legislation to provide treatment of individuals with mental illness who are transitioning back into communities.

Now, we have an unprecedented opportunity to create programs like these in many more communities. NAMI, the Council of State Governments Justice Center, National Association of Counties, American Psychiatric Foundation, Major County Sheriffs Association and other law enforcement and mental health organizations are launching an effort to reduce the unnecessary incarceration of people with mental illness. The "Stepping Up" campaign will provide technical assistance and other resources to counties to foster the kind of collaborative efforts that have already led to such positive results in Harris County and elsewhere.

For the first time in 30 years, reducing incarceration is at the forefront of national attention. These objectives cannot be accomplished without addressing the over-representation of people with serious mental illness in local jails.

We will never have a better chance to end the cruel and unnecessary criminalization of mental illness in America. As representatives of those most affected by this national tragedy, we call on communities to "Step Up" and do the right thing.

Giliberti is executive director of NAMI. Pamerleau is sheriff of Bexar County.

Enough is Enough: We Need to Prevent Campus Suicides

By Darcy Gruttadaro | May. 06, 2015

At William and Mary, there have been four. At the University of Pennsylvania, there have been four. And there have been four at Tulane University. And there has been one at Yale. And there have been three at George Washington University.

But those are not just numbers, they are young lives recently lost to suicide—college students who should be launching into the prime of their lives but instead are gone. They were our sisters, brothers, children, friends, neighbors and the future generation of our nation.

Suicide is happening too often on college campuses. It is unthinkable that suicide is the second leading cause of death in U.S. college students and a high percentage of students who die by suicide have a mental health condition. Clearly they are not getting the help they need. We need a strong community response to address this public health crisis. Effective strategies are needed to make it OK for students to come forward to seek help. No one strategy will work in every case, but colleges and universities must find the right mix of action steps to stem the tide of campus suicides. Enough is enough.

We can all help by asking colleges we attended, that our children or family members attend or that are in our communities—what they are doing to help prevent campus suicides.

Here are 10 practical steps that colleges can use as a starting point:

- **Get leaders talking.** The more that college presidents talk about the importance of mental health and seeking help when needed, the more likely it is that students will do so.
- **Assess adequacy of mental health services.** College administrators should be asking whether adequate mental health services and supports are available for students. Adequacy should be measured by looking at wait times for appointment, what is offered to students who must wait, triage systems and the array of services available.
- **Raise the visibility.** Information on accessing mental health services should be placed prominently on the school's website and in highly visible campus locations for the entire community to see.
- **Develop effective crisis services.** Operate a crisis hotline, provide after-hours crisis services and work with student leaders to ensure that the system in place works for them.
- **Involve student leaders.** Encourage, involve and support student clubs like NAMI on Campus. They enrich the campus community by raising mental health awareness, working to end stigma and finding solutions for mental health issues impacting students.
- **Educate, educate, educate.** Educate administrators, faculty, staff and the entire campus community about the early warning signs of mental health conditions and what to do if they see or experience them. Early action leads to far better results.
- **Location matters.** Make mental health services and supports easy to access. Don't locate them far from the main campus or off in a dark corner.
- **Encourage outreach.** Encourage students who need help to reach out early to family, friends and other trusted sources for support. The operative word is "early" – the longer students wait, the more difficult it gets.
- **Create connections.** Create a connection to the community mental health system for those times when campus-based services are either not enough or not available.
- **Address barriers to care.** Evaluate and address barriers like a limited number of appointments, wait times, coverage for care or the affordability of services and more.

Student suicides are plain and simply tragedies that seriously unsettle and disrupt the rhythm of life on college campuses and beyond. We owe it to youth and young adults to be proactive in ending these tragedies.

NAMI is doing its part by supporting college students in creating NAMI on Campus clubs and providing them with high impact resources and information to make a positive difference. For example our Raising Mental Health Awareness presentation can be presented by students or other campus leaders to get schools talking about mental health. Download the presentation from the NAMI website to get started! Please join us so that together we can save more young lives.

