

# A MINISTRY LEADER'S HANDBOOK

*for Mental Health Emergencies & Social Services*

PHIL COLLIER, PhD  
LINK CARE COUNSELING CENTER



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*The contact information provided in this handbook was correct  
at the time of publication in 2019*

A MINISTRY LEADER'S HANDBOOK FOR MENTAL HEALTH  
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# LINK CARE CENTER

*God is our refuge and strength,  
an ever-present help in trouble.*

*Therefore we will not fear.*

P S A L M 46:1-3

## *foreword*

IT IS MY HOPE that this handbook will be a valuable resource for pastors and Christian workers as they face difficult and challenging crisis situations and mental health issues.

At the age of 18, I began working in youth ministry and during my college years, served on a church staff as a youth pastor. These experiences along with my close relationship to family members who are pastors and continued church involvement have served to inform my understanding of some of the challenges that pastors face in ministry.

In addition to my church ministry background, I have worked for 29 years as a psychologist on the staff of Link Care Counseling Center, a ministry that serves pastors, missionaries and local clients who need counseling services. During 14 of those years I was a full-time psychology professor at Fresno Pacific University. I currently serve as the CEO of Link Care Foundation.

This handbook is drawn from those experiences and provides the specific information that I believe could be helpful to pastors as they

address issues that fall into the mental health arena. This handbook will continue to be refined and I would value any input regarding how we might better meet the needs of pastors. Your comments and suggestions can be sent to [philcollier@linkcare.org](mailto:philcollier@linkcare.org).

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*the purpose*

to provide  
*a quick reference guide for pastors who are  
managing a mental health emergency*

to provide  
*a basic overview of psychological disorders  
pastors may encounter*

to provide  
*information to assist pastors in making referrals  
to appropriate supportive services*

*The contact information in this handbook was current at the time of publication in 2019. To verify current contact information, google the referral source. Space has been made to add your own information.*



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MINISTRY LEADER'S  
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*for Mental Health Emergencies & Social Services*



LINK CARE CENTER

### DISCLAIMER NOTICE

*This book is intended to be an educational supplement and adjunct to a larger training process for pastors and church staff members. While this handbook is intended to inform the process of managing a mental health emergency, it is not intended to provide a comprehensive training for suicide assessment or crisis management. It is also not intended to diagnose or treat mental illness. When in doubt it is important to seek professional consultation or to call 911 or the appropriate emergency response people or organization in your area.*



## *Mental Health Emergencies*

### **ACUTE MENTAL HEALTH EMERGENCY RESPONSE**

Pastors frequently deal with major life issues with their parishioners. Often a pastor is able to provide wise advice and direction for those who seek help. There are situations, however, when a pastor is faced with an immediate life-threatening circumstance. In those moments, the best course of action is to call 911 so that emergency services can respond to the situation as soon as possible.

When calling 911 seek a safe location to make the call. Pay attention to your surroundings so that you can provide as much detail as possible to the 911 operator regarding the location, a description of what is occurring and a description of those who are involved. *\*Please see the box on the left.*

#### **Police Officers & 5150: *Involuntary Hospitalization***

There may be times when you are concerned about a person's safety and you call 911. Calling 911 does not necessarily mean that the person will be taken to the hospital. An officer can only initiate a 5150 (Involuntary 72-hour hold) in cases when the person is gravely disabled or a threat to themselves or someone else. It is possible that when the officer evaluates the individual he/she may determine that the person does not meet the legal criteria for a 5150. If the officer isn't able to

#### **\*DIFFERING EMERGENCY RESPONSE SERVICES**

*There are many places in the world where "911" is not available, nor are there "involuntary hospitalization" programs (5150) available. Also, the only possibility for the hurting person might be to be taken to jail. It is important for you to research this now, rather than waiting until you are in the middle of a crisis. Please enter the appropriate information here for your emergency contact organization.*

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initiate a 5150, then the person in crisis will be allowed to leave without restrictions.

An individual may seem out of control, confused disoriented or paranoid and still not be hospitalized. If it is determined that the person is not an immediate threat to themselves or someone else or gravely disabled, they will not be detained.

This can be very frustrating in that in these situations after the 911 call you may find yourself exactly where you started. Or even worse, have the individual angry at you for calling 911. At this point you may be able to encourage the person to voluntarily receive services. If they are willing to receive help, then you can facilitate them going to a hospital emergency room.

**Denial of Suicidality to Law Enforcement**

It is important to understand that a law enforcement officer legally cannot “5150” someone unless they are convinced that there is an imminent risk of harm. A person may have told you that they are going to commit suicide, and then tell the officer that they didn’t really mean it. It is important that you inform the officer of what you were told or what you observed, providing them with factual information. Do not speculate or make conclusions. If the officer does not believe the person is in immediate risk, he/she will not legally be able to initiate an involuntary hold.

