Formerly News Digest

Mental Health Matters

Vol. 20, No. 4, November 2006 www.centrahealth.com

Dear Reader,

This month, I would like to recognize the staff at Pathways Treatment Center who are working hard to preserve the quality of care in the face of economic realities.

It isn't a secret that reimbursement for substance abuse treatment has steadily declined since the late 1980s, more so than for any other illness. Many substance abuse providers have left the field, leaving more and more treatment to the public sector.

William Semones

Pathways Treatment Center, which has been helping adults recover from chemical dependency since 1984, is no exception. Reimbursement decline and managed care impact our ability to treat this disease.

Pathways has made significant changes in its program to ensure we can meet the needs of the patient who suffers from chemical dependency. With its move from a residential model to a "hotel" model, we've seen positive results and our services continue to be exceptional.

Full credit goes to the staff at Pathways Treatment Center. They should be very proud of what they continue to accomplish.

To your health,

William W. Semones
Vice President

Eating disorders can lead to health problems, death

By J. Preston Bond, M.D., Child and Adolescent Psychiatrist, Piedmont Psychiatric Center

Millions of people are afflicted by eating disorders, and thousands die from them every year. Most frequently developed during adolescence or early adulthood, eating disorders are more common in women than men and often co-occur with other psychiatric disorders such as depression, substance abuse and anxiety disorders. People who suffer from eating disorders can experience a wide range of physical health complications as well, including osteoporosis, serious heart conditions and kidney failure that can lead to death.

An eating disorder is a symptom of something else that is going on in someone's life. The study of eating disorders is a relatively new field, and there is no consensus as to why people develop serious disturbances in their eating behavior. We do know that society emphasizes thinness. Fashion trends, as well as some professions and activities, emphasize dieting to a weight leaner than needed for a healthy body. People with eating disorders also generally feel that their life is out of control, and they compensate by controlling their weight.

The two main types of eating disorders are anorexia nervosa and bulimia nervosa. A third type is referred to as an eating disorder not otherwise specified—a disorder which meets some, but not all, of the criteria specified for anorexia and bulimia.

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Dr. Bond

Dr. Bond received her medical degree from Eastern Virginia Medical School in Norfolk. She trained in psychiatry at Wake Forest University School of Medicine in Winston-Salem where she completed a fellowship in child and adolescent psychiatry.

Anorexia

One–half to one percent of female adolescents have anorexia. That means that about one out of every 100 to 200 young women between the ages of 10

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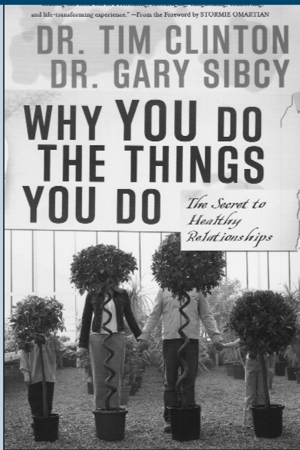

Why You Do The Things You Do
The Secret to Healthy Relationships

By Dr. Tim Clinton and Dr. Gary Sibcy
2006, Integrity Publishers, Brentwood, TN

The latest book by Gary Sibcy, Ph.D., and Tim Clinton, Ed.D., is the revised version of *Attachments: Why You Love, Feel, And Act The Way You Do,* published in 2002.

The authors ask the question, “Why is connecting with people so difficult, especially when you care so much?” According to this book, the answer to why you feel, act and relate the way you do is found in your relationship style, which has its roots in your childhood. How successfully you form and maintain relationships throughout life is related to these early issues of bonding with the people in your life.

Dr. Sibcy is a licensed clinical psychologist and marriage and family therapist at Centra Health’s Piedmont Psychiatric Center. Dr. Clinton is professor of counseling and pastoral care and executive director of Liberty University’s Center for Counseling and Family Studies.

