Crisis Counseling Assistance and Training Program Trainer's Toolkit

Handout 4

Recognizing Severe Reactions to Disaster and Common Psychiatric Disorders

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Introduction

When meeting with disaster survivors, crisis counselors may come into contact with people experiencing severe reactions to the disaster. Because treatment is not part of the Crisis Counseling Assistance and Training Program (CCP), the goal of crisis counseling is to recognize these reactions and know when to alert a team leader or program manager to any concerns. If unresolved, severe reactions, such as social isolation, paranoia, and suicidal behavior, may begin to interfere with daily functioning and develop into psychiatric disorders. The psychiatric disorders most often associated with a traumatic event include depressive disorders, substance abuse, acute stress disorder, anxiety disorders, posttraumatic stress disorder (PTSD), and dissociative disorders.

Crisis counselors may also encounter survivors who have preexisting psychiatric disorders and have become disconnected from treatment, or who may be experiencing an aggravation of their symptoms. These disorders include those described above, as well as bipolar disorder, borderline personality disorder, eating disorders, obsessive-compulsive disorder (OCD), panic disorder, schizoaffective disorder, schizophrenia, and co-occurring mental illness and substance abuse. Crisis counselors need to be able to recognize the possible symptoms of common psychiatric disorders so they know when to request assistance from their team leaders or other professionals in the program.

Since the CCP is not a treatment program, the role of team leaders or other mental health professionals is to recognize and refer those in need of treatment services to local behavioral health services and not to provide treatment themselves. Whenever possible, crisis counselors, in consultation with their team leaders, may follow up with survivors to ensure they have connected with the needed resources.

Please note that only a trained mental health professional can diagnose mental illness and provide psychotherapy, and a psychiatrist or medical doctor typically prescribes medication.

Crisis counselors may encounter developmental disabilities, cognitive impairments, dementia, traumatic brain injury, traumatic or complicated grief, and attention deficit hyperactivity disorder in some survivors.

The contents of this handout are not exhaustive. Crisis counselors should always seek the assistance of supervisors and clinical personnel in any situation where there is a question about a person's level of distress.

Severe Reactions to a Traumatic Event

The following severe reactions may result from an increase in the level of stress brought on by the traumatic event:

Social Isolation

- Social isolation is a feeling of loneliness experienced by the patient as a threatening state imposed by others; a sense of loneliness caused by the absence of family and friends; or the absence of a supportive or significant personal relationship caused by the patient's unacceptable social behavior or social values, inability to engage in social situations, immature interests, inappropriate attitudes for his or her developmental age, alterations in physical appearance, or mental status or illness. It is important to be aware of the possibility of social isolation when counseling people who are known to have developmental disabilities, cognitive impairments, dementia, and traumatic brain injury.
- Symptoms:
  - Feelings of loneliness imposed by others
  - Feelings of rejection
  - Feelings of difference from others
  - Insecurity in public
  - Sad, dull affect
  - Uncommunicative and withdrawn behavior and lack of eye contact
  - Preoccupation with own thoughts or repetitive, meaningless actions
  - Hostility in voice and behavior

Paranoia

- Paranoia is an unfounded or exaggerated distrust of others, sometimes reaching delusional proportions. Paranoid individuals constantly suspect the motives of those around them, and believe that certain individuals, or people in general, are "out to get them." Acute, or short-term, paranoia may occur in some individuals overwhelmed by stress.
- Symptoms:
  - Belief that others are plotting against him or her
  - Preoccupation with unsupported doubts about friends or associates
  - Reluctance to confide in others due to a fear that information may be used against him or her
  - Reading negative meanings into innocuous remarks
  - Bearing grudges
  - Perceiving attacks on his or her reputation that are not clear to others and being quick to counterattack
  - Maintaining unfounded suspicions regarding the fidelity of a spouse or significant other

Suicidal Behavior

- Suicidal behavior is a severe reaction that may result from several psychiatric disorders. Most people who kill themselves have a diagnosable and treatable psychiatric illness.
- Symptoms:
  - History of attempted suicide (Those who have made serious suicide attempts are at a much higher risk for actually taking their lives.)
  - Family history of suicide, suicide attempts, depression, or other psychiatric illness
  - Depression with an unrelenting low mood, pessimism, hopelessness, desperation, anxiety, psychic pain, and inner tension
  - Sleep problems
  - Increased alcohol or drug use
  - Engagement in recent impulsive or unnecessarily risky behavior
  - Making threats of suicide or expressing a strong wish to die
  - Plans of self-harm or suicide
  - Allocation of prized possessions
  - Sudden or impulsive purchase of a firearm
  - Acquiring other means of killing oneself such as poisons or medications
  - Unexpected rage or anger