***Individuals Who Are in Crisis and Open to Hospitalization:***

- Call 911 and an ambulance will take them to the hospital.
- Contact family to provide support and possible transportation for their evaluation, *only if the person appears stable and safe to transport.*

***Walk-in Mental Health Evaluations***

- See if the individual is willing to go to a local Behavioral Health Center for an evaluation. There may be one locally that is available to do a *walk-in* evaluation. Call *before* making this recommendation to make sure they are currently available to do a walk-in evaluation.
- If there is no walk-in location, take them to an emergency room.

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**EMERGENCY ROOMS**

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## BASIC PRINCIPLES IN SUICIDE ASSESSMENT & RESPONSE

*When in doubt call 911*

*Write in local, regional or national hotline here*

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As a pastor you have likely had someone share with you that they are feeling suicidal or making statements regarding being a burden on their family or saying that the world would be better off without them. Clearly in a case like this you are going to want to direct the person to seek professional Counseling Services. Here are some basic principles that are intended to help guide you in this process.

- Don't be afraid to ask the question, "Are you feeling like hurting yourself?" (A person who is suicidal may feel relieved that you have asked.)
- Take the time to listen and let them share their Story.
- If suicidality is reported, ask if he/she has thought about how he/she might do it.
- Determine if the method is easily accessible to the person.
- Develop a Safety plan (*covered in the next section*)

### When You Believe there is Significant Risk

#### *Uncooperative or Unstable Individuals*

If a person is in acute crisis and seeming to be out of control call 911. It is important that emergency services perform an evaluation on-site. Attempting to transport a person who is in an acute crisis is not a safe option. It places both you and the distressed individual at risk.

#### *Cooperative Individuals*

- The safest option is to call 911 so that the person can be transported by ambulance for an evaluation.
- In cases where a person is cooperative and stable and there are family members available to help, having family take them to Community Behavioral Health Center or to an Emergency room are both possible options.
- Help facilitate a referral to outpatient counseling services.
- Follow up to see that they have received services.

### When a Person is Cooperative and Willing to Develop a Safety Plan

In many cases individuals will share their struggles with feeling suicidal, but they are willing to develop a safety plan. In considering a course of action it is helpful to understand some key risk factors as you consider next steps.

#### *Risk Factors for Suicide*

The following is a list of some of the factors that have been found to increase the chances that a person will move from suicidal ideation to a suicide attempt. The more factors present the greater the risk. Please note that different cultures may have different indicators.

- A prior history of suicide attempts **\*GREATEST RISK FACTOR**
- Hopelessness
- Having relatives who have committed suicide or made serious attempts
- A history of talking about suicide/threats
- Substance use/intoxication

- Physical Illness
- Mental confusion instability
- Family history of child abuse
- A defined suicide plan
- History of impulsivity
- History of aggressive behavior
- Available means, a weapon, medication, knives, rope
- Recent contact with someone who has committed suicide
- Local epidemics of suicide
- Recent publicity of suicides
- Recent loss of a loved one

## Developing a Safety Plan

In cases where a person is struggling with some suicidal thoughts it is well advised to develop a safety plan with them should things suddenly get worse. The following steps can help increase safety for individuals who are struggling with suicidal thoughts.

Therapists may develop comprehensive safety plans with individuals managing suicidal thoughts. This safety plan is not intended to provide a comprehensive model, but rather provide some suggestions that can increase safety for those struggling with suicidal thoughts until they are able to meet with a counselor. The safety plan should be a collaborative process and is not intended for individuals in acute crisis, as is the case with people for whom suicide seems very likely/imminent.

- Identify who they would call in the event that they experience an increase in suicidal feelings.
- Provide contact information for the **Central Valley Suicide**

**Prevention Hotline 1 (800) 273-8255** *\*please make note of your local Suicide Prevention hotline here: \_\_\_\_\_*

- Commitment to call 911 if crisis arises.
- Discuss ways that the person can find comfort if feelings return. Examples: prayer, calling a friend, listening to music.
- Are there things that need to happen to make the environment safe? Examples: removing weapons, giving medications to someone to hold. *(Only family members should be asked to hold weapons or medications. It is advised that as a ministry leader you not offer to store weapons or medications for a parishioner.)*
- Assist by providing counseling referrals.
- Engage in a collaborative process with the person to identify individuals who can be a support to them during their difficult time.

## *Referring to Outpatient Mental Health Service.*

### HEALTH INSURANCE:

It is important to have the individual **contact their insurance carrier and obtain an in-network provider list for counseling services.** (They also need to ask for benefits for outpatient mental health services). In-network providers often have lower deductibles and co-pays. When calling providers, make sure to ask if the in-network clinicians at the agency have current openings.

If they have **out-of-network coverage**, (most policies have this as an option) make sure to confirm that the clinician or agency accepts insurance. In some cases, the out of network coverage can be close to the in-network coverage, in other cases there may be thousands of dollars of difference between deductibles and costs.





