Crisis Counseling Assistance and Training Program Trainer's Toolkit

Handout 4

Recognizing Severe Reactions to Disaster and Common Psychiatric Disorders

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In the course of 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 (ASD), anxiety disorders, posttraumatic stress disorder (PTSD), and dissociative disorders.

Crisis counselors may also encounter survivors who have pre-existing 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 (BPD), eating disorders, obsessive-compulsive disorder (OCD), panic disorder, schizoaffective disorder, schizophrenia, and cooccurring mental illness and substance abuse. Crisis counselors need to be able to recognize the symptoms of common psychiatric disorders so they know when to request assistance from their team leader or another professional 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 leader, may follow up with survivors to ensure they have connected with the needed resource.

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.

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

The contents of this handout are not exhaustive. Crisis counselors should seek the assistance of supervisors and clinical personnel if they encounter anyone who appears to be seriously dysfunctional but does not fall into one of the categories presented.

Severe reactions to a traumatic event include the following:

- **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 know to have developmental disabilities, cognitive impairments, dementia, and traumatic brain injury.

- Symptoms:
  - Expresses feelings of loneliness imposed by others.
  - Expresses values acceptable to subculture, but is unable to accept values of dominant culture.
  - Expresses feelings of rejection.
  - Expresses feelings of difference from others.
  - Experiences insecurity in public.
  - Has sad, dull affect.
  - Lacks supportive significance toward family, and friends.
  - Is uncommunicative and withdrawn, and does not make eye contact.
  - Is preoccupied with own thoughts or performs repetitive, meaningless actions.
  - Projects hostility in voice, behavior.
  - Seeks to be alone or exists in subculture.
- Treatment options—the best approach is a combination of a number of interventions including 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 healthcare provider.
  - Assisting the person with the use of Internet-based supports.

- **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." Paranoid perceptions and behavior may appear as features of a number of mental illnesses, including depression and dementia, but are most prominent in three types of psychological disorders: paranoid schizophrenia, delusional disorder (persecutory type), and paranoid personality disorder. Acute, or short-term, paranoia may occur in some individuals overwhelmed by stress.
  - Symptoms:
    - Has suspicious and unfounded suspicions.
    - Believes others are plotting against him or her.
    - Is preoccupied with unsupported doubts about friends or associates.
    - Is reluctant to confide in others due to a fear that information may be used against him or her.
    - Reads negative meanings into innocuous remarks.
    - Bears grudges.
    - Perceives attacks on his or her reputation that are not clear to others, and is quick to counterattack.
    - Maintains unfounded suspicions regarding the fidelity of a spouse or significant other.

- Treatment options:
  - Antipsychotic medication, such as thioridazine (Mellaril), haloperidol (Haldol), chlorpromazine (Thorazine), clozapine (Clozaril), or risperidone (Risperdal), may be prescribed.
  - Cognitive therapy or psychotherapy may be employed to help the patient cope with the paranoia or persecutory delusions.
  - If an underlying condition, such as depression or drug abuse, is triggering the paranoia, an appropriate course of medication or psychosocial therapy is employed to treat the primary disorder.

- **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—major depression, bipolar depression, or some other depressive illness, including schizophrenia; alcohol or drug abuse, particularly when combined with depression; PTSD or some other anxiety disorder; bulimia or anorexia nervosa; a personality disorder, especially borderline or antisocial; and a history of attempted suicide.
  - Symptoms:
    - History of attempted suicide; those who have made serious suicide attempts are at a much higher risk for actually taking their lives.
    - Genetic predisposition.
    - 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.
    - Recent impulsive or unnecessarily risky behavior.
    - Threats of suicide or expression of a strong wish to die.
    - Plans of self-harm or suicide.
    - Allocation of prized possessions.
    - Sudden or impulsive purchase of a firearm.
    - Acquirement of other means of killing oneself such as poisons or medications.
    - Unexpected rage or anger.
  - Treatment options:
    - Cognitive therapy helps suicide attempters consider alternative actions when thoughts of self-harm arise.
    - The medication clozapine is approved for suicide prevention in people with schizophrenia.
    - Improving primary-care providers' ability to recognize and treat risk factors may help prevent suicide among some groups.

