Christian Servanthood 2

Week Six - Recognizing Emotional Disorders

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Introduction

The goal of this discussion is to help you learn to recognize symptoms of emotional disorders which could indicate that someone needs professional help. Hopefully, by the end of tonight you'll be able to identify individuals who need referred to a psychiatrist, or a mental health clinic.

I don't expect you all to become diagnosticians tonight, but it is helpful to be able to think of symptoms in clusters which make up a diagnosis. In the field of psychiatry, we have the Diagnostic and Statistical Manual of Mental Disorders or DSM IV. This is the Bible of Psychiatry and includes descriptive classifications of symptoms or clinical features of emotional disorders. It does not, however include any information on etiology or treatment.

Tonight we're going to discuss six diagnostic categories and how to recognize if someone has an emotional disorder:

- Affective Disorders (Unipolar and Bipolar)
- Schizophrenia (psychosis)
- Anxiety Disorders (Panic Disorder, Agoraphobia, OCD)
- Personality Disorders
- Substance Abuse Disorders
- Eating Disorders

Affective Disorders

There are a number of different types of affective disorders, or mood disorders. There are two Major Affective Disorders:

1. Major Depression
2. Bipolar Disorder.

These are called "Major" because of their severity.

1. **Major Depression**

In order to merit this diagnosis, a person must have at least five of the following symptoms nearly every day for at least two weeks:

- Sad mood
- Tearfulness,
- Psychomotor retardation
- Decreased energy
- Diminished interest or pleasure
- Insomnia
- Poor appetite
- Weight loss
- Poor concentration
- Feelings of worthlessness
- Hopelessness or excessive guilt
- Suicidal ideation

This is the most common type of major depression. However, there is also an atypical type of major depression in which an individual experiences increased sleep and appetite, rather than decreased.

Dysthymic Disorder

If a person has experienced a depressed mood more days than not for the past two years and has at least two of the previously mentioned symptoms, they likely have what is called a Dysthymic Disorder.

This is a chronic low level depression and is not considered a Major Affective disorder, and yet people with a dysthymic disorder may benefit from anti-depressant medication.

Both of the above disorders are considered Unipolar mood disorders because there is only one direction the mood tends to swing to.

2. **Bipolar Disorder**

The other type of Major Affective Disorder is called Bipolar Disorder because the person's mood tends to swing in two directions.

Major Depression and Bipolar Disorder are differentiated by whether or not an individual has ever had a manic episode. The person with a major depressive illness has recurrent depressive episodes through out their life, whereas the Bipolar patient (or Manic Depressive as they once were called) have periodic depressive episodes and have had at least one manic episode in their lifetime.

How does one determine if someone is currently having, or has previously had, a manic episode?

Definition of a Manic Episode: One or more distinct periods, (few days-weeks), with a predominately elevated, explosive or irritable mood, and at least three of the following symptoms:

- Increase in activity or physical restlessness
- More talkative—difficult to interrupt
- Jumping from one topic to another very rapidly (flight of ideas or loose associations)
- Inflated self-esteem, (delusions of grandure)
- Decreased need for sleep, (can stay up for 3-4 nights cleaning etc.)
- Easily distracted
- Excessive involvement in activities with a high potential for painful consequences—like buying sprees, foolish business investments, or sexual indiscretions, etc.

These individuals may even become psychotic during a manic episode. In other words, they may lose touch with reality. They may hallucinate, or experience delusions.

Definition of a delusion: a "fixed false belief which no amount of objective evidence will change."

Schizophrenic Disorders

These individuals are usually quite ill. This is considered a psychotic disorder--they are out of touch with reality. They experience delusions and or hallucinations. We have already discussed delusions.

Definition of a Hallucination: a false sensory perception in the absence of any external stimuli, not merely a misinterpretation of something that is really there, (i.e. not an illusion).

The most common type of hallucination is an auditory hallucination. My first patient came to Harding Hospital with newspaper stuck in her ears in an attempt to lessen the voices she was hearing. To be considered true auditory hallucinations, these voices must be experienced as coming from out in the room, not just from inside one's head.

In addition to delusions or hallucinations, these individuals (with schizophrenic disorders) are typified by disorders of thinking. Their thinking is often not linear – it doesn't follow a logical flow.

Someone once said that being schizophrenic is like dreaming while you're awake. In a dream you may be on the way to the airport and you end up at the zoo and you run into a friend from

work, who you later realize is actually your sister. There is no logical flow to their thought pattern.

In talking with someone who is actively schizophrenic, you may find it very hard to follow them and you may end up thinking "Either they are crazy or I am." This is called *derailment*—where their thinking gets off track. They exhibit what is called loose associations or flight of ideas.

Anxiety Disorders

The predominant symptom in this group of disorders is obviously anxiety. These folks are considered neurotic, not psychotic because they are in touch with reality.

This category includes Panic Disorders with or without Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, PTSD, and Generalized Anxiety Disorder.