Psychiatric Disorders Most Often Associated with a Traumatic Event

If left untreated or if unresponsive to crisis counseling interventions, severe reactions may lead to a psychiatric disorder. These disorders may be preexisting or may result from an increase in the level of stress brought on by the traumatic event and include the following:

Depressive Disorders

- Depressive disorders are illnesses that involve the body, mood, and thoughts. They affect the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. Without treatment, symptoms can last for weeks, months, or years.
- Symptoms:
  - Persistently sad or irritable mood
  - Pronounced changes in sleep, appetite, and energy
  - Difficulty thinking, concentrating, and remembering
  - Physical slowing or agitation
  - Lack of interest in or pleasure from activities once enjoyed
  - Feelings of guilt, worthlessness, hopelessness, and emptiness
  - Recurrent thoughts of death or suicide
  - Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Substance Abuse

- Substance abuse is a pattern of substance use resulting in consequences in major life areas. Substance misuse is the use of a substance in ways or for reasons other than intended for that substance.

- Symptoms:

  - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
  - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
  - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
  - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

Acute Stress Disorder

- Acute stress disorder is an anxiety disorder characterized by a cluster of dissociative and anxiety symptoms that occur within a month of a traumatic stressor. The immediate cause of acute stress disorder is exposure to trauma—an extreme stressor involving a threat to life or the prospect of serious injury; witnessing an event that involves the death or serious injury of another person; or learning of the violent death or serious injury of a family member or close friend.

- Symptoms:

  - Being dazed or less aware of surroundings
  - Depersonalization
  - Dissociative amnesia
  - Reexperiencing the trauma in dreams, images, thoughts, illusions, or flashbacks; or intense distress when exposed to reminders of the trauma
  - Tendency to avoid people, places, objects, conversations, and other stimuli reminiscent of the trauma
  - Hyperarousal or anxiety, including sleep problems, irritability, inability to concentrate, an unusually intense startle response, hypervigilance, and physical restlessness
  - Significantly impaired social functions or the inability to do necessary tasks, including seeking help

Anxiety Disorders

- Anxiety disorders, unlike the relatively mild, brief anxiety caused by a stressful event, last at least 6 months and can worsen if not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder. Specific anxiety disorders include panic disorder, OCD, PTSD, social phobia (or social anxiety disorder), specific phobias, and generalized anxiety disorder.

- Symptoms:
  - Each anxiety disorder has different symptoms, but all the symptoms cluster around excessive, irrational fear and dread.
  - Sometimes alcoholism, depression, or other coexisting conditions have such a strong effect on the individual that treating the anxiety disorder must wait until the coexisting conditions are brought under control.

PTSD

- PTSD is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months; others have symptoms that last much longer. In some people, the condition becomes chronic.

- Symptoms:
  - Persistent frightening thoughts and memories of the ordeal
  - Emotional numbness, especially toward people with which the individual was once close
  - Sleep problems
  - Feelings of detachment
  - Being easily startled

Dissociative Disorders

- Dissociative disorders are characterized by a dissociation from or interruption of a person's fundamental aspects of waking consciousness (such as one's personal identity or history). All of the dissociative disorders are thought to stem from trauma experienced by the individual with this disorder. Dissociative disorders include

dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalization disorder.

- Symptoms:
  - The person literally dissociates himself or herself from a situation or experience too traumatic to integrate with his or her conscious self.
  - Symptoms of one or more of the disorders are also seen in a number of other mental illnesses, including PTSD, panic disorder, and OCD.

Preexisting Psychiatric Disorders

In addition to the disorders described above, the following conditions may also have existed prior to the disaster.