Psychiatric disorders most often associated with a traumatic event include the following:

- **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. Appropriate treatment, however, can help most people who suffer from depression.
  - 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.
  - Treatment options:
    - Antidepressant medications such as the selective serotonin reuptake inhibitors, tricyclics, and monoamine oxidase inhibitors.
    - Short-term psychotherapies such as cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT).

- **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. Substance dependence is a pattern of substance use resulting in physiological or psychological tolerance or withdrawal, in addition to major functional impairments in life areas.
  - Symptoms:
    - Recurrent substance use resulting in a failure to fulfill major role obligation 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).

- Treatment options:
  - Many treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.
  - Medication assisted treatment (MAT) 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.
  - In the United States, MAT has been demonstrated to be effective in the treatment of alcohol dependence with approved drugs such as disulfiram, naltrexone, and acamprosate; and in the treatment of opioid dependence with methadone, naltrexone, and buprenorphine.
  - Support groups and community-based programs, as well as 12-step recovery programs, provide peer support to people suffering from substance abuse.

- **ASD** is an anxiety disorder characterized by a cluster of dissociative and anxiety symptoms that occur within a month of a traumatic stressor. It is a relatively new diagnostic to distinguish time-limited reactions to trauma from the farther reaching and longer lasting PTSD. The immediate cause of ASD 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:
    - Psychic numbing.
    - 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.
  - Treatment options:
    - Medications are usually limited to those necessary for treating individual symptoms.
    - CBT, exposure therapy, therapeutic writing (journaling), and supportive therapy have been found effective in treating ASD.
    - Group and family therapies also appear to help patients with ASD reinforce effective strategies for coping with the trauma, and may reduce the risk of social isolation as a reaction to the trauma.

- Critical incident stress management (CISM) is a comprehensive crisis-intervention system in which a team of specially trained practitioners comes to the site of a traumatic event and provides several different forms of assistance, including one-on-one crisis support; crisis management briefing, which is a 45–75-minute intervention for groups of people affected by the traumatic event; and critical incident stress debriefing, which is a structured group discussion of the event.
- CISM appears to be particularly helpful in preventing burnout and ASD in emergency service personnel, rescue personnel, police, and other caregivers involved in treating survivors of a traumatic event.
- Holistic or naturopathic approaches help with recovery from ASD, including good nutrition with appropriate dietary supplements and regular exercise.
- Yoga and some forms of body work or massage therapy are helpful in treating the muscular soreness and stiffness that is often a side effect of the anxiety and insomnia related to ASD.
- Prayer, meditation, and counseling with a spiritual advisor have been found to be helpful in treating patients who have ASD and whose belief systems have been affected by the traumatic event.

- **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.
  - Treatment options:
    - In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both. Treatment choices depend on the problem and the person's preference.
    - If an anxiety disorder is diagnosed, the type of disorder or the combination of disorders that are present must be identified, as well as any coexisting conditions, such as depression or substance abuse.
    - 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** 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 with people the individual was once close to.
  - Sleep problems.
  - Feelings of detachment.
  - Being easily startled.
- Treatment options:
  - People with PTSD may be treated with psychotherapy (“talk” therapy), medications, or a combination of the two.

- **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 dissociative aspect is thought to be a coping mechanism.
    - The person literally dissociates himself or herself from a situation or experience too traumatic to integrate with his or her conscious self.
    - Symptoms of these disorders, or even one or more of the disorders themselves, are also seen in a number of other mental illnesses, including PTSD, panic disorder, and OCD.
  - Treatment options:
    - Psychotherapy may be used, but a combination of psychopharmacological and psychosocial treatments is often used.
    - Many of the symptoms of dissociative disorders occur with other disorders, such as anxiety and depression, and can be controlled by the same drugs used to treat those disorders.
    - A person in treatment for a dissociative disorder might benefit from antidepressants or antianxiety medication.