## *Violence*

### RESTRAINING ORDERS

In situations where there is an obvious threat it may be necessary to obtain a restraining order. This can be a discouraging process since obtaining a restraining order in some cases can increase the risk of harm. It is advisable to seek a legal consultation if you are considering the possibility of obtaining a restraining order.

The steps involved to obtain a restraining order are somewhat complicated. While it is not impossible to navigate this process without an attorney, it is advisable to seek assistance. If you are unable to afford an attorney call your local Courthouse and ask for assistance.

There are multiple types of restraining orders. It is important to carefully review the criteria on the forms you select to be sure you have the correct type of restraining order which include:

- Civil Harassment Restraining Order
- Domestic Violence Restraining Order
- Request for Elder or Dependent Adult Abuse Restraining Order
- Petition for Work Place Violence Restraining Order
- Petition for Private Post-Secondary School Violence Restraining Order

In cases where there is reasonable proof of great or permanent harm you can request a TRO, (Temporary Restraining Order). This order must be signed by a judge, who can instate the TRO for up to 25 days. *Check*

#### AN IMPORTANT NOTE

*In some countries, there may be no equivalent for dealing with domestic violence with a “restraining order.” You will have to research what resources might be available. You can search un “International domestic violence resources.”*

*We developed these resources according to policies in Central California. Other places may be different.*

*your forms for current timelines.*

The following is an example of the steps that are required to file a Work-Place Violence Restraining Order.

The following is provided to give a general example of the steps needed to complete the process. There may be different procedures for the various types of restraining orders and it is important to carefully follow the steps outlined in each instruction packet for the various orders.

**IMPORTANT:**

*These steps may change. Once the forms are obtained they will guide you through the correct steps to complete the process.*

- Obtain forms from your local courthouse
- ***File completed forms at the court house.***
- Deliver forms to be served (these will be obtained from the courthouse after the judge signs the order) to the appropriate sever. (depending on circumstances).
- The offender must be served prior to the actual court hearing.
- If you are unable to have the offender served, it is advisable to contact an attorney.
- Appear for court, all parties will have the opportunity to present their sides to the judge who will make a decision regarding the restraining order.

**CHILD & ELDER/DEPENDENT  
ADULT REPORTING**

## **Child Abuse Reporting**

### ***Penitential Communications***

In the state of California, if you are a child care custodian you are a mandated reporter of child abuse. For pastors there are some complicating factors relative to this issue and penitential confessions. At Link Care Center, we clarify in our confidentiality documentation that our pastoral care providers do not receive penitential confessions. The following statement is included in our Limits of Confidentiality form.

*Link Care Pastoral Counselors are not authorized to receive penitential communications, and they do not have a duty under the discipline and tenets of this religious organization to keep communications about child abuse, elder abuse, or self-harm confidential. Because of this, any information disclosed to a pastoral counselor regarding child abuse, elder abuse, self-harm or harm to another will be reported to the appropriate authority.*

If you or your organization receives penitential communications, it is important to clarify with your legal counsel the circumstances in which you would be exempt from reporting. It is also advisable that you get information from your organizational leadership or denomination regarding your status as a mandated reporter.

In California, mandated reporter is required to file an immediate report with CPS and a written report ***within 36 hours***, if there is a reasonable suspicion that child abuse has occurred. Broadly defined child abuse includes any type of cruelty inflicted on a child. Examples include physical abuse, mental abuse, sexual assault or exploitation and neglect. Appropriate discipline including spanking is not reportable. However,

spanking that results in injury or slapping a child in the face are clear examples that must be reported.

If someone 18 or older reports they were abused, this is not reportable with the exception of situations where there is evidence that other children are at risk. For example, if abuse is reported and it is known that the perpetrator has direct contact with minors at risk, then a report should be filed.

Counseling students and even professionals often wrestle with the issue regarding whether a specific incident is or is not reportable. When in doubt call CPS. If something is not reportable they will often communicate that to you when you call.

The procedures at CPS do change over time. There was a time when the CPS workers would take phone reports and would not indicate whether the reported event was or was not a reportable incident. During other times, they would tell a mandated reporter when something was not reportable. Filing a report does not mean that there will be a CPS response. CPS workers will make a determination regarding taking action on the report. In the event you are told you do not need to file a report and you feel it is a reportable incident, inform the CPS worker that you want to file a report with them and complete a written CPS report within 36 hours.

*In California, failure to report child abuse by a mandated reporter is a misdemeanor with a penalty up to 6 months in jail and/or \$1,000.*

*What Happens After the CPS Call?*

CPS will classify the severity of the report and respond accordingly. In cases where CPS determines that the event is not reportable, no action will be taken, and the information will be kept on file. In many cases CPS workers will conduct an interview with the child. Depending on assessed risk, the interview may happen days or even more than a week after the report is filed.

