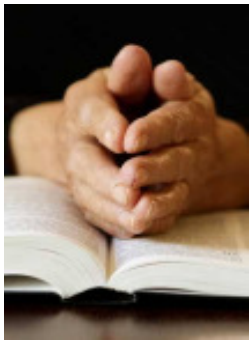
DBSA-CA NEWS

Depression and Bipolar Support Alliance–California
(formerly California Depressive and Manic-Depressive Association)

Volume 15, No 3 Summer 2010

Religion and Spirituality in Psychiatry



edited by Philippe Huguelet and Harold G. Koenig.
New York,
Cambridge University Press, 2009, 384pp., $99.00.
Marc Galanter, MD
New York, N.Y.

This book, which is carefully conceived and well referenced, does justice to its title. But you may ask, how relevant, really, is the issue of religion and spirituality to the practice of psychiatry? Does it have a place in a discipline that is increasingly evidence based and oriented toward biologically grounded research?

In answering this question, you might consider where many patients actually turn for help with their medical problems. The surprisingly high prevalence of alternative medical techniques that people prefer, ones often grounded in religion and spirituality traditions, became clear in data from a national probability survey (1) and subsequent related studies. One-third of all adults had used these unconventional approaches in the previous year, and prayer was principal among those chosen. In fact, one-quarter of the respondents suffering from anxiety or depression had opted for alternative medical approaches-—more than the proportion that turned to professionals for help. Such people often do not report this to psychiatric caregivers, if indeed they seek conventional treatment at all, and insurers are increasingly looking to alternative and complementary techniques to provide interventions that may be less expensive than our evidence-based therapies.

Given the advances we've seen in contemporary science, one might think that there would be a decline in people's spiritual orientations relative to scientific findings. But actually, the opposite may be the case. Since the l960s, when less than a quarter of people surveyed reported having had religious or mystical experiences, they now constitute the majority (2). At the same time, belief in God or a higher power—typically a deity who plays an active role in people's lives—continues to be espoused by at least 90% of the population.

Is the coming generation of psychiatrists attentive to this issue, which apparently is influential in the emotional lives of many patients? In surveys we have conducted, psychiatric residents underestimate by far the importance that patients lend to religion and spirituality in coping with illness (3). Furthermore, when our own residents are asked to present a case related to religion or spirituality, almost without exception they present a patient suffering from religion-related delusions, rather than positive, meaningful experiences. These views are consistent with many of their psychiatric faculty and also with the way religious issues are represented in DSM. This bias against seeing religion and spirituality as a meaningful part of patients' emotional lives

*Continued on page 2(***Religion** **)**

RELIGION*(Continued from pg. 1)*

is bolstered as well by reading our principal academic journals, which are oriented toward a methodology of experimental controls and statistical modeling, quite at variance with an openness to the subjective and idiosyncratic beliefs patients may espouse. A paucity of religion and spirituality-related research also derives from the fact that many of the research paradigms relevant to understanding the intensity of people's beliefs lie more in the social-psychological and anthropological domains. Contemporary psychiatric research rarely deals with such issues.

Perhaps, then, psychiatrists should read this book. It draws together a diversity of topics that illustrate clearly how religion and spirituality are pertinent to psychiatrists. One chapter, for example, on neuropsychiatric issues, reviews recent literature on the relationship between specific neurotransmitters and spiritual and meditative experiences. In associating this literature with genetic correlates of these experiences, the author posits a heuristically useful model for the relationship between physiologic systems and the nature of spiritual and religious practices. This illustrates both the breadth of emerging findings in this research area and opportunities to expand on it.

From an entirely different perspective, another chapter discusses the issue of self-identity as it relates to spiritual experiences. It draws on a wide variety of psychoanalytic writers, from a mystically related Jungian perspective to a developmental model drawn from John Bowlby to the clinical psychoanalytic work of Ana-Maria Ri.zzuto. Case examples given here are illustrative of the value of understanding how religion and spirituality can bear on the practice of dynamically oriented psychotherapy.