MENTAL HEALTH FIRST AID

FREE FOR CUMBERLAND COUNTY RESIDENTS

YOUTH COURSE: JULY 25, 2015

ADULT COURSE: AUGUST 8, 2015

CONTACT TERESA MYERS AT 717 423-6907 or email to tmm336@gmail.com WITH QUESTIONS

BIG STRIDES FOR MENTAL HEALTH REFORM [IN WASHINGTON], BUT WORK REMAINS

By Seattle Times editorial board May 15, 2015

Doug and Nancy Reuter, parents of Joel Reuter, a 28-year-old mentally ill man killed by police in the Capitol Hill neighborhood of Seattle. (BETTINA HANSEN/The Seattle Times)

THE well-documented problems of Washington's mental-health system are not completely about funding. A $90-million cut during the Great Recession widened existing gaps in access to treatment. But the system for years has been confusing and fragmented, often thwarting well-intended families from getting critical care for sick loved ones.

The state Legislature has taken admirable, broad strides this year toward fixing both the money and the policy problems, although its work is still not done.

As for the good news, Gov. Jay Inslee this week signed "Joel's Law," named for Joel Reuter, a bright, young software engineer whose illness made him believe he was shooting zombieswhen he was killed in 2013 by Seattle police.

Joel's Law for the first time gives parents or guardians the right to directly appeal to judges for involuntary commitment of a loved one, a power previously reserved for mental-health evaluators. State Sen. Steve O'Ban, R-Lakewood, and state Rep. Brady Walkinshaw, D-Seattle, deserve particular credit.

This law can help more families now because Washington is finally boosting the number of state-funded psychiatric inpatient beds. This progress took a damning state Supreme Court ruling last year, and the shame of the state's bottom-of-the-nation ranking for access to those beds. But lawmakers took note, and acted.

The Legislature is also following the lead of New York and California in creating a new program that allows judges to mandate outpatient treatment for people with serious mental illness.

Championed by state Rep. Laurie Jinkins, D-Tacoma, this assisted outpatient treatment program recognizes that some very mentally ill people don't recognize they are ill and need medication. Research in New Yorkhas found this approach helps cut the vicious cycle of repeated hospitalization, reducing costs.

But the program only works if there are enough case managers and treatment professionals to serve them. Current budget proposals in Olympia fund less than half of the estimated $9 million a year needed to make it work. That number should be higher, to save both costs and lives.

Despite these gains, reform of Washington's mental-health system remains a work in progress. A stinging rebuke by federal Judge Marsha Pechman last month mandates much quicker evaluation and treatment of mentally ill jail inmates.

In responding to that ruling, state lawmakers and regulators should think broadly about preventing mentally ill people from falling into the criminal-justice system, and diverting them out of it whenever possible. One proposal — to give prosecutors greater incentive to dismiss low-level crimes in favor of treatment — has bipartisan support. But, again, it needs sufficient funding.

Budget writers negotiating in Olympia on a final budget for 2015-17 should not leave this work undone.

Joel Reuter's father, a former Republican Minnesota state lawmaker, accurately summed up the reform efforts this year: "It's a monumental accomplishment to get both parties and both (legislative) bodies on board for this large of a change," he said. But, the gains also acknowledge that "the system here was so broken."

There is still more to do.

Editor's note: If it can happen in Washington, it can happen in Pennsylvania

The New York Times

NO LONGER WANTING TO DIE

By Will Lippencott May 16, 2015

In January 2012, two weeks after my discharge from a psychiatric hospital in Connecticut, I made a plan to die. My week in an acute care unit that had me on a suicide watch had not diminished my pain.

Back in New York, I stormed out of my therapist's office and declared I wouldn't return to the treatment I'd dutifully followed for three decades. Nothing was working, so what was the point?

I fit the demographic profile of the American suicide — white, male and entering middle age with a history of depression. Suicide runs in families, research tells us, and it ran in mine. My father killed himself at age 49 in April 1990. A generation before, an aunt of his took her life; before her, there were others.

Shame runs in families, too, and no one in mine talked much about mental illness.

The first time I was hospitalized for wanting to kill myself, as a teenager, my dad visited me a few days in. I made an effort to greet him with a firm handshake; he shared a few jokes with me. Dad was visibly concerned and told me he loved me. Only after his suicide a few years later did I learn that he, too, had been hospitalized, for depression, when he was in his early 20s.

