Words of Wellness

The newsletter of the Collaborative Support Programs of New Jersey Institute for Wellness and Recovery Initiatives ● www.cspnj.org ● Volume 3, Number 6 ● December 14, 2009

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SERIES ON CONNECTEDNESS AND INCLUSION

Being included in the community is important for wellness. There are lots of ways in which people feel connected and included, and want to feature the ways YOU feel connected and included.

Please consider writing and submitting a 300-750 word article which answers the question "how do I feel connected in my community." We encourage you to write about anything important to you (work, school, family, faith, volunteering, or anything else relevant to you). We welcome your submission (nleditor@cspnj.org).

HOLIDAY WELLNESS IDEAS

As we near the end of 2009 we decided we would offer our readers some *Holiday Wellness Ideas*. The holiday season generally contains a variety of things that impact our sense of balance in the wellness dimensions[1]. The holidays offer opportunities for time with people we care about, a break from the routine of our work and school lives, or perhaps the chance to practice cultural or traditional rituals. Overeating/drinking, overspending, stress due to deadlines, traffic, and travel, and breaks from our normal routines can be sources of stress, and lead to imbalance in the various wellness dimensions. Many strategies for handling holiday stress may be in our personal wellness habits and routines. The following are ideas to help you maintain a sense of balance:

Stick to the routines and activities. For some people, this may mean rigid adherence to wakeup and meal times over a vacation period or while traveling. For others, it may be about making sure to get in your exercise, meditation, prayer, etc. Many of us just need to schedule "down time." Going "cold turkey" from work or our volunteer activities can also be an issue, even if we see the need for a break.

Know what tends to make you to feel stressed or overwhelmed. For some of us, lack of sleep is a serious stressor. Some of us cannot tolerate alcohol or rich foods. Others can become overwhelmed by too much stimulation often associated with holiday events.

The holiday season sometimes trigger loss. People often think of departed relatives and close friends during holiday observances. Be prepared for that moment of mourning. Consider sharing that moment in a conversation with someone else who misses that person, or doing something to honor the departed person's memory.

Put wellness at the top of every holiday list and effort. Consider what impact every action or activity is likely (or possible) to have on your wellness. Make informed choices to engage in, modify, or "pass" on that activity. You cannot attend every gathering, visit every relative, and carry out every family tradition. One good bit of "news" is that many people feel this stress; "I just can't make it" or "We'll have to get together when things are less hectic" should be acceptable (and maybe secretly very welcome) to friends and family. Making decisions to "pass" on some activities also includes self-forgiveness.

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[1] Physical, emotional, social, spiritual, intellectual, financial, environmental, occupational

Think about wellness in the gifts you give. Perhaps you can consider giving others items that supports one of their wellness activities, or opens them up to a new strategy for personal wellness. Can you give somebody a relaxation or exercise class, or a gift of time that enhances his or her wellness? Are the foods you give as gifts or serve to your friends wholesome? Do the gifts you give reflect ***your*** wellness values?

Do it with your head, not over it. Whether "it" is eating, drinking, shopping, or caroling, you need to ***know*** your limits and ***honor*** your instincts. Overspending has become a "tradition" for many, and it is worth thinking about how to avoid gift or spending escalation. Can you give a gift of something homemade, or a photo of a shared memory, or a commitment of future time/effort, rather than something store-bought?

Think about a Wellness Resolution. Choosing to make a resolution is, of course, a very personal issue. Many people do, and their resolutions are generally related to important personal issues. They are resolutions that take the form, "I am going to invest my time, energy, attention, and other resources in order to try to accomplish [my goal] because it is something I wish to do for myself." Some people stick to their resolutions, others may not. We hope if you decide to make a resolution we can offer some helpful tips in the monthly *2010 Words of Wellness.* For now here are some ideas you may find useful in setting and keeping a resolution:

- Identify a goal that is meaningful to you.
- Think about the resources you will need to achieve the goal.
- Learn from prior experiences, but do not assume that a prior failure is a predictor of a future failure.
- Break the goal into measurable objectives, and track yourself to those objectives. You may seek help from a friend, counselor, or life coach to help you to set objectives, measurements, and methods of tracking your success.
- Enlist support. Support can be very helpful from a friend, or someone you trust who can help you in your efforts.
- Remember it is important to replace a behavior or activity, rather than just take something away from yourself.
- Keep reading this newsletter. We hope it offers ideas that inspire your wellness efforts.