Harold Koenig, a coeditor of the book, offers a chapter on how religion and spirituality issues can play a role in the work of a consultation-liaison psychiatrist. The topics discussed here and elsewhere in the book illustrate well how the clinician in such a setting needs to be very attentive to religion and spirituality in relation to patients in cases where anxiety and depression are generated in coping with medical illness. A broad array of medical problems, from dealing with pain to the treatment of substance abuse, are discussed as well.

Chapters like these make the relevance of religion and spirituality to the work of a practicing psychiatrist clearer, and they underline the value of introducing it more actively into psychiatric training. To this end, one chapter offers two examples of four questions that can be used in psychiatric assessment, as well as a longer list of topics that can be addressed. In our experience, religion and spirituality have often been thought to be of marginal importance in patient assessment on teaching units and often relegated to a social worker's evaluation. So we ask residents to pose only one question to all their patients: "Spirituality can be important to people. Does spirituality help you deal with your problems?" The residents are typically quite surprised by the positive

Continued on Page 3 **(Religion)**

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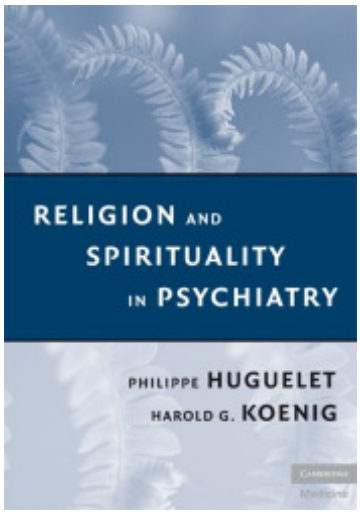
RELIGION*(Continued from pg. 2)*

responses they receive. We have also introduced resident-run spirituality groups on our training units, in parallel with conventional ones.

Although this book is quite comprehensive, not all aspects of religion and spirituality can be addressed in the depth they might deserve. Sociobiologic research, for example,could be covered, as it has given us models for the cognitive and affiliative underpinnings of religiosity, particularly in relation to altruistic commitments. Buddhist approaches could be dealt with in more depth. Religious orientations out of the mainstream, like Christian Science, Mormonism, even Santeria, would illustrate how clinicians may encounter traditions unfamiliar to them and their colleagues.

Some problematic areas in the religion and spirituality domain also merit attention (the book is, in essence, pro-religion and spirituality): highly religious psychiatrists may sometimes miss out on salient clinical problems because they overemphasize religious commitment with their patients (APA has a position statement on this). Religious movements may be cultic or even destructive—plenty in the news on this—and a clinician may be asked to consult to a family or even to the press on this topic. Overall, however, the authors in this volume illustrate in an excellent manner the value and depth of an issue that deserves more attention from our profession than it currently receives.



Footnotes

The author reports no financial relationships with commercial interests.

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1. Eisenberg DM, Kessler RC, Foster C. Norlock FE, Calkins DR. Delbanco TL: Unconventional medicine in the United States: prevalence, costs, and patterns of use. N EngI J Med 1993: 328:246—252 ~Abstract/Free Full Text I

2. The Pew Forum on Religion and Public Life: Many Americans Mix Multiple Faiths, 2009. http://pewforum.org/Other-Beliefs-and-Practices/Many-Americans-Mix-Multiple-Faiths.aspx

3. Galanter M, Dermatis H, Talbot N, McMahon C, Alexander MJ: Introducing spirituality into psychiatric care. Religion and Health 2009 (Epub ahead of print, Sept 1,2009)

Source: Am J Psychiatry July 2010

VA eases rules for stress aid

War-zone vets no longer have to submit evidence to receive benefits or treatment.

Katherine Skiba Reporting from Washington

President Obama, saying that post-traumatic stress is one of two "signature irijuries" of today's wars, announced Saturday that new policies will soon take effect to make it easier for war-zone veterans with the disorder to receive disability benefits.

The president previewed the changes at the Veterans Affairs Department in his weekly address. He said traumatic brain injuries also beset today's veterans and that too few of them "receive the screening and treatment they need" for both conditions.

In the past, veterans were often stymied by a requirement to produce evidence that a specific event triggered their stress disorder. That's kept those who served in noncombat roles in war-zones from getting the care they need, he said.

