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Healthy Aging

NEWSLETTER SUMMER • 2015

by Yvonne Matthews, LUCE Associate Administrator and PJCCMHA Coordinator

Embracing Mental Health

We go to the cardiologist to make sure our heart is healthy, the opthalmologist to make sure our eyes are healthy and the dentist to make sure our teeth our healthy. Many of us schedule routine appointments with our primary care medical doctor to make sure that our bodies are healthy but what do we do to maintain ***Good Mental Health?***

For some, discussing mental health and mental illness is a taboo. We are hoping to explore some issues in mental health in this and other editions of the Healthy Aging Newsletter.

IN THIS ISSUE:

Schizophrenia: A Parent's Nightmare

By Erin Reynolds, LCSW

It was a cold but memorable night when Elizabeth was born. Her parents felt that she was beyond perfect. She had ten little fingers and ten little toes. And they imagined that her smile could soften even the hardest of hearts. Elizabeth brought joy into her parents' lives. However, Elizabeth's parents could not know that they would soon embark on one of the most difficult journeys a family can take: they would one day find that their baby girl had schizophrenia. And for a child with schizophrenia, life's journey is riddled with the conflict between what is real and what is experienced. This conflict would always dominate not only Elizabeth's life but also the life of her parents. Dealing with reality would, at times, leave Elizabeth speechless; it would often make her proud parents distraught and even heartbroken.

According to the Centers for Disease Control and Prevention, it is estimated that worldwide, between 0.5 and 1 percent of the population has schizophrenia. In general, the age of first onset is younger among men (about 21 years of age) than women (27 years). Sadly, families are oftentimes left to manage this condition alone. This can mean that parents spend much of their energy protecting their child from the societal stigma of mental illness.

All too often, the voices and needs of caregivers of adults with schizophrenia are not heard. Unlike many other parental caregivers of adult children, there are fewer and less accessible supports for these parents. This means that they often do not have the help they need to adequately provide for their adult child. This isolates the parental caregivers. It also minimizes the access these adult children have to appropriate services. This lack of support is compounded by the emotional, financial and mental demands upon parents who are caregivers. These parents are often torn between their feelings of parental obligation and their desire for independence in the later years of their lives. Faced with such tension even if they have minimal support, many parents of adult children with schizophrenia choose to be their child's sole caregivers. In essence, they have to redefine their role as parents. They also must give up the dreams and desires they had for their child. As schizophrenia is a lifelong condition, it will affect parents throughout every stage of their lives.

Good parents want what is best for their children. Many parents of a schizophrenic child decide that what is best is the parents' continued care, love and support. Whatever the sacrifice, whatever the obligation, these parents are there to protect and support their child. If you know of such a parent or you are a parent of a child with schizophrenia, you can find resources at Center for Disease Control and Prevention: www.cdc.gov/mentalhealth/basics/burden.htm ■

The Loving Thoughts of a Mother Whose Son Has Schizophrenia

By Kay Smith, Lay Leader

It's me. It's me, O Lord, standing in the need of prayer. Every time the phone rings, Lord, I need your help to remind me that "reckless words pierce like a sword...and stir up strife." Help me to use kind words filled with love and healing. And help me to be still and just listen until my son's ranting is over and the question is asked: "Are you still there?"

Yes, my son, I am still here. Are you still there? There are so many words I long to say to you but I can't. Where is my handsome, talented son, so calm and caring, who performed Jimmy Hendricks' "Star Spangled Banner" perfectly and sketched family portraits worth framing? Are you still there?

I will always remember the day you came to me and announced your decision to join the Army. What a shock. But your mind was made up—no discussion. And off you went. I sent you my love and prayers although inside I was kicking and screaming, No! Don't Go! And didn't I ask you to write me often, to keep in touch? So why was I at the Red Cross getting help to find you?

I don't understand how you are so distant, so unattached. I know you're grown up now. But why are your calls so short? And what is this detachment I feel? Do grown sons really stop hugging and kissing their moms and stop saying "I love you"? You were only away for two years. But what a change!

I also don't understand the rapid flight of your ideas and words: What? What? Why? It's been a long, hard road finding the diagnosis that changed our lives. And now I realize that the telephone is your way of expressing yourself when you think no one is listening to you. Forgive me for dropping some calls; I do that to preserve my sanity.

It's okay if you're irritated with me because you think I'm not listening or not doing what you want. It's okay to call me at the crack of dawn even though I've asked you to call at a much later time. It's okay. I know you are still there.

I admire you for trying so hard to do the right thing for yourself: keeping all your doctor's appointments and taking your medication. Thank you! I hope you continue to enjoy the exercises in your tai chi classes. That keeps you fit and happy.

Now, I pray and meditate each day. I thank God for the protection He built around us, blessing us. So, yes, my son, I am still there—your advocate, your mom and your friend—because I'll always love and support you. ■

What is Compulsive Hoarding?