Bipolar Disorder

- Bipolar disorder, or manic depression, causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic, typically varying greatly during a person's life as well as among individuals. Bipolar disorder is a chronic, generally lifelong condition with recurring episodes of mania and depression lasting from days to months; episodes often begin in adolescence or early adulthood, and occasionally in children.
- Symptoms of mania:
  - An elated, happy mood or an irritable, angry, unpleasant mood
  - Increased physical and mental activity and energy
  - Racing thoughts and flight of ideas
  - Increased talking, more rapid speech than normal
  - Ambitious, often grandiose plans
  - Risk taking
  - Impulsive activity (e.g., spending sprees, sexual indiscretion, alcohol abuse)
  - Decreased sleep without experiencing fatigue
- Symptoms of depression:
  - Loss of energy
  - Prolonged sadness
  - Decreased activity and energy
  - Restlessness and irritability
  - Inability to concentrate or make decisions
  - Increased feelings of worry and anxiety
  - Less interest or participation in and less enjoyment of activities normally enjoyed
  - Feelings of guilt and hopelessness
  - Thoughts of suicide
  - Change in appetite
  - Change in sleep patterns

Borderline Personality Disorder

- Borderline personality disorder is characterized by instability in moods, interpersonal relationships, self-image, and behavior. This instability often disrupts family and work, long-term planning, and the individual's sense of self-identity.
- Symptoms—A pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - Identity disturbance—markedly and persistently unstable self-image or sense of self
  - Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
  - Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
  - Affective instability due to a marked reactivity of mood (e.g., intense episodic irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
  - Transient, stress-related paranoid ideation or severe dissociative symptoms

Eating disorders

- **Anorexia nervosa** is a serious, often chronic, and life-threatening eating disorder defined by a refusal to maintain minimal body weight within 15 percent of an individual's normal weight. Other essential features of this disorder include an intense fear of gaining weight and a distorted body image. Symptoms include the following:
  - Preoccupation with food
  - Refusal to maintain minimally normal body weight
  - Continuing to think of oneself as fat even when he or she is bone-thin
  - Brittle hair and nails
  - Dry and yellow skin
  - Depression
  - Complaining of hypothermia
  - Fine, downy hair growth on the body
  - Strange eating habits such as cutting food into tiny pieces or refusing to eat in front of others

- **Bulimia nervosa** is marked by a destructive pattern of binge eating and recurrent inappropriate behavior to control one's weight. It can occur together with other psychiatric disorders such as depression, OCD, substance dependence, or self-injurious behavior. Binge eating is defined as the consumption of excessively large amounts of food within a short period of time. Symptoms include the following:
  - Constant concern about food and weight
  - Self-induced vomiting
  - Erosion of dental enamel
  - Scarring on the backs of the hands (due to repeatedly pushing fingers down the throat to induce vomiting)
  - Swelling of the glands near the cheeks (a small percentage of people show this symptom)
  - Irregular menstrual periods and a decrease in sexual interest
  - Depression
  - Sore throats and abdominal pain

OCD

- OCD is a psychiatric disorder characterized by obsessive thoughts or compulsive behaviors. While most people at one time or another experience such thoughts or behaviors, an individual with OCD experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life.
- **Obsessions** are intrusive, irrational thoughts or unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the person experiences disturbing thoughts, such as "My hands must be contaminated; I must wash them"; "I may have left the gas stove on"; "I am going to injure my child." On one level, the sufferer knows these obsessive thoughts are irrational. But on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.
- **Compulsions** are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. Individuals repeat these actions, perhaps feeling momentary relief, but without feeling satisfaction or a sense of completion. People with OCD feel they must perform these compulsive rituals or something bad will happen.
- Symptoms:
  - Repeatedly checking things, perhaps dozens of times, before feeling secure
  - Fear of harming others
  - Feeling dirty and contaminated
  - Constantly arranging and ordering things
  - Excessive concern with body imperfections
  - Being ruled by numbers—believing that certain numbers represent good, and others represent evil
  - Excessive concern with sin or blasphemy

Panic Disorder

- Panic disorder is characterized by recurrent panic attacks, at least one of which leads to a month of increased anxiety or avoidant behavior. Panic disorder may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack.
- Symptoms:
  - Sweating
  - Hot or cold flashes
  - Choking or smothering sensations
  - Racing heart
  - Labored breathing
  - Trembling
  - Chest pains
  - Faintness
  - Numbness
  - Nausea
  - Disorientation
  - Feelings of dying, losing control, or losing one's mind
- Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly and then subside. A person may feel anxious and jittery for many hours after experiencing a panic attack.

Schizophrenia

- Schizophrenia often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, and relate to others. A person with schizophrenia does not have a "split personality," and almost all people with schizophrenia are not dangerous or violent toward others while they are receiving treatment.
- Symptoms of schizophrenia are generally divided into three categories (positive, negative, and cognitive):

  - Positive symptoms, or "psychotic" symptoms, include delusions and hallucinations because the patient has lost touch with reality in certain important ways. "Positive" refers to having overt symptoms that should not be there. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, that others are secretly monitoring and threatening them, or that they can control other people's minds. Hallucinations cause people to hear or see things that are not present.