Post-traumatic stress disorder is an anxiety dlsorder that can surface after traumatic events and leave patients feeling scared, confused or angry, according to the VA's National Center for PTSD. They may experience flashbacks, become suddenly angry, have a hard time sleeping or concentrating and develop problems involving relationships, employment and alcohol or drug use.

Rep. John Hall (D-N.Y.), who championed the changes, said veterans had been required to produce incident reports, buddy statements, medals or other corroboration to prove they experienced trauma.

Hall, whose district includes West Point and who chairs a House Veterans Affairs subcommittee on disability assistance, told of a World War II veteran who was on ships that sank in the Pacific and was rescued in both instances. "Like a bad 'Twilight Zone' episode, there were body parts and sharks going by him," the lawmaker said. But when the man sought help during the 1970s, the VA initially dismissed him as having a pre-existing condition, schizophrenia. He now is receiving disability checks, Hall said.

Hall said the new policy will presume there is a service-related connection when a combat-zone veteran suffers from the stress disorder.

More than 400,000 veterans now receive compensation benefits for service-related post-traumatic stress disorder, VA officials said. Officials declined to say how many people might be affected by the new regulation.

In an April 2008 study, the RAND Corp. found that nearly 20% of service members returning from Iraq and Afghanistan — 300,000 in all — reported symptoms of post-traumatic stress or major depression, but only slightly more than half had sought treatment.

The study says these cases of post-traumatic-stress and

Continued on Page 4 **(VA Eases Rules)**

VA EASES RULES*(Continued from pg. 3)*

depression would cost the nation as much as $6.2 billion in the two years after deployments for costs associated with medical care, lost productivity and suicide.

An analysis by the Chicago Tribune published last spring found that overall disability payments to veterans from all wars reached $34.3 billion in 2009, a 76% increase since 2003.

Veterans of recent U.S.-declared wars on terrorism received $329 million in disàbility payments in 2009 related to mentaL disorders, including post-traumatic stress, which is 34% of all disability payments to vets from this period, the newspaper found.

Officials said the changes would be published Monday in the Federal Register and take effect immediately. The new regulation will also make it easier for veterans to receive treatment for post-traumatic stress.

Joe Davis, a spokesman for the Veterans of Foreign Wars, said Saturday that the changewas "a very good step forward." But the VFW favored a more expansive bill introduced by Hall that would have also accepted diagnoses from private sector mental health professionals, not just those at the VA.

"The VA mental-health professionals, as good as they are, are understaffed and overtasked," Davis said.

Still, Davis saluted the VA for "acknowledging that we've got a lot of troops fighting in a war without front lines. Whether you saw it upfront as an infantryman or you were a truck driver or you were working in a medical unit in the rear or, unfortunately, you were sitting in a chow hall when a suicide bomber let go, you were impacted?'

Source: Los Angeles Times
July 11, 2010

New Findings on Heritability of PTSD

By Rick Nauert PhD Senior News Editor
Reviewed by John M. Grohol, Psy.D.

Improved appreciation of the mental and physical effects of trauma has led to the clinical diagnosis of post-traumatic stress disorder. Emerging research on PTSD seeks to discover if genetic factors may contribute to developing the condition.

One factor that appears to contribute to the heritable vulnerability to PTSD is a variation in the gene that codes for the serotonin transporter, also known as the serotonin uptake site.

Having a shorter version of the serotonin transporter gene appears to increase one's risk for depression and PTSD after exposure to extremely stressful situations.

This same gene variant increases the activation of an emotion control center in the brain, the amygdala. More recently, scientists began focusing on factors contributing to resilience to the impact of stress exposure.

Could the same gene that contributes to the vulnerability to PTSD be implicated in the recovery from PTSD?

In their new study appearing in *Biological Psychiatry,* Dr. Richard Bryant and colleagues assessed whether serotonin transporter genotype predicted a change in patients' PTSD severity following treatment.

Specifically, patients with PTSD were classified according to their genotype, and they received eight weeks of cognitive behavioral therapy.

Approximately one third of patients do not respond to this treatment, and this study has now demonstrated that there may be a genetic basis for not responding to this therapy.