Compulsive hoarding is a disorder characterized by difficulty discarding items that appear to most people to have little or no value. This leads to an accumulation of clutter such that living and workspaces cannot be used for their intended purposes. The clutter can result in serious threats to the health and safety of the sufferer and those who live nearby. Often people with compulsive hoarding also acquire too many items - either free or purchased.

In order to meet criteria for a diagnosis of compulsive hoarding, a person must experience significant distress and/or impairment in functioning as a result of their hoarding behavior. Common types of functional impairment include: fire or health hazards caused by excessive clutter, infestations, inability to have guests over to the home, inability to prepare or eat food in the home, inability to find important possessions because of clutter, inability to finish tasks on time, and interpersonal conflicts caused by the clutter.

Not all hoarding is compulsive. Hoarding and saving behaviors can be seen in people with various neuropsychiatric disorders, such as psychotic disorders, dementia, eating disorders, autism, and mental retardation, as well as in people with no psychiatric disorder. However, it is most frequently associated with obsessive compulsive disorder (OCD). Between 25-40% of people with OCD have compulsive hoarding symptoms. It is not clear at this point whether compulsive hoarding is part of OCD or whether it is a separate disorder that is common in people who have OCD.

Frequently Asked Questions

What typically drives compulsive hoarding?

- Discarding valuable items that might be needed or useful someday
- Losing important information
- Making a mistake
- Being wasteful
- Losing something that reminds a person of a loved one
- Not being able to do things as completely or as well as one would like

Typical behaviors seen in compulsive hoarding include:

- Saving far more items than are needed or can be used.
- Acquisition of more items than can be used.
- Avoidance of throwing things away.
- Avoidance of making decisions.
- Avoidance of putting possessions in appropriate storage areas, such as closets, drawers, or files.
- Pervasive slowness or lateness in completing tasks.

What are some other symptoms of compulsive hoarding?

Compulsive hoarding is part of a discrete clinical syndrome that also includes indecisiveness, perfectionism, procrastination, difficulty organizing tasks, and avoidance behaviors.

How disabling is compulsive hoarding?

Compared to people with non-hoarding OCD, those with compulsive hoarding typically show:

- More functional impairment
- More social and family disability
- More severe anxiety and depression symptoms
- Older age when presenting for treatment
- Poor insight into the severity of the problem

The clutter that accumulates in the homes of people who hoard is often a serious fire risk. These homes are also frequently vulnerable to infestation from rodents, insects, and molds, which can put the inhabitants of the home at risk for various health problems, including asthma, allergies and infections.

Family members are often frustrated by the gradual worsening of symptoms and the extent of the person's impairment. They often want very much to help but feel powerless to do so.

They may become angry at the person's inability to clean or discard clutter, not understanding that this is not possible without treatment.

Are people with compulsive hoarding just lazy?

No. Compulsive hoarding is not due to laziness or weakness of character, nor is it due simply to disorganization. Rather, the compulsive hoarding syndrome may be due to distinct brain abnormalities that will not improve without treatment. People with this problem are often acutely aware that the degree of clutter in their home is socially unacceptable and often believe that others will think them lazy or even crazy. Not surprisingly, they are frequently secretive about their problems and will often isolate themselves from family and loved ones. This may also be why they are reluctant to seek treatment.

How many people suffer from compulsive hoarding in the United States?

The true prevalence is unknown, but it is estimated that up to 1.2 million people suffer from compulsive hoarding in the USA.

What causes compulsive hoarding?

Compulsive hoarding may be hereditary. Up to 85% of people with compulsive hoarding can identify another family member who has this problem. Abnormal brain development and brain lesions may also play a role. Compulsive hoarding can begin after brain damage, such as strokes, surgery, injuries, or infections. Family experiences and psychological factors may also play a role in the development of hoarding and emotional stress may heighten symptoms.

Research indicates that people with the compulsive hoarding syndrome have unique abnormalities of brain function that are be different from those seen in people with non-hoarding OCD and those with no psychiatric problems. However, we do not yet fully know what causes these brain abnormalities.

All people with significant hoarding behaviors should receive thorough assessment to evaluate possible causes of hoarding behavior, determine the correct diagnosis, and develop an appropriate treatment plan.

What is the age of onset of compulsive hoarding?

People with compulsive hoarding who participate in research and treatment studies have an average age near 50. Onset typically occurs during teenage years, but may occur later in life, after brain damage, a traumatic life event or episode of depression.

Regardless of the age of onset, there is usually a significant time lag of many years between the onset of symptoms and when a person first seeks treatment.

What is the course of compulsive hoarding syndrome?

Compulsive hoarding tends to be a chronic disorder. Left untreated, it usually worsens gradually over time.

What treatments are available for compulsive hoarding?

Cognitive behavior therapy (CBT) using the technique of exposure and response prevention appears to improve compulsive hoarding symptoms. This technique decreases excessive fears of making decisions, losing important possessions, throwing things away, and organizing saved items out of sight, by gradual exposure to tasks that provoke these fears. People with compulsive hoarding problems

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Hoarding *(continued from page 5)*

are encouraged to resist their urges to engage in their usual behaviors, such as postponing decision making, saving things "just in case," or putting things in piles rather than storing them. This ultimately results in a decrease in anxiety, avoidance, and compulsive behaviors, and changes the way people with compulsive hoarding think about their possessions.