We wish you a happy, healthy, and peaceful holiday season. In 2010 we warmly welcome your ideas for articles we can feature in ***Words of Wellness***.

Routines and Habits: A Key Factor Impacting Wellness

An important factor contributing to health and wellness is following ***self-defined routines and habits*** that offer personal balance and satisfaction. The following discussion will outline the importance of defining and following a set of routines and habits that we feel contributes to our own sense of balance and personal satisfaction.

Routines and habits are generally determined by our *basic needs* (nutr*ition/food, shelter, social affiliation, safety and security,* etc), and the various (and many times multiple) *roles* we occupy (*family member, worker, students, hobbyist, community member, advocate, etc*). The demands, as well as constraints of our *environment and community*, impact our habits and daily routines.

Life demands, stress, crisis or trauma can impact or alter our routines and habits. In time, this can lead to emotional (anxiety, depression), social (cranky, isolate, angry) or physical (tired, run down, body aches, agitated) imbalances which ultimately may contribute to the occurrence of a cold or flu. Though stress and demands can have negative impacts on our sense of personal 'balance,' it is more likely that we can set and follow habits and routines that lead to: a good feeling (emotional), satisfaction, and contentment in terms of our relationships (social), feeling energized and inspired (physical, and emotional), and feeling that we are using our creative talents, skills and abilities to be engaged in productive activities (occupational, intellectual, spiritual).

The pursuit of wellness, as well as managing an illness, stress, disappointment, and crisis can be fulfilled through establishing and implementing a personally defined set of habits and routines. Being aware of needs, demands, priorities, and energy level are important indicators to assess first. Think about your needs, demand, obligations and priorities each day, week, month and year.

Here we stress ***self-defined balance.*** This is because we each have a different set of needs, preferences and demands. Creating a standard set of habits is not useful, because as individuals we have a unique set of physiological needs and social and emotional demands and capabilities. Everyone has different needs, and our level of self-defined 'balance' is quite personal.

Personally, I have created a system whereby I regularly review my personal habits and routines to see what is helping me 'feel' a sense of 'balance' in the eight wellness dimensions (occupational, social, emotional, intellectual, physical, spiritual, environment, and financial). Setting regular habits and routines are the tools that help me manage stress, disappointment, and the demands of the variety of social roles) I choose to occupy my time in roles which I value, including worker, family member, friend, citizen, and, most important for me, swimming enthusiast. I try to go to sleep and wake up at about the same time seven days per week. I feel at my best when I get 7 or 8 hours of sleep. Sometimes that is not possible. If 2-3 days go by and I have not had adequate sleep, I notice that it starts to impact my productivity and reactions to people around me. I then plan to swim early in the evening and set a specific time when I will go to bed (and do not watch the news which sometimes can be upsetting and interfere with my sleep).

There is a set prescription that everyone should follow that will produce the same results. Each person, individually and with support can learn to be aware of their needs and demands and outline the habits and routines that support their individual well-being. The following are some things to consider.

- Sleeplessness can be very distressing. Insomnia may impact social relationships, physical and emotional reactions, productivity, ability to concentrate, our ability to accomplish tasks, and our sense of well being.
- Sleep and wake cycles are a very important. (Do you go to bed and wake up at about the same time everyday?).
- It is important to be active in satisfying activities that we feel have 'purpose'. Feeling pressured to do things that can be stressful or not having very many activities in our daily routines that we feel are meaningful can lead to feeling distressed or depressed.
- Level of social contact. Everyone has a different tolerance for the amount of social contact that can energize or drain them (What is the just right amount of social contact you can tolerate?)
- The impact of time zone changes or daylight savings time on our routines and how to re-adjust.
- Different people have differing levels of comfort at being in a routine. Some would rather feel their days and weeks are more varied.
- People who do not follow a fixed routine sometimes use (or would benefit by using) checklists or other "cueing mechanisms." This is also helpful for people who are trying to get into a routine, or for things which are part of a routine, but may occur infrequently (changing your furnace filter, checking your credit report, going through the fridge and freezer for outdated foods, etc.). Another example of a checklist would be a housekeeping checklist.
- Habits are habit-forming. By repeating a behavior until it becomes routine, practicing it becomes automatic.

We hope you continue to create habits and routines that support your own sense of personal wellness. ***We*** welcome ideas, opinions, and resources you can offer so we can help each other to identify and follow a set of self defined habits and routines that contribute to our sense of wellness.