Psychotic symptoms, disorders and differential diagnosis

By Michael E. Judd, M.D., Adult Psychiatrist, Piedmont Psychiatric Center, and Gary Sibcy II, Ph.D., Licensed Clinical Psychologist, Marriage and Family Therapist, Piedmont Psychiatric Center

Editor’s Note: This is the last in a series about severe mental disorders.

Key issues in assessment of psychotic symptoms

When evaluating individuals with psychotic symptoms, several key issues need to be addressed. The first issue involves safety. The provider must ask the question, “Does this person pose a significant threat to himself or others?” If the patient is unable or unwilling to contract for safety, other measures are required (i.e. calling the police, etc.). It becomes very important to recognize that not every patient with psychotic symptoms requires hospitalization. The therapist is then put in a difficult position, as he or she must try to determine if someone is “safe” to leave the office. One has to balance the patient’s safety versus risking, and potentially destroying, any therapeutic alliance.

When in doubt, patient safety must come first. The patient should be detained until he or she can be appropriately transported to another facility for further evaluation and treatment. If a stable patient begins to exhibit mild psychotic symptoms, a referral can be made to a local psychiatrist or primary care provider for potential medication management.

Common Medication Treatments

As we have discussed, the primary treatment for the emergence of psychotic symptoms involves antipsychotic agents. At this time, atypical antipsychotic agents appear

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Dr. Sibcy

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to be the first line treatment for psychotic symptoms. These agents are felt to have a better side effect profile than older "typical" agents. Generally speaking, these newer agents are less likely to produce a number of side effects, most notably, extrapyramidal side effects or tardive dyskinesia. Atypical antipsychotic agents include: Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprasidone), Abilify (aripiprazole) and Clozaril (clozapine).

In addition to providing relief from psychotic symptoms, these agents also function as mood stabilizers.

While the "atypical" agents are felt to have a safer side effect profile, they are not without side effects. The primary problems, which generally speaking appear to be a class effect, involve weight gain and metabolic issues (diabetes, elevated cholesterol/triglycerides).

Older, "typical" antipsychotic agents are considered second line therapy. Examples of these agents include Haldol, Navane, Prolixin, Thorazine, Trilafon and Stelazine.

Patients with major depressive disorder who develop psychotic features are typically treated appropriately with antidepressant agents. The short-term use of antipsychotic agents also may be indicated.

Counseling and Psychotherapy: Key to Preventing Relapse

Counseling can be helpful for clients who have problems with reality testing and psychotic symptoms. One of the chief goals for working with such clients is to prevent relapse. There are many strategies for accomplishing this goal, but we believe two are most important.

First, we focus on helping clients remain compliant with their medications. This may be especially challenging for clients with bipolar disorder, who may actually enjoy their manic symptoms. It is also challenging for clients who believe that using medication is a sign of "lack of faith in God's healing power." We work to help these clients realize that taking antipsychotic medication does not imply a lack of faith.

We encourage clients to see that these medications can remove many barriers that make it difficult for them to enjoy and participate in healthy relationships. Just as we don't hesitate to tell people who suffer from physical ailments that it is important for them to take their medication, it is equally important that we encourage patients with severe mental illness to take their medications to manage their symptoms.

This strategy can be enhanced by using a specific type of cognitive-behavior therapy (acceptance/commitment therapy) designed for patients with psychotic disorders. It focuses on helping patients accept (which does not mean they have to like or want) their symptoms and simultaneously commit to seeking their goals and values.

Another important strategy for preventing relapse is helping patients establish more secure-based relationships in their family and other important relationships. Research shows that patients are more likely to relapse when their most important relationships are characterized by a high degree of expressed emotion.

Such families tend to be highly judgmental, hostile and emotionally overinvolved with family members. They are also more likely to make negative attributions about the client's mental illness, believing that symptoms are directly under the patient's control. Research indicates that when families are highly critical of the patient's symptoms and attribute them to personal deficits, patients are more likely to relapse.