CBT for compulsive hoarding can be effectively done either in someone's home or in a therapist's office setting.

Medication – Drugs with potent effects on the brain chemical serotonin seem most effective. Serotonin reuptake inhibitors (SRI's) are highly effective and FDA-approved for treatment of OCD, but it is not clear whether they are as effective for compulsive hoarding as for other OCD symptoms. Very few studies have tested SRI's or other medications specifically for treatment of compulsive hoarding. Some studies have found that SRI's are beneficial for compulsive hoarding, while others found that hoarding symptoms were associated with poor response to SRI's.

If someone does not have an adequate response to SRI's, adding other types of medications can often help to improve response. New medications and new combinations of medications are always being tried, giving reason for greater hope in the future.

A combination of medication and CBT appears to be the most effective treatment regimen for most people with the compulsive hoarding syndrome. ■

Source: Reprinted with permission from the University of California - San Diego Obsessive - Compulsive Disorders Clinic; 5060 Shoreham Place, Suite 200; San Diego, CA 92122
http://psychiatry.ucsd.edu/OCD_hoarding.html

Smothered Greens

These healthy greens get their rich flavor from smoked turkey, instead of fatback.

3 cups water
¼ pound smoked turkey breast, skinless
1 tablespoon fresh hot pepper, chopped
¼ teaspoon cayenne pepper
¼ teaspoon cloves, ground
2 cloves garlic, crushed
½ teaspoon thyme
1 scallion, chopped
1 teaspoon ginger, ground
¼ cup onion, chopped
2 pounds greens (mustard, turnip, collard, kale or mixture)

Nurtitional Information per cup	
Total Calories =	80 calories
Fat =	2 g
Saturated Fat =	0 g
Cholesterol =	16 mg
Sodium =	378 mg
Total Fiber =	4 g
Protein =	9 g
Carbohydrates =	9 g
Potassium =	472 mg

1. Place all ingredients except greens into large saucepan. Bring to boil.
2. Prepare greens by washing thoroughly and removing stems.
3. Tear or slice leaves into bite-size pieces.
4. Add greens to turkey stock. Cook for 20–30 minutes or until tender.

Yield: 5 servings

Serving size: 1 cup

Recipe from page 14 of *Heart Healthy Home Cooking African American Style: With Every Heart Beat is Life* cookbook. (NIH Publication No. 08-3792; Revised May 2008) http://www.nhlbi.nih.gov/files/docs/public/heart/cooking.pdf

Stay Well!

By Julia Ostropolsky, LCSW, President/CEO
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We live during an exciting time of change. Any change, though, might lead to feelings of distress, even if the change is a very good development in one's life, like the birth of a grandchild, learning to navigate a computer, or beginning a new wellness program. Seniors don't always feel prepared to catch up with the changing times. It is common to feel out of place, lost within the system of care, or overwhelmed by retirement, housing and other life changes.

Exacerbated by deteriorating physical health, the body and mind can react with confusion, loss of interest in previous hobbies, feeling anxious or overwhelmed, and even forgetful. When these feelings surface, a senior may believe it's another symptom of aging. His or her family members (adult children) may share this belief and accept the change in the parent's mood or affect as something irreversible and a part of growing older.

Older adults are contributors. They are the vessels of history and wisdom. Older adults are able and willing to learn and to expand their horizons; to teach and to experience every part of technological advancements, changes in healthcare rules and regulations, volunteering, voting and government participation, and making their voices heard.

Unfortunately, we still shy away from discussing our mood and affect concerns with our families and doctors (or other providers), when we feel sad or anxious, forgetful or tearful, or are coping with loss of a loved one. We don't discuss when we are experiencing lack of sleep and persistent worry. Mental health is perceived as a taboo, still stigmatized by us, our families and our providers. Yet, to feel alive, to be able to enjoy each sunny day and increase vitality, we must focus on all aspects of our overall health. Our minds don't work separately from our bodies. Pain, loss, or chemical changes create a dissonance within the whole person. Forgetfulness is not a normal part of aging. While it's more difficult to retain new information, once learned, it may be enjoyed and mastered. Yet, forgetfulness may be linked to developing dementia, depression, anxiety, or even a bladder infection.

Socialization with peers, intergenerational programs, wellness efforts, or doing something good for a neighbor or someone in need will keep one's mind active and alive. And sometimes, a doctor may help by prescribing medication or referring to a therapist or a support group for counseling. Seniors must remember that they ARE in control of their lives and any sign of distress or symptom of illness is equally important, whether it is increased blood sugar or increased worry about death and dying.

Take control!

Talk to your doctor, talk to your family, talk to anyone who will hear and listen. Ask for help if you feel sad more days per week than not, if you experience fear of loss, or intrusive thoughts, and if you are forgetting things.

Please, stay well! ■

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