THE RELATIONSHIP BETWEEN FIBROMYALGIA AND DEPRESSION

By Maureen Falkowitz

This is Part 4 of a four-part series. Part 1 (September, 2009), discussed Fibromyalgia/ Fibromyalgia Syndrome (FMS), and some of the symptoms and possible causes. Part 2 (October, 2009), covered conventional and alternative ways to manage fibromyalgia. Part 3 (November, 2009), presented diet as another alternative way to manage fibromyalgia. In this final issue, we will discuss the relationship between fibromyalgia and depression.

Fibromyalgia and Depression[2]

At some point, 30 to 40 per cent of people living with fibromyalgia also experience depression. Some doctors assume that this depression is situational. Depression seems related to the following: people experience chronic pain, distressing symptoms (i.e., insomnia, fatigue, headaches, etc.) along with the stress of dealing with a chronic illness.
Many people experience clinical depression, which is a separate condition with its own causes. Since the two conditions occur together so often, however, there is a close association.

Fibromyalgia as a Psychiatric Disorder[3]

Even as early as the 1940s, there were suspicions that fibromyalgia and depression were closely intertwined. Some researchers, in fact, are convinced that fibromyalgia is a psychiatric disorder, and some people in the field have suggested that the term "*fibromyalgia*" be replaced by terms such as "*affective spectrum disorder*"[4] or "*somatoform pain disorder*."[5]

A study reported in the July 2004 issue of the professional journal of *Pain*, suggested that a genetic predisposition toward major depression can also trigger fibromyalgia. The study was headed by Karen Raphael, Ph.D., an associate professor of psychiatry at New Jersey Medical School.

Raphael and her coworkers decided to investigate whether fibromyalgia and major depressive disorder share a common familial predisposition or genetic origin. They limited their study to women, since fibromyalgia is more prevalent in women. First they called women at random in the New York-New Jersey metropolitan area to locate subjects who had fibromyalgia, a history of a major depressive disorder, both illnesses, or neither illness. They ended up with 274 individuals, whom they divided into four groups:

1. those with both fibromyalgia and a history of major depressive disorder;
2. those with fibromyalgia but no history of major depressive disorder,
3. those without fibromyalgia but with a history of major depressive disorder, and
4. those persons with neither fibromyalgia nor major depressive disorder.

The researchers then attempted to contact as many as possible of the first-degree relatives of the subjects in the four groups. They made contact with 659 relatives in all. They determined how many relatives of subjects in each of the four groups had ever had a major depressive disorder and compared the numbers for the four groups. They found that the rates of major depressive disorder were elevated to an equal level in relatives of persons in the first three groups as compared with the fourth group.

In other words, relatives of subjects who had 1) both disorders, 2) fibromyalgia but no major depression, and 3) major depression but no fibromyalgia turned out to have the same elevated risk of major depression when compared to the relatives of the fourth group. The relatives of the fourth group (i.e., those without either fibromyalgia or depression) had a much lower risk of major depression.

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[2] Franke, J. (2005). *How Psychotherapy Can Help FM-Related Depression*. Retrieved November 30, 2009, from the National Fibromyalgia Association Web site: www.fmaware.org/site/News2?page=NewsArticle&id=6235 Reprinted from FM Online

[3] Arehart-Treichel, J. (2004). Fibromyalgia, Depression May Be Part of Same Spectrum. Retrieved November 30, 2009, from *Psychiatric News* Web site: http://pn.psychiatryonline.org/content/39/18/33.1.full

[4] Affective spectrum medical and psychiatric disorders. Retrieved November 30, 2009, from Wikipedia: http://en.wikipedia.org/wiki/Affective_spectrum

[5] Somatoform pain disorders. Retrieved November 30, 2009, from Wikipedia: http://en.wikipedia.org/wiki/Somatoform_disorder

This finding, the researchers concluded, implies that "fibromyalgia is a depression spectrum disorder, in which fibromyalgia and major depressive disorder are characterized by shared, genetically-mediated risk factors..." The results allowed researchers to conclude that the frequent occurrence of fibromyalgia and major depressive disorder in the same patient is not due to the stress of living with fibromyalgia. In fact, it happens because they are very closely linked disorders with a genetic basis. Calling fibromyalgia a "depression spectrum disorder" does not mean that fibromyalgia is a type of depression. In patients with both fibromyalgia and depression, it is just as appropriate to call depression "a fibromyalgia spectrum disorder." That's how closely linked they are.

This writer has found this research to be personally gratifying and validating. At last I know there is research confirming what I already believed. That the symptoms of depression and fibromyalgia may occur at the same time, and are closely related.

