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Did you know?

89 percent of health care expenditures are for 48% of the non-hospitalized persons who have at least one chronic condition.

74 percent of private health insurance spending involves 45 percent of privately insured people who have chronic conditions.

72 percent of all health care spending for the uninsured goes to the 31 percent of this group who have chronic conditions.

83 percent of Medicaid spending is for the nearly 40 percent of institutionalized beneficiaries who have chronic conditions.

Only four percent of those without chronic illnesses were hospitalized in 2001.

31 percent of those with five or more chronic conditions were hospitalized in 2001. (*Chronic conditions include, but are not limited to: diabetes, depression, coronary artery disease, hypertension, high cholesterol, asthma, serious mental illness, HIV, AIDS*)

Individuals who die from suicide represent only a fraction of those who consider or attempt suicide.

For those with a major depressive episode who also engaged in alcohol or drug abuse, the likelihood of suicide attempts or suicidal thoughts were even greater.

10.4 percent (1.7 million people) of adults aged 18 or older who experienced a major depressive episode made a suicide attempt, 14.5 percent (2.4 million people) made a suicide plan, 40.3 percent thought about committing suicide, and 56.3 percent thought that it would be better if they were dead.

When alcohol abuse -- particularly binge drinking or the use of illicit drugs -- is added to a major depressive episode, the proportion of suicide attempts rises to nearly 14 percent for alcohol abuse and nearly 20 percent for illicit drug use.

In 2004, an estimated 106,000 visits to E.R.'s were attributable to suicide attempts. A mental disorder was diagnosed in 41 percent of the drug-related suicide attempts; the foremost of these disorders was depression. (data from the 2004 National Survey on Drug Use and Health and SAMHSA's Drug Abuse Warning Network. For more information visit www.oas.samhsa.gov).

"Jingled" Blues

By Allyson Ashley, LCSW

The holidays are here once again. Shopping, concerts, lighting ceremonies, office parties, more shopping, special church or civic events,



family get-togethers and less daylight to get it all done in. It is a busy, busy time of year. With demands on our time running at full tilt, and too little of us to go around, the "Happy" of the Happy Holidays and the "Merry" of the Merry Christmas don't always seem so happy or merry to many people.

While the normal stresses of the holiday season can lead to the "blues" or a "bah humbug" attitude, consider that for many, the normal stresses of the holidays are often compounded by the additional stresses of a critically ill family member or friend, financial difficulties, disabilities, family members at war, property taxes, disrupted family relationships, homelessness, alcoholism ... the list goes on and on.

When stresses get too big and too many, a common reaction is to get "down" or "blue" because it's supposed to be a happy and wondrous time of year. We ask ourselves why it isn't or try to cover it up in order not bring anyone else down, and in the process we end up even more out of sync with the season. This year try something new.

Limit your commitments to your available time.

Think of new ways to give that don't cost so much money.

Keep up your healthy nutrition.

Get plenty of exercise (a great stress reliever).

Get plenty of sleep.

Reach out to those less fortunate with a kind thought or prayer.

Remember, you are not alone with the jingled "blues" . . . more people than you think feel just like you.





ADVISOR

Vol. 7, Issue 4

"With you every step of the way."

December 2006

The Perfect Gift



By: Fred Overton RN, C

It's probably happened to all of us. At one time or another, we've set out to pick out the perfect gift for that special someone and we've missed the mark horribly. Some of my more memorable gifts were intended for my wife early in our marriage. I like to think of myself as a sensitive and thoughtful man. Would you believe I actually wrapped up and placed under the tree such things as; a fishing pole, briefcase and even an exercise video? For the record, she had mentioned wanting two out of three of those items, I just didn't understand that she didn't want them for Christmas. This type of thing happened to me long before I was married. I remember one Christmas I solved my mother's living room lighting problem with a really cool hanging lamp. It had a backwoods natural look that would have been perfect for a place where hunters and fishermen hung out. Unfortunately, it did not match my mother's decor. Moms are different than wives, this hideous thing hung in her living room for more than 10 years. I didn't learn her true feelings about the lamp until after she had passed away.

Most people spend a lot of time over the holidays making lists, running around, shopping and desperately seeking out the perfect gifts for those in their lives. The department stores devote great portions of their floor space to perfect gifts. We are bombarded with television, Internet and print images of just the right thing for just the right person. Unfortunately, many people in our society don't receive what they want for Christmas, even though what they want and desperately need doesn't cost a thing. Examine your holiday memories, how many really revolve around stuff? I can remember card games, watching favorite Christmas movies together, playing with nieces, nephews and cousins, catching up and reminiscing. Those are the things that first come to mind. If I reach a little further I can remember the GI Joe Helicopter, Girder and Panel building set and power drill but the most cherished memories are about people, not things.