Panic Disorders consist of sudden distinct episodes of extreme anxiety which include four or more of the following symptoms:

- Shortness of breath, heart palpitations, chest pain, dizziness, sweating , shaking, or a fear of loosing control or dying
- These individuals may also have agoraphobia and are afraid to leave their homes. Agoraphobia means literally fear of open spaces. These people often find it very difficult to be in a crowd. For example, they may get overwhelmed and experience a panic attack in a grocery store.

Obsessive Compulsive Disorder is characterized by recurrent obsessions or intrusive, unwanted thoughts, or compulsions, which are repetitive behaviors or mental acts which the person feels driven to perform in response to and obsession or according to certain rules or rituals.

The individual realizes these thoughts or actions are abnormal or excessive, but is unable to control them. They are a significant source of distress to the individual or interfere with social functioning. In other words, these are more than merely excessive worries about real life problems.

Examples of OCD include people who are obsessed with contamination and therefore feel compelled to wash their hands 50 times a day, or shower 2 or 3 times daily. Jack Nicholson did an excellent job of portraying OCD in the movie, “As Good As It Gets.”

People with OCD may be obsessed with symmetry, like the main character in “Sleeping with the Enemy.” They tend to organize their spices, socks, etc. and feel the need to keep the towels perfectly straight.

Some folks with OCD feel compelled to count, hoard, or check things over, and over, and over again.

Generalized Anxiety Disorder is the most common anxiety disorder. Symptoms include excessive worry that interferes with daily functioning, and at least 3 of the following:

- Muscle tension, insomnia, poor concentration, feeling restless or keyed-up, irritability, or fatigue

This disorder is more common in women and often occurs in people who also suffer from depression.

Personality Disorders

We all have certain personality traits that we have developed over the years. These are enduring, ingrained patterns of perceiving and relating to the environment and ourselves. When these personality traits become inflexible and maladaptive and cause either significant impairment in social or occupational functioning, they constitute a personality disorder.

Examples include: Narcissistic, Paranoid, Avoidant, Dependent, Anti-social, Histrionic, Schizoid, Passive-Aggressive, and Borderline Personality Disorder.

These people are very difficult to relate to and can be the most abrasive human beings. They often alienate people and become caught in a cycle of fragile relationships, which they periodically shatter because of their behavior. They often do not view themselves as being at fault, and therefore don't consider that they themselves need to change. They often have very rigid strategies for coping with people or situations, and therefore have difficulty assimilating healthy, biblical methods of responding to situations.

They may be so fearful of rejection that they cling on so tightly to a person that they end up pushing the person away. They set themselves up over and over again in relationship after relationship with the same self-defeating paradigm.

They also often misconstrue essentially benign events. For example, if you bring a friend to a party at their house, they assume it was because you didn't want to talk to them. They are supersensitive to rejection or being slighted in any way.

Substance Abuse

The important point here is to determine if a person abusing drugs or alcohol merely needs to be admonished in order to overcome their problem, or if their abuse is serious enough to merit treatment in a chemical dependency program of some sort.

It is important to determine the severity of their abuse, because abruptly stopping the drug or alcohol could cause withdrawal seizures. Some individuals require inpatient detox or a 30-day inpatient drug rehab program in order to safely come off the substance they were abusing.

A pattern of pathologic use involves intoxication throughout the day, the inability to stop or cut down, or blackouts.

The difference between alcohol or substance abuse verses dependence is that someone has become dependent if he has developed tolerance or withdrawal symptoms. Tolerance is the need for markedly increased amounts of the substance to achieve intoxication. Withdrawal symptoms include tremor, nausea, agitation and seizures.

It is also important to determine if he has had to miss work because of his abuse, and if he has had any legal problems, such as an OMVI.

Eating Disorders

ANOREXIA

- Intense fear of getting fat
- Disturbance of body image—think they are fat even when thin
- Weight loss of at least 25% of original body weight
- Refusal to maintain body weight over a minimal normal weight for age and height
- No known physical illness that would account for weight loss
- Amenorrhea--lose menstrual cycle

BULIMIA

- Recurrent episodes of binge eating—rapid consumption of large amounts of food in a discrete period of time, and a sense of lack of control over-eating, or often eat in secret
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, fasting or excessive exercise
- The binge eating and compensatory behavior both occur at least twice a week for 3 months
- Preoccupation with weight and shape
- Not due to any physical disorder

For example, if you're living in a ministry house and you notice food continues to disappear, you may have a bulimic living among you. You will need to directly confront them about their bingeing and purging, since secrecy is paramount to the bulimic and openness is key to their recovery.

Attention Deficit Disorder

This disorder has a number of symptoms which overlap with Bipolar Disorder, but the symptoms are not episodic in ADD but are consistent from day to day.

Symptoms include: poor concentration, distractibility, tendency not to finish projects, easily bored, impatience, tendency toward addictive behavior, poor listening, and the tendency to drift away in the middle of a page or conversation.

In addition to ADD, there is also Attention Deficit Disorder with Hyperactivity which includes hyperactivity as a core symptom. In order to be diagnosed with ADD, the symptoms must have begun in childhood. This disorder does not begin in adulthood.