Pre-existing psychiatric conditions can include any of the previously mentions conditions or any of the following:

- **Bipolar disorder**, or manic depression, causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly during the course of a person’s life as well as among individuals. Bipolar disorder is a chronic and generally lifelong condition with recurring episodes of mania and depression that can last from days to months; episodes often begin in adolescence or early adulthood, and occasionally even in children.
  - Symptoms:
    - Mania describes the activated phase of bipolar disorder. The symptoms of mania may include the following:
      - 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
    - Depression is the other phase of bipolar disorder. The symptoms of depression may include the following:
        - 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.
    - A mixed state is when symptoms of mania and depression occur at the same time. During a mixed state depressed mood accompanies manic activation.
- Treatment options:
    - Medication is an essential element of successful treatment for people with bipolar disorder.
    - Psychosocial therapies, including CBT, IPT, family therapy, and psycho-education, are important to help people understand the illness and to internalize skills to cope with the stresses that can trigger episodes.
    - Changes in medications or doses may be necessary, as well as changes in treatment plans during different stages of the illness.
    - Medications include lithium (Eskalith or Lithobid), divalproex sodium (Depakote), carbamazepine (Tegretol), olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), ziprasidone (Geodon), aripiprazole (Abilify), haloperidol (Haldol), and fluoxetine (Symbyax).

- **BPD** 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. BPD affects 0.07–2 percent of the general population.
    - Symptoms—a pervasive 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.
    - Treatment options—treatment for BPD has changed radically; in turn, the prognosis for improvement or recovery has significantly improved. Unfortunately, specialized treatment for BPD is not yet widely available.
        - Therapists must pay attention first to suicidal and self-mutilative behaviors.
        - Next, deal with any threats to interrupt therapy prematurely.
        - Third, in order of seriousness—nonsuicidal symptoms, such as mild-to-moderate depression; substance abuse; panic and other anxiety manifestations; or dissociation.
        - Psychopharmacological treatment will often be used adjunctively to help control any target 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, a distorted body image, and amenorrhea (absence of at least three consecutive menstrual cycles when they are otherwise expected to occur). In addition to the classic pattern of restrictive eating, some people will also engage in recurrent binge eating and purging episodes. Starvation, weight loss, and related medical complications are quite serious and can result in death.
    - **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. The food is often sweet, high in calories, and has a texture that makes it easy to eat fast. "Inappropriate compensatory behavior" to control one's weight may include purging behaviors (such as self-induced vomiting, abuse of laxatives, diuretics, or enemas) or nonpurging behaviors (such as fasting or excessive exercise).
    - Symptoms:
        - Anorexia nervosa:
            - Preoccupation with food.
            - Refusal to maintain minimally normal body weight.
            - Continuing to think oneself looks 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:
        - 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).
        - A small percentage of people with bulimia show swelling of the glands near the cheeks.
        - Irregular menstrual periods and a decrease in sexual interest.
        - Depression.
        - Sore throats and abdominal pain.
- Treatment options:
    - Anorexia nervosa:
        - Most complications experienced by people with anorexia nervosa are reversible when they restore weight.
        - People with this disorder should be diagnosed and treated as soon as possible because eating disorders are most successfully treated when diagnosed early.
        - Some patients can be treated as outpatients, but some may need hospitalization to stabilize their dangerously low weight.
        - The most effective strategies for treating a patient have been weight restoration within 10 percent of normal, and individual, family, and group therapies.
        - Some form of psychotherapy is needed to deal with underlying emotional issues.
        - Group therapy is often advised so people can share their experiences with others.
        - Family therapy is important particularly if the individual is living at home and is a young adolescent.
        - A physician or advanced-practice nurse is needed to prescribe medications that may be useful in treating the disorder.
        - A nutritionist may be necessary to advise the patient about proper diet and eating regimens.
    - Bulimia nervosa
        - Most people with bulimia can be treated through individual outpatient therapy because they are not in danger of starving themselves as are people with anorexia.