In cases of sexual abuse or severe physical abuse uniformed law enforcement officers will respond with CPS to conduct interviews. If they determine the child is in immediate risk, the child will be removed from that setting. CPS will then place the child in a foster care setting, or with family members if it is determined that the family is a safe alternative to foster services.

**REPORTING CHILD ABUSE IN FRESNO COUNTY**

*Please fill in a list of the contact information for your local Child Services/ Child Protective Services Agency.*

***Child Services Information:***

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***Elder and Dependent Adult Abuse Reporting***

In California failure to report elder or dependent adult abuse is a criminal offense if you are a mandated reporter. This includes all employees of a care facility, or agency that provides care for elders and dependent adults, as well as any care provider that provides part or full-time care to seniors and dependent adults.

Elder abuse includes physical & sexual abuse, abandonment, isolation, neglect, mental suffering or financial exploitation. While not everyone is a mandated reporter, if you become aware of abuse it is important to report it to Adult Protective Services.

***Elder Abuse Information:***

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***Domestic Violence Response***

In California providing services to individuals who are the victims of domestic violence requires specialized training and certification. Well-meaning counselors who lack the proper training in dealing with domestic violence may actually increase the risk of injury to someone dealing with a violent partner. For licensed clinicians it is unethical to provide counseling services addressing issues of domestic violence without the proper training. Those who provide pastoral care and lack training in domestic violence should avoid providing ongoing counseling services without the support of a counselor trained in addressing domestic violence.

A google search will likely provide a list of agencies and counselors who are trained to address domestic violence. *List them below:*

***Domestic Violence Information:***

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# *The Aftermath of a Crisis*

BRENT LINDQUIST, PhD

## **Emergencies & Crisis Response**

### *Definition of Crisis*

Crisis is defined as a time of intense difficulty or danger. Often there is the potential for significant personal physical or emotional harm as a result. While a crisis can be a single event, it often occurs with other events or causes a cascade of things to happen. Personally, a person could have an individual accident, which is a crisis to him/her, but it could end up being a crisis to other family members, colleagues, or other areas as well.

A community crisis is an event or events, which are intense and sudden, which have lots of consequences. In Central California, we are familiar with fires or earthquakes, which happen suddenly and cause long term disruption to individual and community stability.

Recovery from crisis depends on many factors in the individual and community. Where resources exist, and the person has family, friends and church around, recovery can proceed well. Where the person has few resources and is disconnected from community, the possibility of longer-term struggle becomes significantly greater.

In Central California, and indeed across the country, there are many resources available to individuals, churches and communities. This





chapter will only briefly describe some resources and how to access them over the Internet. Some of these links below may work for people in international settings. Many of these entities are global and have national affiliates.

- **LINK CARE COUNSELING CENTER** will provide a free consultation, assistance and referrals to churches navigating a crisis situation. (559) 439-5920
- **THE RED CROSS** is often a standard community first responder for people who lose housing due to fires, etc. From the main website you can access training and resources across a wide variety of issues. ([www.redcross.org](http://www.redcross.org))
- **THE SALVATION ARMY** provides relief services for crisis response. This website gives access to a wide variety of services and programs to assist families in crisis. ([https://www.needhelppayingbills.com/html/fresno\\_salvation\\_army\\_assistan.html](https://www.needhelppayingbills.com/html/fresno_salvation_army_assistan.html)).
- **THE CALIFORNIA STATE SOUTHERN BAPTIST CONVENTION** has numerous relief ministries and trainings. They also have portable kitchens to serve on site meals. (<http://www.csbc.com/ministry-resources/csb-disaster-relief-ministries>)
- **THE U.S. GOVERNMENT** has many resources and a widely searchable website. Also, it has links to many other resources. ([www.ready.gov](http://www.ready.gov))
- **COMMUNITY EMERGENCY RESPONSE TEAM (CERT)** offers training to individuals and groups on how to meet immediate community needs arising from a crisis. I would recommend a team from each church go through the training. (<https://www.fresno.gov/police/community-and-neighborhood-resources/cert/>)

- **HUMANITARIAN DISASTER INSTITUTE AT WHEATON COLLEGE** has training, resources, and degree programs in disaster response. (<https://www.wheaton.edu/academics/academic-centers/humanitarian-disaster-institute/>)
- The above list is by no means meant to be a complete list. Many denominations have their own response systems, for example.

It is quite likely that a local church may not be able to respond in the middle of a complex crisis. These events are carefully managed by governmental agencies, and access is limited to people who are trained or licensed (for example, CERT, or Red Cross Certification). The most important role a church will probably play is in follow-up during the following weeks and months after a crisis.

It is important to remember that a crisis is not the ending, but the beginning of something new. Each crisis in our life leads to potentially good or bad outcomes. Crisis can cause people to re-evaluate their circumstances and make meaningful changes, which may prove to be positive in the long run. It can be quite painful to experience loss as a result of crisis, but with the church's help, people can cope, adjust and keep growing.