The rates of mental illness, substance abuse and even suicide increase around the holidays each year. Many of those who experience the "holiday blues," do so because of feelings of isolation and loneliness. They feel all alone at that time of year when being with family and friends is so important. So this year, cut down on the shopping or decorating and call up that old friend that you haven't heard from in years. Invite the lonely widow or widower from down the block in for cookies and a visit. Take your family to the local nursing home and carol. Drop in on that aunt or uncle you've been avoiding with a copy of, "It's a Wonderful Life." You never know, you, your time and your compassion just might be someone's perfect gift!



Adolescents in the United States grow up in a world filled with messages about alcohol. Most of the messages present alcohol in a positive light, and most of them show alcohol as a normal part of teen and adult life. Warnings about the dangers of underage drinking may well be drowned out by the barrage of daily messages about alcohol in daily life. (National Research Council, Institute of Medicine, "Reducing Underage Drinking")



Why Teens Use Alcohol & Drugs



By: Wanda Weddington, BSW CASAC

It has long been acceptable practice when working with adult substances users not to spend much time asking about the reasons they use. Instead, the focus is on addressing ways to rebuild and recover from the damaging effects their use has created in their lives. However, with adolescents, exploring the reasons they use can be beneficial in determining level of care of services, and offer insights into how clinicians and family members can be supportive of their recovery efforts. All addictions start with curiosity and experimentation. From there, two distinct patterns emerge. While the patterns sometimes overlap, it is much more difficult for those in the second group to return to casual experimentation.

Pattern One develops from the WANT to use: Teens in this pattern often describe their reasons for using as wanting to fit in, wanting to exert their independence, and wanting to find out first-hand what it feels like to use. Pressure from friends, accessibility, and general societal acceptance that using is a rite of passage often subtly support their belief that everyone uses. For kids in this pattern, if use begins to interfere with school, sports or their relationships with others, they may make the decision that continued use is not worth the potential losses they would have to face.

Pattern Two develops from the NEED to use. Teens in this category often make the comment that their using, even from the beginning, gave them the feeling of relief and self acceptance they had been searching for. They may talk about needing the drug to make them feel "normal," and will often choose to continue to use even when they experience consequences from family, their school, and even from the juvenile office. In fact, when consequences do occur, these users will turn again to the drugs or alcohol to cope with the stress brought on by their use. They may feel trapped and want to quit, but are afraid they will not be able to cope with every day stressors, both external and internal.

Interventions for Pattern One users may be as simple as encouraging them to become involved in school activities, sports or other hobbies to keep them busy, and teaching them to set short and long-term goals for their future. Pattern Two use can be more complicated, and might involve seeking professional help in assessing whether the child may be experiencing underlying problems such as depression, self esteem issues, or problems in communicating their fears and emotional conflicts.

The first step in any intervention is to talk to your child. Find out their attitudes about substance use, and let them know yours. Strive to be an involved parent, and remember that going through adolescence can be one of the toughest times in life. Let them know that when the tough times come they can turn to you rather than to drugs.

Tell Me Where It Hurts



By James A. Chappelle, MA, RSAP, PLPC

Pain is a part of everyone's life at some point or another. Pain is subjective: Pain is whatever the person is experiencing, whenever he or she says it does, and it is highly individualized to that person. Most of the time we feel like we can handle the pain, because we figure it can't last forever. But chronic pain, or pain that persists usually beyond three months, can have devastating effects on both physical and mental health.

Quality of life is affected when a person feels that he or she is so helpless that the pain keeps them from doing things they have done in the past. A person wants to function at the level before the pain started controlling their lives. Feelings of worthlessness can develop and self esteem drops to the point of non-existence.

Without adequate self esteem and self worth, anger could increase. Before the chronic pain, the person was in control. With the loss of control, an individual might feel anger and take it out on others.

There is a chance that depression could develop when a person feels that his or her quality of life will never be normal again. Family and friends may not understand what a person is going through and make negative judgments. Add to that the financial anxiety about bills piling up because no money is coming in; and a person who was at first just dealing with their chronic pain is now struggling with depression and/or other forms of mental illness. Suicide can sometimes be a product of depression and anxiety that develops when a person is feeling hopeless. Suicide might seem like an option when the individual sees no other way of dealing with the pain.

Barriers to pain management need to be identified in order to help control the pain. For instance, an individual might be reluctant to report pain for fear that pain means that the disease is worse. Some just want to be a "good patient" and not to distract the doctor from treatment of the underlying disease. Other barriers include: not wanting to take medication, fear of being thought of as an addict, fear of unmanageable side effects, and fear of becoming tolerant to pain medications.