Setting out to start my own life after college, I felt that suicide was a clear and present opportunity, one that glowed more brightly during my depressive episodes.

But I had an ambitious plan to beat it. I'd be a performer: work hard, keep my goals in the line of sight at all times, and make as much money as I could. Professional success would be my first line of defense to keep hopelessness at bay. In parallel, I'd find excellent doctors and be a compliant patient, take my meds and show up for talk therapy.

And for a long time, through my 20s and 30s, that plan worked.

Then, in 2008, a business deal fell through, and I couldn't shake my disappointment.

I slipped into a low mood, unfamiliar in both its persistence and depth. The doctors tried different drugs, different combinations of drugs. There were re-evaluations and second opinions. A course of electroconvulsive therapy was ineffective. My diagnosis shifted from depression to treatment-resistant depression.

Three and a half years later, I was done. I'd stopped sleeping through the night; I'd go to the office before dawn to avoid being alone with my thoughts. If not for daily business lunches, a custom in the publishing industry, and the brownies and whole wheat biscuits my partner baked in loving desperation, I would've lost far more than the 30 pounds I'd dropped just in a few months.

I diligently planned my death, contacting a lawyer to finish my will and updating my health care proxy. In case I botched the job, I wanted to leave clear instructions that nothing be done to try to revive me or to prolong my life. I intended to hang myself in the garage of my upstate house.

When I told my brother in an email that I was giving him power of attorney over my affairs, he replied immediately: You must not leave us! He reminded me of our father's dark legacy, and what it had felt like when he'd left us behind. I remembered that agony, didn't I?

His message confused me. I wanted to die, but I did not want to inflict suffering on the people I loved the most.

I became willing to consider long-term hospitalization, something I hadn't yet tried because of its great expense. After a frantic search for an open bed at a treatment facility and the funds to pay for it, I left New York for the Menninger Clinic in Houston.

A few weeks after I arrived, I was enrolled in a dialectical behavior therapy skills group.

D.B.T. is a therapy that was developed in the 1980s by the psychologist Marsha M. Linehan as she worked with suicidal patients suffering from borderline personality disorder. In spite of my 30 years as an avid, often desperate medical consumer, I'd never heard of it.

Dr. Linehan had struggled with mental illness as a young woman. When she started seeing patients, substantial research showed that cognitive behavioral therapy — which focuses on helping patients identify and change negative, often erroneous thoughts (e.g., "I am stupid") that underpin negative feelings and behaviors — could help many depressed people. But Dr. Linehan found that C.B.T. didn't always work for her suicidal patients. Some found its emphasis on changing their own thinking tantamount to the belittling notion that their pain was "all in their head." Many of them had experienced very real trauma, and many had tried fruitlessly to change many times before. C.B.T.'s implication that their emotion was "wrong" — merely a consequence of inaccurate thoughts — made the therapist seem unsupportive, and reinforced their sense of isolation and hopelessness.

Drawing on her own experiences and further study of both psychology and Zen practices, she began to create a form of C.B.T. that spoke to the particular vulnerabilities of her patients. Before her patients could or would change, she saw, they needed to accept themselves, and to be accepted, exactly as they were

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in the present. This dialectic tension between acceptance and change is the root concept of dialectical behavior therapy.

Dr. Linehan also recognized that people who struggled with the urge to commit suicide were often people who might be biologically vulnerable to being emotionally overwhelmed. It's not that we have the "wrong feelings"; it's that our feelings flood and overwhelm us, in ways they might not overwhelm someone with different genes, and that it takes longer for those feelings to ebb and subside. In response, she began articulating strategies, or "skills," for people with these vulnerabilities.

It is in the pivotal moment between experiencing a feeling and acting on it, the theory goes, that I have a chance to "act opposite": to behave differently from how I have historically, and often destructively, managed distress.

There were behaviors I wanted to change. When I was depressed, the self-possession I presented to the world belied just how out of control I felt inside. In my search for relief from anxiety, anger or sadness, I'd act impulsively — spending money when I couldn't afford it, isolating myself from friends, lashing out at those people closest to me, even hurting myself physically. Afterward, I was kept low by regret. My urges to act out may have been satisfied, but now I had a set of new problems: debt, broken relationships, a hangover. Unable to forgive myself for my mistakes, the anger returned.