Editor's Note: There is a significant body of research on the co-occurrence of fibromyalgia and psychiatric disorders at various levels, including both clinical and genetic. Arnold , Hudson, Keck, Auchenbach , Javaras & Hess (2006)[6] found co-occurrence rates not only for major4 depression, but for bipolar disorder: anxiety disorders, eating disorders; and substance use disorders. Of course, some of these may be about the effects of the fibromyalgia, rather than independent co-occurrences, but it is hard to know since they are so closely intertwined.

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[6] Arnold LM, Hudson JI, Keck PE, Auchenbach MB, Javaras KN & Hess EV (2006). Comorbidity of fibromyalgia and psychiatric disorders. *The Journal of Clinical Psychiatry; Aug;67(8):*1219-25.

THINKING, PLANNING, AND ACTING - PART I[7]

Many of the articles in this newsletter focus on a variety of things we can choose to DO - – go back to school, improve our diets, choose to pursue employment, etc. This article discusses some practical suggestions we can use as we to move forward with many different kinds of decisions, actions, and life changes.

Decisions may fall into a number of categories:

- *Minor decisions*, for which you do want to make a good choice, but which do not have significant long-term impact. An example would be deciding whether to serve broccoli or spinach with dinner. Most of us will make these decisions based on our instinct or habit without extensive thought.

- *Moderate decisions*, which involve some more expense and impact, but are not life altering. Deciding which suit to buy, or where to go on vacation, or what color to paint a room may be examples of this category. Some thought is called for, but this may not require days of planning and decision making.

- *Major decisions*, like where to live, what job to take, where to go to college, or who to marry will have life-altering consequences. Many people will use a thorough process to make and implement such decisions.

- *Decisions which need to be made quickly* (turn left or right, accept or decline this lunch date, etc.) whether minor or moderate, do not lend themselves to a lot of planning and thinking. Sometimes, a quick decision can be made to take the urgency out of the main decision (pull over and check the directions, "I'll call you back tomorrow"). Obviously, some decisions which can have life-altering consequences (seeking

[7] There is significant science around learning, decision making, motivating yourself or someone else to action, and overcoming biases which affect people's decisions and actions. This is a casual article which is ***not*** explicitly based on those areas of science.

emergency medical help, exiting an unsafe situation) may need to be made quickly.

From time to time we all may encounter some trouble with decisions. Some people have difficulty sorting the minor from the moderate (spending half an hour picking what shirt to wear). Others may experience fear or anxiety around minor or moderate decisions. Coupled with that, some people experience "deciders regret," and worry about the decision after they have made it. Still others may be impulsive, and make moderate or major decisions without much thought. Some people frequently buy things in haste, and have a home full of things that do not meet their needs and a growing debt, may need to work on making their purchasing decisions more systematic. We hope that the ideas in this article are helpful to readers in terms of their own decision making or assisting others in improving their sense of overall wellness as it relates to decision making.

Moderate and major decision requires identifying the "who, what, when, and why" of the decision. "What" and "why" should be obvious for most decisions. "When," of course, is the timeframe. When does the decision need to be made, when do you want to make the decision, and what is the timetable for implementing and monitoring the decision/action. Not understanding and honoring the timeframe sometimes leads to "decisions by default," like when a job offer expires. Sometimes timeframes require us to think about the short-term and longer-term effects of a decision ("buying this suit means that I will not be able to go out to the movies for three months, but I will have a nice suit for my cousin's wedding, and for other special occasions for years to come").

"Who" - Some decisions are your decisions to make. Other decisions involve a group of stakeholders (a family, a group). You may need to make a decision for someone else (like your young child), or a decision which affects others (like how your job selection affects people who depend on you). When it is your decision to make, you are making the decision based on your wants, needs, knowledge, and values, though it may be influenced by outside opinions of others.

Many of you are aware of the concept of "wise mind" taught in mindfulness trainings and techniques, and dating to ancient Buddhist thought. It is based on the idea that when we combine our intellect with the best parts of our emotions, we make the best decisions. Our decisions can be impacted by a physical, social and/or emotional imbalance leading to bad decisions. Building on HALT – a reminder from 12-step support group models –that people are vulnerable when they are Hungry, Angry, Lonely, and Tired, we suggest that it may be wise to consider the need for very cautious decision making you are EPS-HALT (Experiencing Pain or Symptoms (medical, psychiatric, substance), Hungry, Angry, Lonely, or Tired.