When people talk to their healthcare provider (physician, nurse, physician assistant, nurse practitioner, mental health counselor, etc.) about pain, they need to let the healthcare provider know what other factors in an individual's life that have had an

continued on pg. 3



Reflections . . . on CARS



By: Dee Kempker, CASAC

You know, they say that a person's dog looks like them. Winston Churchill's pugs certainly did. Queen Elizabeth's Corgi's have a prim ladylike quality. My Uncle Bob had a series of dogs, all named "Pup", but no matter what mixed variety their heritage, they were all frisky, wiry, and full of pep and omeriness, just like him. So, you can tell a lot about a person just by looking at their dogs, but I also think that a person's car can

reflect how they feel about themselves, can give you a clue into their self-image.

We all have a picture in our minds of how we perceive ourselves. Whether or not we look like that on the outside is another matter, but we begin to paint this picture when we are little kids, and continue to add on, subtract, or adjust our self-images throughout life.

Sometimes, this image influences the type of cars we buy. Cars are very personal items. We are a car society and very few households have only one car. Mom, dad, and kids over 16, all have cars and if you looked in the drive-way, you could probably tell just whose car belongs to whom. But then again, maybe not.

Soccer moms may think they have to have SUV's or vans to haul all of those kids and groceries, but does this really fit their self-image? Are they secretly longing to be driving a cherry red convertible with the top down and their hair blowing in the wind, a reflection of the free spirit contained in their self-image versus the tied-down responsibility of motherhood? And how about those rich, dark-suited businessmen who drive BMWs during the week, but can't wait for the weekend to roll around so they can don their leather jackets and hop onto their Harley's and hit the road?

Some of us are lucky enough to be able to express our self-image all the time, and drive the car that reflects our inner spirit. We don't have to live up to anybody else's image except our own. Five years ago, as I was on my way to have lunch with my sisters and cousin, I stopped at a car dealership in Eldon. I had been thinking of buying a new car and had a pretty good idea of what I wanted, so I would often pull off the road and check out a car lot, just to see what was there. Well, I found the car I was looking for, and in less than an hour, the car was mine - well, mine and the Chase Manhattan Bank. I drove to my sister's house feeling pretty darn sharp in a cream colored, Chrysler Sebring coupe with a moon roof, leather interior, and Infiniti speakers. This was definitely not an "old lady" car. It's hard to get in and out of; it sits so low to the ground, that I ran over several parking barriers because I couldn't see them; it's a dickens to back up in because the side and back windows are too narrow; but baby, that car's got speed and power and I feel like a young chick when I drive it. Now, granted this car wasn't cheap, but I never regretted making any of those 60 payments, because the car made me feel good. Had I purchased some stodgy, four-door sedan, I would have grumbled over every payment because that car would have made me feel old. Now the car is all mine and in a couple of years I will be looking for a new one. I wonder what my self-image will lead me to purchase next time - a yellow Hummer?

Even if we can't have the perfect car that reflects our self-image, we can do a lot of things to personalize our cars. You've perhaps watched the TV show, "Pimp My Ride", where a bunch of mechanics and body shop technicians steal someone's car and give it a complete makeover. If you were given the chance, what would you want done to your car to make it uniquely yours? Maybe you've already added your personal touch. Do you have a pair of fuzzy dice hanging from the rearview mirror? Do you have a bobble-headed dog in the back window? Or is your favorite bobble-headed baseball player wagging his head on the dash? Maybe you've named your car, just like the cowboys in the old days who named their horses: Roy Rogers had Trigger; The Lone Ranger had Silver; and if you ever see a reindeer named Rudolf, you know that Santa Clause can't be far behind. When my No. 5 Son bought his grandfather's '61 Ford pick-up, he naturally named it "Grandpa". I have owned a green '51 Chevy, named "Old Green"; a silver Pontiac Phoenix, called the "Silver Bullet"; and a black cherry colored Dodge Shadow, called the "Black Shadow". Now these names may not sound very creative but they do add a certain pizzazz to what would otherwise be just plain old cars. I think when I buy that yellow Hummer I am going to name it the "Humdinger".

The ADHD Nation



C.J. Davis, Psy.D.

If you could name the most common medical conditions that children suffer from in today's world what would they be? Most parents would readily identify allergies, asthma, diabetes, or perhaps even headaches, but what about Attention-Deficit Hyperactivity Disorder or ADHD? According to some statistics, ADHD is now the third most commonly diagnosed condition among children and adolescents. In fact, even more alarming is the rate that this diagnosis is now given by healthcare professionals. According to Ladies Home Journal, there were only 150,000 documented cases of this condition in 1970; however, this number has jumped

to nearly four million cases today. This number is also consistent when observing the overwhelmingly large number of children diagnosed with ADHD in every school classroom in America, in spite of the fact that the prevalence rate of this condition is only three to five percent of the general population. So why is this happening and should we continue to medicate children at younger and younger ages to control the cardinal symptoms of this disorder that includes impulsivity, hyperactivity, and distractibility or inattention?