That cycle was killing me. D.B.T. provided me with a rubric for figuring out what was causing my anxiety, anger or sadness — and new options for how to behave in light of it. Classical D.B.T. treatment originally involved multiple components and required the participation of a team of specially trained professionals, keeping its price tag high. But in recent years, research has confirmed that a more streamlined, more affordable form of D.B.T. — D.B.T. skills training — is also remarkably effective.

Over the last decade or so, clinicians have adapted D.B.T. to help people with treatment-resistant depression, attention deficit disorder, post-traumatic stress disorder and eating disorders. New research published in March 2015 in JAMA Psychiatry highlighted the effectiveness of including the skills-training component in D.B.T.

The study's finding wasn't news to me. Once a week for the last two and a half years I've attended a D.B.T. group and learned a set of skills that have been nothing short of transformative. I pay $80 for each 90-minute session, which I pay for out-of-pocket, though it's covered by some insurance companies.

Learning D.B.T. is like learning a new language. Organized in four modules, each one taught in rounds lasting four to seven weeks, it offers its own vocabulary, idioms, even mnemonics. I was no longer suicidal, but I wasn't sure that would last. Since my 20s, I'd managed anxiety with aggressive use of benzodiazepines like Xanax and Klonopin, which had grown into an unhealthy dependence. I returned home without them after a tough detox at Menninger.

I was now subject to the full sensory assault of New York. Riding the subway to work, walking the dog, even tying my tie in the morning could provoke panic attacks. Frightened by the power of these feelings, I scrambled to apply the skills from the first D.B.T. module I'd learned, distress tolerance.

I followed the strategy of distracting myself with highly specific tasks just long enough — usually for two or three minutes — to lower the intensity of the fear before it overwhelmed me. Depending on where I was — at home, at work or on the street or train — I'd reach for a situationally appropriate activity. And because I can't rely on my memory when anxiety swells, I'd carry lists on an index card or on my phone: pull out a piece of paper and write down all 50 states and their capitals — in my nondominant hand; grab ice cubes from the fridge and hold them on the back of my neck; snap the rubber band on my wrist. At the office or in a meeting, I learned to make subtle changes to my posture like bunching my toes, half-smiling to activate facial muscles, even slowing my breathing.

And as imperfect as my D.B.T. practice was early on, I found that just taking anxiety down a degree or two gave me a measure of control over my decision making in the presence of intense emotion. The lesson was profound. I couldn't eliminate anxiety from my life, but I could learn how to tolerate it, and cope without making the situation worse.

As I made slow, sometimes unsteady progress, I became curious about Dr. Linehan's other D.B.T. modules. Mindfulness challenges me to accept emotions and situations as they are, not as I want them to be. I've learned how to "observe and describe": to state the nature of a problem with facts, not judgments, so I can determine how best to solve it.

The interpersonal effectiveness training helps me ask for what I need in relationships and to manage conflict positively, and to do both while preserving my self-respect.

Prepping in advance for tough conversations and avoiding overapologizing are key skills. Emotion regulation teaches me how to identify and understand the functions of my emotions, and how to decrease my historic vulnerability to extreme moods. If I'm aware of how I feel physically when I'm sad, or how my speech pattern changes when I'm angry, I can recognize where I am and change course before the intensity of the emotion gets too high.

The time needed to learn D.B.T. can feel impossibly huge, especially for those of us who despair that change can't come fast enough to save our lives. Yet, by empowering me to make the next minute or hour better than the one before it, in even the slightest, most incremental way, this therapy kindles hope. Better hours become better days, and several years on I've discovered my own resilience.

Now I am able and willing to fully participate in life, ready to experience its joy and pain equally as I reach for my long-term goals.

D.B.T. is a relatively young therapy. There is much more research to be done. Still, there is already compelling evidence of its effectiveness in its modified, less expensive formats. Mental health professionals and patients need to consider it directly alongside the usual programs and not as a treatment of last resort.

Suicide rates in the United States are at a shocking 25-year high. They spike in the spring, for reasons not entirely clear. But depression is treatable, and suicide is preventable. Don't lose hope. You are not alone. I, too, once firmly believed that I was broken beyond repair — but I was wrong.

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