## Social Services

### *Bereavement (Grief Counseling Services)*

Many who have lost a loved one do not require support groups or professional counseling to address the loss. Individuals who have close family connections or deep friendships may naturally journey through their loss and transition through a normal grieving process to a place of health.

What is a normal grieving process? First, consider that we are all unique and grieve differently. It is easy to try to fit someone into one's

personal model of what healthy grieving looks like. For some people healthy grieving involves crying and expressing their emotions to other people, desiring close personal contact, such as being held. For others, in their moments of deepest grief they may desire solitude. While ways of grieving vary from person to person, a healthy grief process involves reaching a place of acceptance and peace. The journey to that place can look very different for each individual.

The most common model referenced regarding the grief process is Elizabeth Kubler Ross's stages of grief. These include Denial, Bargaining, Anger, Depression and Acceptance. While these stages are often outlined in this order, not all people experience all of the stages and not all individuals go through them in the same order. While the journey of healthy grieving varies, most individuals will ultimately reach a place of healthy acceptance.

For most, the loss of a loved one is overwhelming and intense in the early stages. In the midst of this grief, life continues to roll on. They will return to work and normal activities, while experiencing times of intense sadness, loss, loneliness or emptiness. When these feelings arise, they will allow themselves to journey through them with tears which is a healthy expression of the loss. While the sense of loss may never go away, over time the intensity of the loss becomes less and less profound.

It is not unusual for an individual to swing into a period of depression as a result of loss. If this lasts for a few months, then this in most cases falls within the range considered as normal bereavement.

In **complicated bereavement**, the person may swing into deep depression and isolation for an extended period of time. For these individuals, grief support services or professional counseling can be beneficial. If you are considering whether a referral might be beneficial, attempt to discern whether they are journeying through their grief or if they are "stuck"

in their grief. For those that are stuck professional counseling or grief support groups can be beneficial.

How long is healthy grief? Again, there is no one answer for this. So many things impact the severity and duration of grief. Loss of an elderly parent will be very different than the loss of a child. Sudden unexpected loss versus an anticipated loss due to a long illness will also have a different impact on a person who has lost a loved one. When in doubt, recommend grief and supportive services such as personal counseling.

*Hospice or Grief Resources:*

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**HOMELESS SERVICES/FAMILY SERVICES/MEALS**

Individuals who approach a pastor seeking food, money or shelter should be referred to the agencies best equipped to respond to their needs. .

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pastoral care as part of our Restoration and Personal Growth Program for pastors and missionaries. Those in the program see both pastoral counselors along with our clinical staff so that both psychological and spiritual issues are addressed. When referring an individual for pastoral care, consider what resources the church can provide to address spiritual growth issues for the client.

This is not to imply that the counselors at Link Care do not address spiritual matters with clients. Many who seek Christian counselors want prayer and scripture to be a part of their journey. Ethically we can work with individuals from within their world view, and value system. The church, however, can play an important role during this journey by providing additional resources and spiritual support to those seeking professional care.

The following section will focus on psychological categories, but the importance of the pastor and church's role in caring for the spiritual needs of a person, along with providing loving support cannot be overstated.

## Depression

### *It's not just a bad day!*

Frequently people use the term depression to refer to times when they are feeling down or having a bad day. While most people have times of feeling "depressed" the individual who is experiencing a severe major depressive episode is in a very different place, unable to break free from the feelings of depression.

For these individuals, encouragement to get out of the house, spend time with friends or take a vacation can leave them feeling worse. In severe cases of depression, engaging in behaviors that used to bring a

person joy can lead to further despair when a person realizes that the activities they once enjoyed no longer bring them pleasure or even make them feel worse.

### *Major Depression is Extended and Persistent*

When a person has been depressed for over a *2-week period* with little or no relief from the depression they are likely experiencing a Major Depressive Episode.

#### *The symptoms of depression include:*

- Loss of interest in all activities or pastimes
- Feelings of dysphoria
- Sleep difficulties (sleeping too much or not sleeping)
- Feelings of hopelessness
- Suicidal ideation
- Difficulty thinking or concentrating
- Weight loss or weight gain
- Feelings of worthlessness, guilt, or self-reproach
- Recurrent thoughts of death
- Social isolation

When you realize that a person is struggling with depression it is beneficial to encourage them to seek help from a professional counselor. The good news is *depression is very treatable!* The sooner a person can get help, the greater the likelihood that they will be able to have a positive outcome. In addition to a referral for counseling services, it is very important that a person dealing with depression see their medical doctor for a thorough medical workup. There are numerous medical conditions that lead to a major depressive episode.