        - If the bulimia is out of control, admission to an eating disorders treatment program may help people let go of behaviors so they can focus on treatment.
        - Group therapy is especially effective for college-aged and young adult women because of the understanding of the group members.
        - CBT, either in a group setting or individual therapy session, has been shown to benefit many people with bulimia.
        - CBT is often combined with nutritional counseling or antidepressant medications such as fluoxetine (Prozac).

- **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. OCD is often described as "a disease of doubt." Sufferers experience "pathological doubt" because they are unable to distinguish between what is possible, what is probable, and what is unlikely to happen.
    - **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 handwashing, 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.
    - Treatment options:
        - Medication can regulate serotonin, reducing obsessive thoughts and compulsive behaviors.
        - Behavior therapy is "exposure and response prevention," and it is effective for many people with OCD. Consumers are deliberately exposed to a feared object or idea, either directly or by imagination, and are then discouraged or prevented from carrying out the usual compulsive response.
        - Most people with OCD are treated with a combination of medication and behavior therapy.

- **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 in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours after experiencing a panic attack.
  - Treatment options:
    - Cognitive therapy is used to help people think and behave appropriately. Patients 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.
    - Medication is most effective when it is used as part of an overall treatment plan that includes supportive therapy. Antidepressants and antianxiety medications are the most successful medications for this disorder.
    - Healthy living habits may also help people overcome panic disorder. Exercise, a proper and balanced diet, moderate use of caffeine and alcohol, and learning how to reduce stress are all important.
    - Peer support is a vital part of overcoming panic disorder. Family and friends can play a significant role in the treatment process and should be informed of the treatment plan and of the ways they can be most helpful.

- **Schizophrenia** often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early twenties, often later for females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives, and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. 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—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.
- Treatment options:
  - While there is no cure for schizophrenia, it is a treatable and manageable illness. However, people sometimes stop treatment because of medication side effects, the lack of insight noted above, disorganized thinking, or because they feel the medication is no longer working.
  - People with schizophrenia who stop taking prescribed medication are at risk of relapse into an acute psychotic episode. It is important to realize that the needs of the person with schizophrenia may change over time.
  - Recovery supports and relapse prevention—peer–to-peer programs are designed to help individuals with mental illness learn from those who have become skilled at managing their illness.
  - Family support—caregivers benefit greatly from family education programs, taught by family members who have the knowledge and the skills needed to cope effectively with a loved one with a mental disorder.
  - Hospitalization—individuals who experience acute symptoms of schizophrenia may require intensive treatment, including hospitalization. Hospitalization is necessary to treat severe delusions or hallucinations, serious suicidal thoughts, an inability to care for oneself, or severe problems with drugs or alcohol.
  - Medication—antipsychotics help relieve the positive symptoms of schizophrenia by helping to correct an imbalance in the chemicals that enable brain cells to communicate with each other.
  - Conventional antipsychotics include chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), thiothixene (Navane), trifluoperazine (Stelazine), perphenazine (Trilafon), and thioridazine (Mellaril). Some of the risks that may be incurred from taking these medicines include dry mouth, blurred vision, drowsiness, constipation, and movement disorders such as stiffness, a sense of restless motion, and tardive dyskinesia.

- "Atypical" antipsychotics appear to be equally effective for helping reduce the positive symptoms, such as hallucinations and delusions, but may be better than the older medications at relieving the negative symptoms of the illness. The atypical antipsychotics include risperidone (Risperdal), clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel), and ziprasidone (Geodon), and Clozapine (Clozaril). All these antipsychotics have serious side effects, such as weight gain and the risk of diabetes, but they all do not carry the same relative risk for these conditions.
- Psychosocial rehabilitation—research shows that people with schizophrenia who attend structured psychosocial rehabilitation programs and continue with their medical treatment manage their illness best.
- Substance-use counseling, housing, work, and educational skill development are among other supports frequently required to maximize a person's prospects for a higher functional level.