It is also important to address some of the misconceptions that these families have about serious mental illness. This strategy can play a very important role in helping the family reduce hostile criticism and other forms of negative emotional expressions. Helping the family establish secure-based relationships involves not just decreasing the amount of negativity, but also increasing the level of warmth and acceptance.

Enhancing secure-based relationships in these families includes (1) assessing the degree of expressed emotion (using family emotional involvement and criticism scale), (2) teaching the family skills for recognizing their patterns of criticism and hostility, (3) how to use appropriate empathy and warmth and (4) how and when to use effective communication and problem-solving skills.

Finally, it is helpful to discuss with the patient the paradox of support-seeking for those with serious mental health problems. Research shows that when patients express too much distress and neediness, others either become critical or withdraw and avoid. On the other hand, when patients do not discuss or express their distress, others view them as not wanting any support or help. Consequently, in both circumstances, the patient is left feeling rejected and alone. This pattern can exacerbate symptoms and lead to relapse.

Alternatively, we help patients find a middle ground where they express their needs, but do so in a manner that does not overwhelm their caregivers or support figures. As they learn to express themselves more effectively and their caregivers learn to respond more sensitively, the patient is significantly less likely to relapse and more likely to comply with medication treatment.

* This article was published originally in *Christian Counseling Today*, 2005, Vol. 13, No. 2.

Eating disorders *continued from page 1*

and 20 are starving themselves, sometimes to death. It is far less common for a man to suffer from anorexia.

Symptoms of anorexia include:

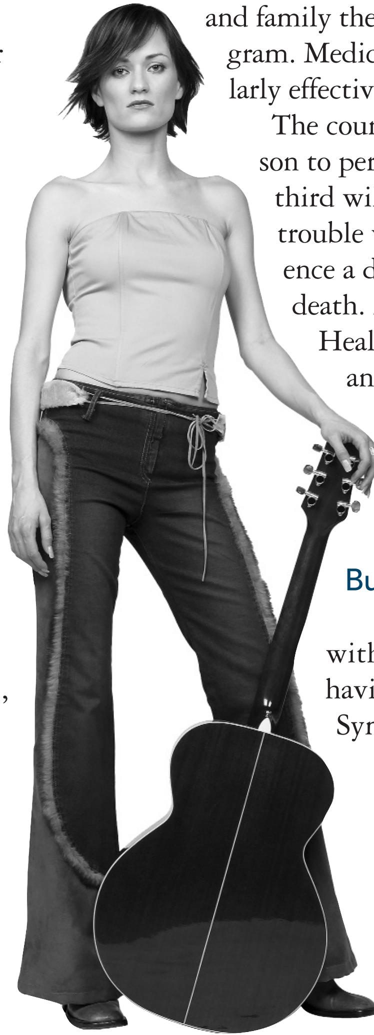
- Failure to maintain weight of more than 85 percent of the minimal weight considered healthy for age and height
- Intense fear of gaining weight or becoming fat, even if underweight
- Perceptual distortion in the way one sees oneself
- Denial of the seriousness of low body weight
- Infrequent or absence of menstrual periods in females past puberty

Two subtypes of anorexia are:

- Restricting (the primary means of anorexia is not eating much)
- Binge eating/purging (induced vomiting, excessive exercising, using laxatives, diuretics, enemas)

Depression, anxiety and obsessive compulsive behaviors generally co-occur with anorexia. One physical concern is osteoporosis.

Anorexics obsess about food. They eat vicariously: they collect recipes and cook for other people. Odd eating habits develop such as pushing food around on a plate, cutting meat into extremely small pieces, carefully weighing and portioning food. They hoard food—if they can't eat it, they save it. Their personalities become shell-like with no sense of self as they become weight managers only.



The greatest risk for anorexia falls within professions where thinness is emphasized.

People who develop anorexia are most often high achievers and live in highly functioning, stoic families that are part of higher economic groups.