## Dysthymia

Some individuals do not meet the full criteria for a *Major Depressive Episode*, but struggle with a chronic sense of feeling depressed. *Dysthymia* is a low-grade depression that persists for a period of two or more years. Often Christians struggling with dysthymia have exhausted efforts at overcoming depression through focused prayer, scripture reading and seeking counsel. It is recommended that a person struggling with dysthymia be referred to their physician and a professional counselor.

## Psychosis

Many specific diagnostic categories differentiate various *psychotic disorders*. In this handbook we will briefly outline the primary features of psychotic episodes in general terms. Individuals who are in an active psychotic episode need to be referred to *Psychiatric Services* for evaluation and medication management.

*Traditional psychotherapy does not generally help those in an active psychotic phase until they have been adequately stabilized on medication.*

There are several key features that are reflective of psychosis. It is important to understand that an appropriate diagnosis by a medical or counseling professional is critical in treating psychotic symptoms.

*Common Psychotic Symptoms include:*

- Hallucinations
- Delusions

- Disorganized Thought, Incoherence, Illogical Thinking
- Catatonic Behavior

## Hallucinations

*Auditory hallucinations*, (hearing voices) are a common type of hallucinations experienced during a psychotic episode. In religious individuals the hallucinations may take on a spiritual theme such as demons, God or saints talking to them. The individual may have command hallucinations which are voices that direct them to certain behaviors. *Visual hallucinations* also can occur where a person will see things that are not there. In more rare cases, *olfactory hallucinations* occur where the person reports smelling odors that are not present.

## Delusions

Delusions are beliefs which are not based in fact. Delusions are absurd beliefs such as the belief one is receiving others' thoughts or able to send their thoughts to others, that they are being controlled by others or they are someone they are not. They also can include delusions of persecution or be grandiose (the belief they are royalty).

## Disorganized Thought

Individuals with disorganized thought may sound incoherent, jumping from subject to subject, rambling in a nonsensical manner. It can be very difficult to get individuals with this symptom to follow communications.

## Catatonic Behavior

Individuals manifesting catatonic behavior may assume bizarre postures,

rigidly staying in the same position for extended periods of time. They may also exhibit repetitive meaningless behaviors for extended periods of time.

### ***Differential Diagnoses***

#### *Psychotic Symptoms Can Develop in Individuals with the Following Diagnosis*

- Schizophrenia (by definition will have psychotic symptoms)
- Major Depression (extended cases can develop psychotic symptoms)
- Bi-Polar Disorder (in extreme cases)
- Organic Brain Disorders
- Amphetamine Psychosis

### ***Outcomes***

Individuals manifesting psychotic symptoms should immediately be referred for a medical and psychiatric evaluation. Psychotic symptoms can occur for a variety of different reasons.

The potential for a good recovery depends on the cause of the psychotic episode.

### **Schizophrenia**

*Schizophrenia* is usually a progressive illness with onset in late adolescence or adulthood. Schizophrenics demonstrate either hallucinations, delusions or disorganized thinking. Often Schizophrenia is a progressive disorder that requires antipsychotic medications for the rest of the individual's life. Without medications most individuals with this diagnosis will relapse into active psychosis.

### ***Spiritual Issues and Schizophrenia***

It is common for individuals with psychosis to have religious themes which can be reinforced by inferring that the person is demon possessed. I have observed church settings where individuals with mental illness were being prayed over to cast out demons. For the individual with schizophrenia this can serve to further entrench the delusion that they are possessed and hearing demons. It is our recommendation that a thorough history and medical evaluation be conducted on any person manifesting psychotic symptoms.

### ***Major Depression with psychotic features***

May require the use of antidepressant medications and neuroleptic medications. These individuals may appear to have developed schizophrenia but with proper medication management they can return to completely normal functioning.

### **Bi-Polar**

Patients may also develop psychotic features, but their prognosis is relatively positive once on a mood stabilizer. Active psychotic episodes may require short term antipsychotic medications for stabilization.

### **Organic Brain Disorder**

An *organic brain disorder* such as a tumor etc. often involves progressive deterioration unless a surgical or medical intervention is able to address the condition.



## Amphetamine Psychosis

*Amphetamine Psychosis* and other drug-induced conditions can result in psychotic symptoms. Psychotic symptoms that are the result of active substance abuse can dissipate as the chemical leaves the system. In the case of Amphetamine Psychosis, symptoms may persist up to 6 months after cessation of the use of Amphetamines.

## Refusal of Services

Individuals dealing with psychosis may be resistant to treatment and cannot be forced to take medications. Often the family is left with the burden of managing these individuals trying to persuade them to comply with their medications. This can be extremely stressful for family members who have seen their loved one experience multiple episodes of relapse due to cessation of medication.

Many of those who lack family support will discontinue medications, ultimately winding up abandoned and homeless without proper medical care.