Dr. Bryant explained: "Patients with PTSD who carried the short alley of the serotonin transporter gene promoter responded more poorly to treatment than other PTSD patients. This study highlights that the serotonin system is implicated in responding to cognitive behavior therapy."

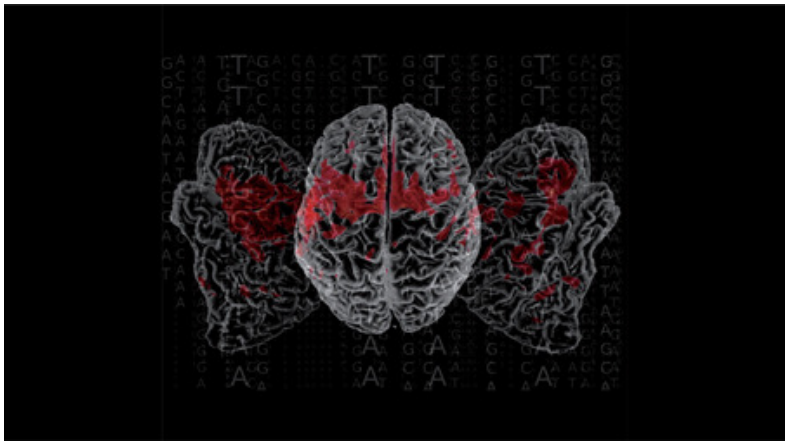
The recent focus on personalized medicine has emphasized the impact of variation in genes that influence the responses to medications. This study supports the reasoning that genetic variation would also influence the response to psychotherapeutic or rehabilitative treatments.

Dr. John Krystal, editor of *Biological Psychiatry,* noted, "While this study identifies a potential predictor of poor treatment response, it also may help to identify groups of individuals who respond relatively favorably to treatment.

"It is interesting this 'good outcome' group is a group that is also more resilient, i.e., less likely to develop PTSD or depression, after stress."

Although further research is necessary, this initial finding indicates that PTSD treatments may need to be modified to accommodate patients' genetic profiles.

Source: Elsevier
As seen in: VA Watchdog dot Org
June 18, 2010



Serotonin Transporters

Test for Genetic Risk of Bipolar

A genetic test for bipolar disorder is on the horizon say researchers from Indiana University School of Medicine.

The scientists published a "prototype" for laboratory testing in the online edition of the *American Journal of Medical Genetics Part B: Neuropsychiatric Genetics.*

"This is an important advance in the development of a prototype for lab tests for bipolar disorder, and can serve as a model for developing tests in other complex disorders," said lead author Alexander B. Niculescu III, M.D., Ph.D.

Dr.. Niculescu and colleagues used two different populations from large scale genetic studies and compared those individuals' genes to a small panel of 56 genes implicated in bipolar disorder by their work, to predict who has a predisposition to the disease.

"The coupling of a high score with certain environmental factors may be a predictor, not a certainty, that the individual will develop bipolar disorder" said Dr.. Niculescu, who also is a staff psychiatrist at the Indianapolis Roudebush VA Medical Center.

"Genes explain a small portion of the risk of developing the illness," said Dr.. Niculescu.

"Unlike some genetic predisposition to diseases like Huntington's or cystic fibrosis, the variances in genes that can predispose people to mood disorders are found in all of us. What we are learning is that it may take a combination of factors - too many gene variances in the wrong environment and you are at higher risk."

The predictive value of the genetic risk factors could be useful in screening before the disorder manifests itself clinically, and the implementation of interventions to lower stress, adjust regular sleep hours and other life style factors that could serve as an environmental deterrent for developing bipolar disorder.

Closerfollow-up and earlier therapeutic intervention may be useful for individuals who are a higher risk.

Authors on the study include Sagar D. Patel, Dr.. Helen Le-Niculescu, Dr.. Daniel Koller, Stephen D. Green, Dr.. Debomoy K. Lahiri, Dr.. Francis J. McMahon and Dr.. John I. Numberger, Jr.

The research was funded by the Veterans Administration as well as the National Institute of Mental Health.

In a corresponding editorial in the *American Journal of Medical Genetics,* Dr.. Alexander B. Niculescu and Dr.. Helen Le-Niculescu advocate for a more efficient way to identify genes involved with mental disorders.