No one sets out to be anorexic. A person may begin a diet, and at some point the focus on weight loss becomes out of control in the brain. Anorexics look in a mirror and see themselves as overweight even though they are dangerously thin. In addition to the deception and self-denial, anorexics develop a host of somatic complaints such as weakness, dizziness and nausea.

Treatment of anorexia is a long and difficult process, primarily because of the denial and resistance that accompany the disorder. Multidisciplinary treatment in specialized inpatient programs is the most effective. Individual and family therapy are also a part of the treatment program. Medications have not been found to be particularly effective in the treatment of anorexia.

The course and outcome of anorexia vary from person to person. Approximately a third will recover, a third will continue to have a moderate amount of trouble with weight and another third will experience a deteriorating illness up to and including death. According to the National Institutes for Health, the mortality rate among people with anorexia has been estimated at approximately 5.6 percent per decade, which is approximately 12 times higher than the annual death rate due to all causes of death among females ages 15 to 24.

Bulimia

Bulimia is more common than anorexia, with approximately 2 to 3 percent of females having bulimia nervosa in their lifetime.

Symptoms include:

- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a feeling of lack of control over that episode
- Inappropriate compensatory behavior to prevent weight gain such as self-induced vomiting or misuse of laxatives, diuretics, enemas, fasting or excessive exercise

These behaviors occur at least twice a week for three months.

People with bulimia usually are within a normal weight range or may be slightly under or overweight, hence the signs of bulimia are not readily obvious. Physical symptoms can include "chipmunk" cheeks, erosion of dental enamel and scars or calluses on the backs of fingers from induced vomiting. Like people with anorexia, bulimics feel intensely dissatisfied with their bodies and want to lose weight. They perform their behaviors in secret and are ashamed of the purging, but the process is cathartic and gives them a release from their stressors. Binging may be accompanied by a sense of a lack of control, a frenzied state or feelings of dissociation. Triggers include interpersonal stress, intense hunger or a dysphoric mood.

While anorexia can occur prior to puberty, binge

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Terry Wise offers hope in personal story of recovery

When Terry Wise swallowed 200 Percocets, 60 doses of morphine and a pint of gin, she didn't expect to wake up. Clinically depressed after the death of her husband from Lou Gehrig's Disease (ALS), Wise was a 35-year-old widow who wanted to die.

Her husband had been diagnosed with the untreatable neurological disease three weeks prior to their wedding. For the next four years, Wise cared for the man whose mind became trapped inside a paralyzed body, until the disease took his life. A year later, Wise tried to take her own.

Somehow, Wise survived her suicide attempt. Unconscious for almost two days, she was found by a friend who brought her to an emergency department near her Massachusetts home. Hospital physicians ran tests, but never a toxicity screen. A spot on an X-ray of her lung led a resident to believe untreated pneumonia had caused her to have near-liver failure. Filled with shame, fear and guilt, Wise kept the real reason a secret. Her survival, without brain or organ damage, remains a medical mystery.

"I take full responsibility for what I did," said Wise. "I do not tell this story for sympathy. I tell it to highlight how easy it is for people to miss the signs of clinical depression and being suicidal."

After her release from the hospital, and still suffering from depression, Wise spent the next two years in therapy with Betsy Glaser, Ph.D., a clinical psychologist in Massachusetts, who Wise calls "devoted, talented, and most of all, compassionate."

Terry Wise, J.D.

Wise said, "I originally thought that the reason I was suicidal was because my husband died. There is no question that losing him was an enormous part of the equation. But I learned that my suicide attempt wasn't completely the result of his death, but the consequences of full-time caregiving and contributing factors that went back to my childhood."

Originally refusing to discuss anything that predated her husband's diagnosis, she told Glaser, "I am a 35-year-old widow, and that's why I am depressed—end of story."

But that was only the beginning of the story, not the end. Her husband's death was the catalyst that brought a number of past experiences to the forefront, including childhood sexual abuse and exposure to domestic violence.