## Bi-Polar Disorder

The diagnosis of *Bi-Polar Disorder* is a fairly complex diagnosis with sub-classifications of *Bi-Polar I* and *Bi-Polar II*. This handbook will not describe specific categories of bi-polar disorder, but rather provide a very general overview of the disorder. It is normal for individuals to experience normal ups and downs over time. In the more extreme cases of bi-polar disorder individuals will experience **severe episodes of depression**, often struggling with suicidal ideation contrasted with **episodes of manic behavior**.

## Manic Episodes

*Manic Episodes* involve an individual experiencing elevated mood or irritable mood. During manic episodes a person may show a major increase in their activity and energy levels. They may become much more talkative, experience a flight of ideas and racing thoughts. They can display inflated self-esteem and a sense of grandiosity, which may reach a level that is delusional. They can experience decreased need for sleep, with some sleeping only a few hours per night. While they have high levels of energy they often have very low productivity in that they go from task to task without follow through. They also have the potential for engaging in activities that have extremely negative consequences such as buying sprees, sexual acting out, poor business decisions, reckless driving etc. It is likely that sleep deprivation plays a role in the emergence of psychotic behavior for those experiencing a manic episode.

There are milder forms of bi-polar related disorders such as *Cyclothymia* where individuals show features of depression and mania but demonstrate lower level symptoms which may not greatly impair functioning.

It is critical for individuals with severe bi-polar disorder have active ongoing medical care which provides appropriate mood stabilizing medications is paramount. Individuals in the depressive side of a bi-polar episode should receive counseling along with medication management. Traditional therapy is relatively unproductive for individuals in a manic episode until their Mania is stabilized medically.



## *Personality Disorders*

Personality disorders are a cluster of disorders that are considered developmental disorders. In general, these are disorders that are long term conditions that can be somewhat difficult to effectively treat.

### *Personality Disorders:*

- Borderline Personality Disorder
- Antisocial Personality Disorder
- Narcissistic Personality Disorder
- Dependent Personality Disorder
- Schizotypal Personality Disorder
- Compulsive Personality Disorder
- Schizoid Personality Disorder

### **Borderline Personality Disorder (BPD)**

Individuals with this diagnosis can often be overwhelming for ministry leaders and lay counselors attempting to provide care. In many cases experienced clinicians find providing care challenging. Often those with BPD will be in and out of counseling throughout their lives, often with a long list of counselors that they have worked with and in some cases who they feel have failed them.

One of the most debilitating issues with which individuals with borderline personality disorder struggle is their experience of extreme emotions and their inability to regulate those emotions. They quickly

shift from being very happy to feelings of extreme despair or anger, which can be overwhelming to those trying to provide support. For many with this diagnosis, they struggle with recurrent episodes of being suicidal which can also be overwhelming to those trying to provide support.

A very common struggle for those with BPD is an overwhelming sense of **abandonment** by others. For many, the abandonment is real in that they may have a history of relationships where initially they felt supported and cared for and over time those in relationship with them will become overwhelmed and begin to distance. This further fuels the feelings of abandonment. In addition to tumultuous relationships, those with this diagnosis often have difficulty maintaining employment and subsequently depend on low fee counseling services through programs where therapists are often in academic placements that transition year after year. This again can be a trigger for an ongoing pattern of lost relationships.

One of the most challenging aspects of supporting individuals struggling with BPD is the propensity to see things as *all good* or *all bad*. Initially when providing support to someone with BPD, you may experience extreme appreciation and glowing affirmation. However, when you are unable to continue to meet their needs (as they perceive them), or you act in a way that triggers their disappointment or feelings of abandonment you may be put into the *all bad* category. At this point the individual may turn on those who are attempting to provide support with harsh and angry criticism, or accusations of not caring. In church settings these individuals may be rather vocal in their criticism of those who have tried to care for them.

Other features common to BPD are impulsivity and unpredictability that can be self-damaging. They frequently have a history of unstable and intense relationships in which they alternate between idealizing others and then devaluing them. Often, they struggle with issues around

identity, self-image, gender identity, sexuality and career. Another key and usually predominant feature are intense feelings of emptiness.

Self-damaging behaviors are also common, with a common behavior including self-injury through cutting, as well as frequent suicide attempts. Relating to and supporting someone who is frequently suicidal can be exhausting and emotionally distressing for those in the church who are trying to provide loving support.

### *Ministering to those with BPD*

It is important to encourage those with BPD to find supportive counseling services. If they lack financial resources, referrals to reduced fee services such as On-Site Counseling Program, or Link Care (request low fee services) are potential options for counseling. For those that have good insurance, a licensed professional is ideal in that this provides a greater potential for ongoing care with the same therapist which is preferred for those with BPD.

Recognize that you may have to set healthy boundaries and in doing so, this may trigger feelings of abandonment leading to them placing you in the *all bad* category. I have heard many pastors share that they have a 3-session limit relative to counseling sessions. Three sessions are not a magic number, however, the principle of not engaging in an extended counseling process can be one way of avoiding developing a dependency relationship which then turns to the care provider being labeled *all bad* when he/she is unable to meet the person's expectations.