Probably the most important thing to keep in mind regarding medication and ADHD is the accuracy of the diagnosis. Any parent who is concerned about the

possibility of his or her child suffering from this condition should have their child evaluated by a mental health professional qualified in the diagnosis/treatment of this condition. Accurate and

as issues related to undiscovered thyroid problems, sleep deprivation, learning problems, or a host of other behavioral health disorders such as Post Traumatic Stress Disorder.

" . . . ADHD is now the third most commonly diagnosed condition among children and adolescents."

So should we medicate this condition as much as we do? The answer to this question, albeit debatable within professional circles, is yes and no. Most literature would suggest that the best

careful diagnosis is very difficult with this condition because, as most parents can attest, virtually every child exhibits signs and symptoms of inattention, impulsivity, and hyperactivity over the development life-span, especially boys. Additionally, many of these signs can also be intensified by an underlying medical condition such

treatment of ADHD is a combination of medication management, behavioral interventions, family counseling, and individual counseling; however, healthcare professionals are beginning to realize that a "one size fits all" approach to ADHD may not be beneficial. In other words, there are probably different degrees of the con-

dition or severity levels that should dictate treatment options. For children with less pronounced symptoms, he or she may do well without medications as long as other psychological treatments are implemented consistently and the family is willing to collaborate with a behavioral healthcare professional. Conversely, more extreme or severe cases of ADHD are treated extremely effectively with psychotropic medications. In many cases, a 15-minute visit to a family physician, where many ADHD diagnoses are given, may not accurately address the concerns brought up by parents. Perhaps most noteworthy is the fact that medications should definitely be considered in legitimately diagnosed cases of ADHD as long as the parents are informed of the potential side-effects and they can be assured the diagnosis is accurate.

"Tell Me Where It Hurts" continued from pg. 2

effect on them. This could be employment, family, children, spouse, medical history, possible addictions to other substances, past/present psychological or emotional issues, and legal issues. If the patient is preoccupied with any of the above issues, then dealing with pain may not be a major concern, or these factors may be feeding into the pain and how it is controlling their lives.

Psychosocial treatment for pain management includes the following treatments and techniques: **Relaxation** and imagery provides the capability of relaxing the mind and body. The mental relaxation means alleviation of anxiety and includes simple focused-breathing exercises, progressive muscle relaxation, meditation, and music-assisted relaxation. **Distraction** is focusing on other things in life such as singing mentally to one's self, praying or making self statements like "I can cope." **Reframing** consists of changing a negative feeling into something that can be controlled. **Hypnosis** is a state of heightened awareness and focused concentration that can be used to manipulate the perception of pain and has been proven effective. **Prescription medication** is also part of pain management.

It is important to note that the goal of chronic pain management is not to be pain-free, but to achieve adequate pain control to improve quality of life. Individuals experiencing chronic pain need to develop a strong, clear and concise communication system with their healthcare providers in order to receive the best care possible. Family should also be involved in therapy to gain knowledge on how to provide the best support.

The "Placebo Effect" in Psychiatric Medicine



By: Casey S. Prough, MD

One very interesting phenomenon in medicine is the "placebo" effect, or the clinical improvement of a patient's symptoms from taking

medicine without the medicine actually making chemical changes. The name comes from the "sugar pills" that all research trials use when developing REAL medications, to see if they are "superior to placebo." A medication, in any realm of health care, must be found to be more effective than a sugar pill in treating the illness that it is designed for in order to be approved by the Food and Drug Administration.

Many medications, including some antidepressants, are only slightly more effective than placebo in treating mental illness. Others, such as the antipsychotics, are far superior to placebo in treating illnesses such as Schizophrenia.

When a patient starts a medication, they will often feel better within the first week. This is often a "placebo effect", where little to no chemical changes have been made in

the brain, but the person feels better anyway. This is especially true for "early response" to antidepressants. There are many postulated reasons for this. First, simply visiting the doctor and finally getting help from suffering is therapeutic. Second, active participation in a mental health care plan, even if it means taking a pill a day, can provide the reassurance and hope that many mentally ill patients need. Finally, the power of suggestion, such as "I am taking something that WILL make me better," can be enormously powerful.

As a clinical psychiatrist, I am happy to see anything that will improve a patients' quality of life. The placebo effect of medications can be one of these things. That effect may go away for some people. However, the actual chemical and receptor changes that our current psychiatric medications offer will usually catch up to the placebo effect and help a patient remain stable or improve even more.

More research needs to be done into the power of the placebo effect and ways to improve it. You can learn more by talking to your doctor or reading more about this subject online or in your local library.

Visit us online at www.pathwaysonline.org/