

A Mind and a Body: Another Dimension of Recovery

by Ken Duckworth, M.D.

One of my most memorable moments as a psychiatrist came from a lovely woman whom I was treating for Schizophrenia.

She said to me, "What is it with you shrinks? Can't I have a mind and a body?"

She was, of course, alluding to the side effects she was experiencing while on clozapine. She had, thankfully, burst my bubble. She was "doing great" by all measures, except that she was gaining weight and drooling; she worried about seizures and blood count changes; and she felt sedated all the time. In short, she was "doing great" above the neck, but struggling below it. Together we figured out how to improve in these important areas.

Thus began my journey toward becoming a more complete doctor. Today, as the chief psychiatrist for the Commonwealth of Massachusetts, I often look at our professional obligation to consider the whole person, not just reduce their psychiatric symptoms. We ask questions like these:

How do we best attend to the physical elements of what it means to have a psychiatric illness?

How do we create a culture of care where opportunities abound for people who are ready to improve their physical health?

I leaned quickly that timing is everything. Not all people with psychiatric conditions are ready to look at this issue. People in the early stages of recovery will have many other challenges.

I have also come across many professionals who view good physical health as an unrealistic goal for people with psychiatric illnesses, creating a landscape of missed opportunity. And, in my experience, almost everyone wants good health. So how do we begin to support ourselves and each other in this quest?

First we need to be able to support people who want to make choices for themselves that promote their health. I was taught as a doctor that controlling symptoms was my job, and that lifestyle choices were the patient's job. But now, as our treatments increasingly affect people's lifestyles and health we have an obligation to address this. One example is obesity, which I have come to think of as the new tardive dyskinesia. The U.S. Surgeon General has declared obesity a national epidemic, but many psychiatric medicines compound this risk. Yet, as a field I believe that psychiatry is not being proactive in helping people minimize this predictable side effect.

In Massachusetts, we did a study of the causes of death for people with psychiatric illnesses. My work at a community mental health center was the impetus; the individuals there experienced a lion's share of health problems; some of them very serious and some causing premature death. My new role as the Department of Mental Health's chief psychiatrist gave me a unique opportunity to delve into this vexing problem.

We found that the risk of cardiovascular-related death was much higher for people with psychiatric illnesses in Massachusetts for 1998 and 1999. It ranged from twice as high to about six times as high, depending on age. Also, the usual protections women enjoy were not evident in the review—their rates were the same as those for men. We don't know exactly why, but our findings appear to be multifaceted. I'll try to review what we assess as the biggest risks, and how we can think and work together to address and ultimately find solutions to these problems.

Smoking

Research shows what we already know--smoking is a form of self-medication, working as a mild antipsychotic and antidepressant. People with psychiatric illnesses tend to smoke more often, more cigarettes per day, and smoke more deeply. At one Boston clinic, 80 percent of individuals there smoke, compared to less than 20 percent statewide. My interest now lies not in a "temperance model" of quit or else, but in one that promotes harm reduction. Can people be supported to reduce their intake? How does a reduction impact their symptoms? We are funding research in Massachusetts to help people with Schizophrenia who want to reduce their smoking.

Obesity

Many of the new psychiatric medications cause weight gain, though no one is sure how. One prominent theory is that people lack the sensation of fullness--or satiety—which is the cue to stop eating, so they keep eating. This is the kind of information people should have before they start taking any medication. Along with that, they should be able to plan for side effects, and expect support in dealing with them. Prevention of weight gain is easier than reduction. Can we offer dietary counseling, support for walking groups, and a scale for people who are beginning a medication regimen? I believe we need to, but my observation reveals the reality that many clinicians aren't active in this area. Keeping information from people is a mistake in my experience—once weight gain takes hold, people frequently stop taking their prescribed medicines. There are medical interventions for weight gain, but lifestyle choices remain a key.

Diabetes

People with psychiatric illnesses are at risk for developing diabetes. Type II diabetes, also known as adult onset diabetes, is commonly caused by weight gain, which changes the shape of the cells making them more resistant to insulin. This increases the amount of sugar in the blood. Diabetes sets the stage for a number of health complications, particularly if sugar levels are not well controlled. People who live in our

residential system in Massachusetts have about twice the incidence of diabetes as their age-matched counterparts. Diabetes is a treatable condition, but we all need to consider it before it can be assessed. Common symptoms include frequent urination and fatigue, and diagnosis is often delayed for years.

Activity Level

Walking is all it takes to reduce our heart risk. A good pair of walking shoes can be just as effective as the latest technology and medication in terms of reducing your heart risk. Walking with another person is very helpful for many people—it is a natural support system.

Understanding that most people start and stop exercise programs is important, too—few people are always on a program. Walking a few blocks or taking a flight of stairs may be all it takes to reduce our risk. Clubhouses in Massachusetts are moving in the right direction with an increasing interest in setting up gyms. The good news is people are using them—this is a healthy trend.

From my vantage point I can say that most of us are trying to do better in these areas—heart disease is a national problem that is a higher risk for ourselves and our loved ones with serious psychiatric illnesses. It is also important to have an annual checkup with a physician who can assess your cholesterol, triglycerides, risk of diabetes, blood pressure, weight—the major risk for heart disease—and can evaluate whether you need more intensive medical assessment. Most people like myself have a natural aversion to going for a checkup—we might find out bad things even though we feel fine. But it is another important step to a better heart risk profile.

Finally, I'd like to see some resources devoted to understanding the best lifestyle interventions for people with mental illnesses. I am pleased to say that NAMI is leading the way on education in this crucial area.

Together with NAMI's Consumer Education and Support Staff and the NAMI Consumer Council, the Massachusetts Department of Mental Health has developed Hearts and Minds, a curriculum for interested consumers and family members that features successful risk-reduction accounts, outlines the medical risks that accompany many psychiatric disorders, and offers strategies to deal with them. I am delighted to partner with NAMI on this urgent and important issue.

*Psychiatric illnesses challenge and stretch our hearts in a figurative way—
let us use our advocacy and passion
to raise the awareness of the issue of heart health
in a literal way as well.*