  - Negative symptoms include emotional flatness or lack of expression, an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life. "Negative" does not refer to a person's attitude, but rather to a lack of certain characteristics that should be there.

- Cognitive symptoms pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, certain kinds of memory functions, and organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial, but rather a part of the mental illness itself.

Schizoaffective Disorder

- Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. It is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder.
- Symptoms:
  - A person needs to have primary symptoms of schizophrenia (such as delusions, hallucinations, disorganized speech, and disorganized behavior), along with a period of time when he or she also has symptoms of major depression or a manic episode. Accordingly, schizoaffective disorder may have two subtypes: (1) depressive subtype, characterized by major depressive episodes only, and (2) bipolar subtype, characterized by manic episodes with or without depressive symptoms or depressive episodes.
  - The mood symptoms in schizoaffective disorder are more prominent and last for a substantially longer time than those in schizophrenia.
  - Schizoaffective disorder may be distinguished from a mood disorder by the fact that delusions or hallucinations must be present in people with schizoaffective disorder for at least 2 weeks in the absence of prominent mood symptoms.
  - The diagnosis of a person with schizophrenia or mood disorder may change later to that of schizoaffective disorder, or vice versa.

Co-occurring Mental Illness and Substance Abuse

- Co-occurring mental illness and substance abuse are often referred to as co-occurring disorders. To recover fully, a consumer with co-occurring disorders needs treatment for both problems—focusing on one does not ensure the other will go away. Dual-diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.
- What follows are some statistics, provided by the National Alliance on Mental Illness, on the prevalence of co-occurring disorders:
  - Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
  - Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
  - Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.
  - Of people with a 12-month addictive disorder, 42.7 percent had at least one 12-month mental disorder.
  - Of individuals with a 12-month mental disorder, 14.7 percent had at least one 12-month addictive disorder.
  - Forty-seven percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population).

- Sixty-one percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).

- Often, people can suffer from more than one psychiatric disorder at a time. In addition, people can suffer from psychiatric and medical disorders simultaneously and may need treatment referrals for both.

Treatment Approaches

This section identifies general treatment approaches for a variety of psychiatric disorders. The following interventions are used either alone or in combination, depending on the treatment approach chosen by the survivor in consultation with his or her mental health treatment professional.

- A comprehensive approach to treatment would include a combination of interventions, such as the following:
  - Connecting the person with a peer counselor
  - Referring the person to a support group
  - Supporting family communication
  - Enhancing spirituality
  - Establishing a personal connection with a health care provider
  - Assisting the person with the use of Internet-based supports
- It is important to note several additional points:
  - Medication is most effective when it is used as part of an overall treatment plan that includes supportive therapy.
  - Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance-use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful.
  - Support groups and community-based programs, as well as 12-step recovery programs, provide peer support to people suffering from substance abuse.
  - Cognitive therapy is used to help people think and behave appropriately. People learn to make the feared object or situation less threatening as they are exposed to, and slowly get used to, whatever is so frightening to them.
  - Healthy living habits may also help. Exercise, a proper and balanced diet, moderate use of caffeine and alcohol, and learning how to reduce stress are all important.

Ten Fundamental Components of Mental Health Recovery

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

- **Self-direction**—Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and person-centered**—There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment**—Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic**—Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Nonlinear**—Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths based**—Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer support**—Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect**—Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in

oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

- **Responsibility**—Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope**—Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The previous information comes from the *National Consensus Statement on Mental Health Recovery*, which can be found at http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf

Conclusion

This handout was designed to give crisis counselors more information about severe reactions to trauma and psychiatric disorders that they may encounter in a small number of disaster survivors. When a severe reaction or psychiatric disorder is suspected, the crisis counselor needs to alert the CCP team leader and clinical personnel. The crisis counselor should work should work with the survivor to determine if referral is needed, and then, the crisis counselor should make use of the resource linkage to refer the survivor to the appropriate resource. If possible, crisis counselors can follow up with survivors to see if they have made use of the referred services. Use of the Adult Assessment and Referral Tool is a way to keep track of survivors who may be suffering from severe reactions to disaster. As with all issues related to severe reactions and psychiatric disorders, use of the tool for this purpose should be done in consultation with CCP team leaders and clinical personnel.

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