Source: DBSA TAMPA BAY NEWSLETTEER May-August 2010

More mental disorders treated with drugs only

By Amy Norton

NEW YORK Thu Aug 19, 2010 11:14am EDT

NEW YORK (Reuters Health) - More Americans with psychiatric conditions are being treated with drugs alone compared with a decade ago, while "talk therapy" — either by itself or in combination with medication — is on the decline, a new study finds.

The implications of the trend, as well as its underlying causes, are not fully clear, according to researchers. But they say the findings indicate that outpatient mental health care in the U.S. is being redefined.

The results, reported in the American Journal of Psychiatry, are based on data from two government health surveys conducted in 1998 and 2007.

Over that period, the percentage of Americans who said they'd had at least one psychotherapy session in the past year remained steady — at just over 3 percent in both 1998 and 2007.

However, among Americans receiving any outpatient mental health care, the proportion being treated with drugs alone rose from 44 percent in 1998 to 57 percent in 2007.

Meanwhile, combined treatment with drugs and psychotherapy declined from 40 percent to 32 percent, and the use of psychotherapy alone slipped from 16 percent in 1998 to about 10 percent in 2007.

National spending on psychotherapy also declined — from an estimated total of $11 billion in 1998 to $7 billion in 2007. Overall spending on mental health care remained fairly steady, however — at $15.4 billion in 1998 and $16 billion in 2007- suggesting an increase in the proportion of mental health spending devoted to drug therapies. "This represents a fairly dramatic shift in mental health treatment, and it is not necessarily good news for many patients," said Dr. Daniel Carlat, an associate clinical professor of psychiatry at Tufts University School of Medicine who was not involved in the study.

"What concerns me most," he told Reuters Health in an email, "is that there was a 20 percent drop in treatment combining therapy with medication."

Such "integrative" treatment, Carlat said, is often the most effective.

"I think there are some reasons for concern," agreed Dr. Mark Olfson, a professor of clinical psychiatry at Columbia University in New York and one of the study's authors.

He said that with depression, for example, there is evidence that combination therapy is superior to medication alone.

In an interview, Olfson pointed out that the largest investigation so far of depression in teenagers found that combined therapy was generally more effective than either drugs or talk therapy alone. In that study, known as TADS

***Continued on page 6*(Drugs Only)**

DRUGS ONLY*(Continued from pg. 5)*

(Treatment for Adolescents with Depression Study), combination therapy was better at reducing teens' suicidal thoughts, for example.

Yet the current study of trends in psychotherapy use found that among Americans treated for depression, the proportion on medication alone rose from 41 percent in 1998 to 51 percent in 2007. The percentage receiving combination treatment dipped from 50 percent to 42 percent.

On the "positive" side, Olfson said, the trend toward greater medication use means that some people who might

not have received any mental health care at all in the past are now getting treatment.

"Mental health care," he said, "is evolving in a way that means more people are receiving treatment, but are not necessarily getting the most effective therapy."

The study was not designed to weed out the reasons for these trends. But one potential factor, Olfson said, is the increased marketing of psychiatric drugs not only to doctors, but to the public as well.

Other factors, he speculated, could include patients' increased acceptance that mental health disorders have biological underpinnings and, for some people, a perception that medication may be the simpler approach —requiring less time and effort and potentially offering quicker results.

In addition, primary care doctors can prescribe psychiatric medications, while psychotherapy requires a referral to a mental health specialist — a psychiatrist, psychologist, social worker or mental health counselor.

Primary care doctors now account for the large majority of psychiatric-drug prescriptions issued in the U.S., Olfson and colleague Dr. Steven C. Marcus note in their report.

What all of this means for Americans' mental health is not entirely clear. But Olfson recommended that people who are being newly prescribed a psychiatric medication ask their doctors if any alternative treatments are available for their particular condition.

This is especially relevant for people with milder symptoms. In general, Olfson said, psychiatric drugs have been shown to be most effective for patients with more severe disorders.

Someone with relatively mild depression symptoms, for example, might respond to some form of mental health counseling alone.