- **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, there may be two subtypes of schizoaffective disorder:
      - Depressive subtype, characterized by major depressive episodes only.
      - 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.
  - Treatment options:
    - The most effective treatment for schizoaffective disorder is a combination of drug treatment and psychosocial interventions.
    - The medications include antipsychotics, along with antidepressants or mood stabilizers.
    - The newer atypical antipsychotics, such as clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole, are safer than the older typical or conventional antipsychotics such as haloperidol and fluphenazine.
    - The newer drugs may also have better effects on mood symptoms.
    - These medications do have some side effects, especially at higher doses. The side effects may include excessive sleepiness, weight gain, and sometimes diabetes.

- Changing from one antipsychotic to another one may help if a person with schizoaffective disorder does not respond well to or develops distressing side effects with the first medication. The same principle applies to the use of antidepressants or mood stabilizers.

- **Cooccurring Mental Illness and Substance Abuse** are often referred to as cooccurring disorders. To recover fully, a consumer with cooccurring 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 for Mental Illness, on the prevalence of cooccurring disorders:
    - Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
    - 37 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.
    - 42.7 percent of individuals with a 12-month addictive disorder had at least one 12-month mental disorder.
    - 14.7 percent of individuals with a 12-month mental disorder had at least one 12-month addictive disorder.
    - 47 percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population).
    - 61 percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).
  - Treatment options:
    - Providing appropriate, integrated services for people with a dual diagnosis not only will allow for their recovery and improved overall health, but can ameliorate the effects their disorders have on their family, friends, and society at large.
    - Individuals with a substance abuse disorder are more likely to receive treatment if they have a cooccurring mental disorder.
    - Research shows that when consumers with dual diagnosis successfully overcome alcohol abuse, their response to treatment improves remarkably.
    - Effective integrated treatment consists of the same health professionals working in one setting and providing appropriate treatment for both mental health and substance abuse in a coordinated fashion.
    - The caregivers see to it that interventions are bundled together; the consumers, therefore, receive consistent treatment, with no division between mental health and substance abuse assistance.
    - The approach, philosophy, and recommendations are seamless, and the need to consult with separate teams and programs is eliminated.
    - Integrated treatment also requires the recognition that substance abuse counseling and traditional mental health counseling are different approaches that must be reconciled to treat cooccurring disorders. It is not enough merely to teach relationship skills to people with bipolar disorder. They must also learn to explore how to avoid the relationships intertwined with their substance abuse.

- Assertive outreach has been shown to engage and retain clients at a high rate; while those who fail to include outreach lose clients. Therefore, effective programs—through intensive case management, meeting at the consumer's residence, and other methods of developing a dependable relationship with the client—ensure that more consumers are consistently monitored and counseled.
- Motivational interventions help empower deeply demoralized clients to recognize the importance of their goals and illness self-management.
- Counseling helps develop positive coping patterns and promotes cognitive and behavioral skills.
- Social support is critical. The immediate environment has a direct impact on choices and moods; therefore, consumers need help strengthening positive relationships and jettisoning those that encourage negative behavior.
- Cultural sensitivity and competence help various groups, such as African-Americans, homeless people, women with children, Hispanics, and others, benefit from services tailored to their particular racial and cultural needs.

o 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.

This handout gives crisis counselors more information about severe reactions to trauma and psychiatric conditions they may encounter in a small number of disaster survivors. When a severe reaction or psychiatric condition is suspected, the crisis counselor needs to alert the CCP team leader and clinical personnel. Survivors should then be referred to treatment providers. 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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