When to refer

The RED FLAGS to look for in discerning if someone needs professional help are:

1. suicidal ideation…
2. out of touch with reality (psychosis)
3. OCD
4. severe depression with changes in sleep, energy, appetite, and motivation
5. Addiction to (dependence on) substance
6. physical causes of depression or anxiety which require an evaluation by an internist

Let's look at some of these in more detail

1. **SUICIDAL IDEATION**

This must be asked directly if you suspect someone may have thoughts about hurting themselves. It's important to get them to verbalize these thoughts, since they are less likely to act on them if they talk about it. Ask them if they have thought of a plan. Also ask them if they've ever had these thoughts before or ever made a suicide attempt in the past.

If they say "I wish I were dead", this is not taken nearly as seriously as if they say I'm thinking about taking an overdose. If they have a plan it must be taken seriously and you should take them to NetCare, Riverside Emergency Room, or a Community Mental Health Center.

2. **NEED FOR MEDICATION**

If an individual is psychotic, significantly depressed, or experiencing O.C.D., they ought to be referred for an evaluation by a psychiatrist in order to determine if they need medication. Individuals with symptoms of Major Depression, Bipolar Disorder, and in some cases Dysthymic Disorder will likely need anti-depressant medication.

Also people with O.C.D., Panic Disorder with or without agoraphobia, or other anxiety disorders such as trichotillomania (hair pulling), may benefit from an anti-depressant or an anti-anxiety medication.

Obviously those with a schizophrenic illness will need an anti-psychotic.

There has been some recent evidence to suggest that eating disorders may benefit from medication, but group therapy can be quite helpful for these folks. If someone with an eating disorder also has a mood disorder they may benefit from an anti-depressant.

Unfortunately, medication doesn't seem to help people with a personality disorder. However if someone with a personality disorder also happens to be depressed, then an anti-depressant may be helpful. They used to say the only effective treatment for someone with a borderline personality disorder was weekly psychotherapy for a minimum of 5 years. I think therapy can help these individuals but personal sanctification is probably their best bet.

Many people are reluctant to take medication because of the cultural stigma attached to it. They fear it will imply that they are "crazy." However, if someone has gotten depressed, medication can correct an imbalance in their neuro-chemistry and restore normal functioning.

Medication alone is not always sufficient, but individual and/or marital therapy in combination with medication is very often helpful. Most research shows that the combination of medication and therapy provides the best chance for recovery.

People often need to have their thinking or perspective brought in line with God's truth in order to help prevent future recurrence of problems.

3. **NEED HOSPITALIZATION**

If suicidal or homicidal they need to be admitted. These days that is about the only way to get someone admitted to the hospital. If they are psychotic and unable to care for themselves then they may also be admitted.

4. **NEED FOR DETOX**

If they are dependent on drugs or alcohol they may need to be hospitalized in order to be detoxed. This is because if someone who is dependent on alcohol stops drinking cold turkey they are at risk for withdrawal seizures. In the hospital their vital signs can be monitored closely and they can be administered medication which can prevent withdrawal seizures.

5. **NEED FOR SPECIFIC PSYCHOTHERAPY**

I believe that the most Biblical type of psychotherapy is probably cognitive behavioral therapy. This type of therapy attempts to identify wrong thinking and replace it with the truth. This is particularly good therapy for OCD, social anxiety disorder and phobias. The Center for Cognitive Behavioral Therapy is on Bethel road.

6. **NEED FOR REFERRAL TO AN INTERNIST**

It is always important to rule out any physical causes for depression or anxiety. If someone is fatigued and unmotivated they may actually be anemic, or hypothyroid. If someone's thyroid is too high they may appear anxious. Blood work can identify these physical causes.

Conclusion

So in conclusion, it is helpful to look at hurting people in terms of these types of symptoms. If you suspect someone is depressed, for example, you may want to inquire about their sleep and

eating patterns. It is also crucial that you directly ask if they have had any thoughts about hurting themselves. If so, do they have a plan?

If someone becomes delusional or begins hearing voices, you would want them evaluated as soon as possible. Particularly if they are experiencing command hallucination which are telling them to hurt themselves.

In my opinion, it is always better to error on the safe side. In other words, I take it seriously when someone mentions suicide and will try and draw them out and find out what they are thinking. If they have a plan, I think it is best to get them in to see a professional right away. Professionals have been trained to determine lethality, and it should be up to them to decide if someone needs to be hospitalized, not you. You should also give a written report to the Xenos office of the event and what you did in response.

Your job as leaders/workers is to get them to see a professional. As I mentioned earlier, you can take them to OSU or Riverside ER, or a Community Mental Health Center such as North Central at 1301 High St. just south of campus. You can also contact Netcare which has a 24 hour psychiatric emergency services at 276-2273, or call OSU at 293-9600.

I occasionally refer people to Dr. Larry Pfahler, who is a Christian psychiatrist at Alpha Psychiatric Care in Worthington. Other Christian counseling resources include Cornerstone Psychological Services at 1601 Bethel Rd. (459-3003) or Wellspring Counseling (792-2340).

Any questions?

Assignment Due Next Week

Study passages related to conflict/unity (make sure you pick up the handout) and distill the principles in each.

Memory Verses

None this week

Key Points to Know for Exam

1. You should know the “red flags” that indicate someone should be referred for professional help.