The National Institute of Mental Health estimates that one in **10** American adults experiences depression in any given year, and that 18 percent of adults suffer from some form of anxiety disorder.

One of the most common and best-studied forms of psychotherapy is cognitive-behavioral therapy, which involves examining how thoughts affect emotions and learning ways to change behavior patterns that may be negatively affecting a person's mental well-being.

SOURCE:link. reuters. com/xu p95n
American Journal of Psychiatry, online
August 4, 2010.

Warning Issued on Seizure Drug

Federal health regulators are warning doctors and patients that a seizure drug from GlaxoSmithKline can cause rare inflammation of the brain and spinal cord.

The Food and Drug Admmistration said it was working with the British drug maker Glaxo to add new warnings and labeling information for Lamictal.

The agency said it had received reports of 40 cases of aseptic meningitis since Lamictal's approval in 1994 and last November. Thirty-five patients needed to be hospitalized, the agency said in a statement.

Aseptic meningitis is a dangerous inflammation of the brain and spinal cord that can cause headache, fever, chills and vomiting.

Source: L A Times
August 13, 2010

Major Weight Gain Follows First Manic Episode

July 1, 2010, VANCOUVER, BC— People with bipolar disorder on medication following their first manic episode are far more likely to experience significant weight gain in the next year compared to people without the disorder, new research has found.

Canadian researchers said that while numerous studies have demonstrated an association between bipolar disorder and obesity, there has been little data on weight gain early in the course of bipolar.

They studied people with and without the disorder, and found that even among people who had previous episodes of depression or hypomania, clinically significant weight gain began after the first manic episode. This was especially true among men.

That weight gain also led to higher blood glucose and serum triglyceride levels, both risk factors for diabetes, stroke and heart disease.

The weight gain is most likely related to maintenance treatment with mood stabilizers and second-generation antipsychotics, but researchers cautioned that the small number of people in the study put limitations on any kind of analysis.

The study, which appeared in the *Journal of Affective Disorders,* was entitled "Weight gain, obesity and metabolic indices following a first manic episode: Prospective 12-month data from the Systematic Treatment Optimization Program for Early Mania (STOP-EM)."

Source: bp Magazine
Summer 2010

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National Mental Health Association
800 / 989-6642 • www.nmha.org
Confidential depression screening:
www.depression-screening.org

Post-Traumatic Stress Worsens Course of BP

June 1, 2010, SALVADOR, Brazil—People with bipolar disorder who are also suffering from post-traumatic stress disorder (PTSD) are more likely to fare worse than those without PTSD, a new study suggests.

Brazilian researchers said until now, there was little data on the interaction between bipolar and PTSD. They looked at patients with bipolar I disorder from two teaching hospitals, and found those who also had PTSD had a lower likelihood of recovery, elevated number of rapid cycling periods, increased risk of suicide attempts and worse quality of life.

The study, which appeared in the *Journal of Affective Disorders,* was entitled "The impact of comorbid post-traumatic stress disorder on bipolar disorder patients."

Source: bp Magazine
Summer 2010

Mental Health History Can Make Quitting Smoking More Difficult

May 1, 2010, ATLANTA, GA—New research adds to the evidence that people with mental illness find it more difficult to quit smoking. The new study compared smokers with a self-reported lifetime history of anxiety, depression, anxiety with depression, or major depressive episode.

Researchers from the U.S. Centers for Disease Control and Prevention found that smokers with a history of anxiety or depression smoked more frequently, had higher dependence on nicotine and lower success at quitting.

The researchers said their study underscores the need to address underlying mental health conditions that are common with smoking.

The study, which appeared in the journal *Addictive Behaviors,* was entitled "Smoking among adults reporting lifetime depression, anxiety, anxiety with depression, and major depressive episode, United States, 2005-2006"

Source: esperanza
Spring 2010

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http://www/hrh.org
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David J. Miklowitz, Ph.D.
Professor of Psychiatry, UCLA Semel Institute for Neuro-science and Human Behavior. Child and Adolescent Psychiatry.

Ask The Pros

Himasiri De Silva, M.D.
Past President of the Orange County Psychiatric Society,
Founder of the DBSA of Orange County,
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