"I learned that many times there is more than one reason for depression or a suicide attempt," Wise said. "When you experience a significant or premature loss, all of the traumatic experiences that have been on simmer can come to a full boil. There were a lot of pieces of the psychological puzzle that had to be put together to understand why I felt the way I did."

When Wise completed therapy, she wrote a book about recovering from depression. In *Waking Up: Climbing Through the Darkness*, she gives a rarely heard perspective of

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Suicide Prevention Coalition of Central Virginia

Established in 1999 to address the issue of suicide in central Virginia, the Suicide Prevention Coalition continues to fulfill its goals and make a difference in the community.

The annual conference in October, featuring Terry Wise, helped train mental health professionals and educate the general public about the importance of seeking help for depression and other disorders that can lead to suicide.

Recognizing that suicide is a significant community health problem with a devastating impact on families and communities, the coalition's mission is to reduce the occurrence of suicide and support families surviving suicide through community education and to enhance clinical knowledge and skill in the treatment of suicidal persons.

Activities include an annual conference, media outreach and referral to support groups and other resources.

The coalition is made up of volunteers from public and private mental health agencies, psychiatric services and crisis intervention, law enforcement, public and private education, faith-based organizations and local government.

For more information, visit www.suicidepreventioncoalition.org.

Terry Wise continued from page 5

the patient through the dialogue of patient and practitioner. Her story explores a range of issues underlying depression, including loss, child abuse and a candid look into suicide. After the director of clinical psychology at Columbia University reviewed the book, he asked her to speak to his class. Other speaking engagements followed, and before long, she had embarked on a full-time speaking career, traveling nationwide over the past 2 1/2 years.

Wise has given presentations in 55 cities this year alone, one of which was to the Suicide Prevention Coalition's annual conference in October in Lynchburg. In her presentations, she speaks about her personal experiences and how she recovered. Her primary message is one of hope—hope to patients and their loved ones who need to feel better and hope to clinicians who need to feel that the therapeutic process can make a difference.

"I try to answer the most frequently unasked questions," Wise said. "People want to know what did it feel like to wake up, was I relieved to be alive, why didn't I tell anyone I was suicidal, was there something that could have been done to prevent my suicide attempt, what gave me hope and the will to live.

"By answering these questions—and others—I can provide hope," she said. "For myself, every time I help someone find a better quality of life, it feels like a gift."

For more information about suicide prevention, visit www.suicidepreventioncoalition.org. For additional information about Terry Wise, visit www.terrywise.com.

Eating continued from page 5

eating usually comes later in life, and often occurs in adulthood. The opposite of anorexics, people with bulimia are outgoing, entertaining, colorful and sexually active. Self-destructive relationships, substance abuse and misdemeanors such as shoplifting are common. The families of bulimics are generally outspoken, less close and more conflictual.

Mood, impulse, bipolar and dissociative disorders, as well as a history of sexual abuse, are associated with bulimia. The primary physical problem—and most deadly—is that purging leads to electrolyte imbalances, which can cause sudden cardiac arrest.

Bulimics do not want to be binging and purging, and are more receptive to help. But although they are less resistant to therapy, the course of treatment can be stormy and prolonged. Serotonin-type antidepressants are somewhat successful in preventing binging and purging. However, cognitive behavioral, group, individual and family therapy are the mainstays of treatment.

Eating disorder not otherwise specified

Eating disorders that do not meet all the criteria for bulimia or anorexia but include some of the symptoms are:

- Purging without binging
- Repeatedly chewing and spitting out, but not swallowing large amounts of food
- Binge eating without purging

In summary, unlike other psychiatric disorders, there is no gold standard treatment for eating disorders. Because people with these disorders do not recognize or will not admit they are ill, their resistance often makes treatment difficult. Recovery takes a long time, but is possible with comprehensive treatment.

Mental Health Matters

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