As intelligent adults, we are aware that not only do we bring biases to decisions, but the people who we seek advice from also bring their own biases. Sometimes the biases people bring when they advise us are based on their own beliefs and experiences. This is important to consider as sometimes people overstate the positive (or negatives) based on their personal biases. Good decision makers generally seek input from a variety of sources, including input from people less likely to gain by overstating the positives.

In Part II of this article, we will discuss a variety of specific considerations people can keep in mind when making decisions. We hope that these ideas help you as you make decisions that support your own sense of satisfaction and personal wellness.

Assessment of Smoking Culture for Peer Support Settings

The 'culture' of setting both reflects and influences how things are done, what the prevailing attitudes are, and how those attitudes shape people's actions. Words of Wellness (WOW) readers are very aware of the negative impact smoking has on many people's lives. Many of us involved in peer support settings such as Self-Help Centers, Drop-in Centers, and Clubhouses have observed that our culture in these settings as it relates to helping one another quit smoking varies greatly between settings. In our observations (*even today when entering a center*!) there is sometimes a big disconnect between stated policies and rules and "the way things really are."

On the next page you will find an "Assessment of Smoking Culture" which can be used at these various kinds of peer support settings (and potentially adapted for self-help groups, professional service settings, residences, etc.). This assessment is not based on research, and we hope it is used in a practical manner. We hope it is useful for your group to create an awareness of how you can collectively help one another live a longer life.

There is no "official scoring" for this assessment. If you score at or near the maximum of 13, you are obviously paying attention to this important issue, and hopefully the health of your membership is improving. Please feel free to share successes and stories with us (nleditor@cspnj.org). If you scored lower, your group may want to think about whether helping members to reduce smoking is important to you, and what you and your group may want to do to help one another.

Wellness Dimensions

PHYSICAL
SPIRITUAL
SOCIAL
EMOTIONAL
FINANCIAL
OCCUPATIONAL
INTELLECTUAL
ENVIRONMENT

Words of Wellness

As part of its broad array of services to foster wellness and recovery for individuals with disabilities, the CSP-NJ Institute for Wellness and Recovery Initiatives at Collaborative Support Programs of New Jersey offers this monthly newsletter, *Words of Wellness*. This publication features valuable information and resources, including details about educational events, to help people to achieve and maintain wellness. The purpose of this newsletter is to bring useful information to all of our readers, whether pursuing recovery themselves, supporting recovery in clients or family members, helping to administer and change our mental health and related services system, or researching the field and educating future practitioners. *Words of Wellness* co-editors are Jay Yudof and Peggy Swarbrick. Free e-mail subscriptions are available from nleditor@cspnj.org.

We hope 2010 is filled with opportunities for you to engage in positive, meaningful activities. We hope you are surrounded by people who support your pursuit of wellness routines and goals.

Assessment of Smoking Culture	Score
Smoking Rules: ___We allow smoking in our vehicles and/or somewhere inside our building (score 0) ___We do not allow smoking in our vehicles or inside our building, but there is little or no enforcement, and people do it sometimes (score 1) ___We do not allow smoking in our vehicles or inside our building, and we consistently enforce these rules (score 3)	
Getting Cigarettes ___Cigarettes and other tobacco products are sold inside our facility at our canteen or in vending machines (score 0 for yes, 2 for no)	
Smoke-Free Access ___You cannot get into our facility without walking through a smoking area (score 0) ___We have some kind of “smoke free route,” but it is out of the way or rarely used (score 1) ___The main access to our space is via a “smoke free route” (score 2)	
Smoke-Free Image ___Our outdoor smoking area is visible from the street (score 0 for yes, 1 for no)	
Sharing Information About Smoking Cessation ___Information about smoking cessation resources, and the harm of smoking is prominently displayed in our facility and discussed at our meetings (score 2) ___Information about smoking cessation resources, and the harm of smoking is somewhere in our facility (but not so easy to find) and is rarely discussed at our meetings (score 1) ___Information about smoking cessation resources and the harm of smoking is basically not visible in our facility, and rarely or never discussed at our meetings (score 0)	
Celebrating Success ___People proudly report their successes regarding attempts at cutting down or stopping smoking in our facility/at our meetings, and we encourage and applaud these (score 1 for yes, 0 for no)	
Access to Peer Help on Smoking Cessation ___We offer an on-site smoking cessation group and/or transport members to a Nicotine Anonymous group, QuitCenter, or similar resource (score 2 for yes, 0 for no)	
Totals	