### **Antisocial Personality Disorder (ASP)**

Many individuals who are incarcerated meet the diagnosis of *Antisocial Personality Disorder*. As minors those with ASP often have problems in

school, are truant, have run away, engaged in substance abuse, inappropriate sexual behavior, expulsions for school, arrests, thefts, vandalism, persistent lying and other negative behaviors.

As adults they may struggle to keep a job, to responsibly parent and fail to maintain stable relationships. They may be irritable, aggressive and violent at times. Often there is a failure to plan ahead, they may act impulsively and engage in reckless or illegal behavior.

In some cases, these behaviors are socialized behaviors, which may develop from a neglected childhood, an abusive home, early exposure to a criminal lifestyle and substance abuse. Individuals who have learned their behaviors may have life changing transformations through participation in supportive programs.

Substance abuse and addiction can also directly contribute to an individual meeting the diagnosis of ASP. No doubt you have seen many cases where a person is able to overcome their addiction and transition to a healthy lifestyle.

Some individuals with ASP do not seem to have a developed conscience and do not appear to experience a healthy sense of guilt for misdeeds. For these individuals supportive service may not yield a favorable outcome, in that they lack the capacity for empathy and appear to really only care about their own pleasure and wellbeing. Ultimately this group will attempt to manipulate and use those who try to help them for their own gain.

### **Narcissistic Personality Disorder (NSP)**

*Narcissistic Personality Disorder* is characterized by a grandiose sense of self-importance. Individuals may view themselves as special, exaggerate their achievements and have fantasies about their brilliance and success.

Those with NPD are often resistant to treatment and will not seek counseling unless they have had a significant disruption in their lives. In cases where the NSP results in relationship failures, loss or other painful outcomes, those with NSP may seek counseling and can potentially benefit from work with a therapist trained in working with NSP.

### **Dependent Personality Disorder (DPD)**

Those with *Dependent Personality Disorder* have great difficulty taking responsibility for their own decisions and their lives. They will seek others to care for them and to make their decisions. They are often vulnerable and end up in abusive relationships.

Those with DPD can benefit from individual psychotherapy.

### **Schizotypal Personality Disorder (SPD)**

This disorder involves bizarre unusual behavior that does not meet the criteria for a diagnosis of *Schizophrenia*. Common features are magical thinking, superstitiousness, belief in clairvoyance, sensing the presence or force of someone near them. They often lack ability for normal social interactions and may have odd speech. In some cases, they struggle with being suspicious or may even have mild paranoia.

Unfortunately, individuals with this disorder are often resistant to treatment and current treatment models show limited effectiveness. Ideal referrals would be to a psychiatrist who has supportive counseling services within his/her practice.

### **Compulsive Personality Disorder (CPD)**

Individuals with CPD may have difficulty expressing warmth to others. They often are highly perfectionistic and may focus so much on details that they are unable to grasp the full picture. Further, they may attempt

to get other people to do things their way with little flexibility. They may also struggle with indecisiveness.

It can be difficult to get individuals with CPD to participate in treatment, but they are able to benefit to varying degrees from individual counseling.

### **Schizoid and Avoidant Personality Disorders**

Both *Schizoid* and *Avoidant Personality* disorders are very difficult to treat. Individuals with both of these diagnoses often live solitary lives. The *Schizoid* individual does not really desire close friendships and is content to be alone or to have one or two friends. They are often emotionally distant and do not show warm affectionate feelings towards others. These individuals frequently will not agree to counseling, content with their choice of lifestyle.

Those with *Avoidant Personality* may be more likely to engage in a counseling process in that they have a desire for affection and acceptance but have a major fear of rejection and struggle with low self-esteem.

## *Anxiety Disorders*

Ministry leaders frequently interact with individuals who are dealing with anxiety. The Bible is rich with scriptures that can be comforting to those experiencing anxiety. A quick google search of scripture about anxiety will yield many scriptures which address this issue. Encouraging a person to read and to meditate on these scriptures, prayer, worship/worship music and personal caring support can serve as powerful tools in helping individuals work through seasons of anxiety, especially in cases where their anxiety is tied to immediate life events, which are directly linked to the feelings of anxiety.

When individuals have a long-standing struggle with anxiety, they may have an anxiety disorder that necessitates a referral to a counselor trained in working with anxiety disorders.

### **Medication Warning/Substance Caution**

Some struggling with anxiety will attempt to self-medicate with alcohol or other substances. This frequently results in a worsening of the problem in that alcohol dependence can develop which can severely increase anxiety, especially during times of withdrawal. Substance dependency must be aggressively addressed for those struggling with anxiety.

It is important that a person referred for a medical evaluation be referred to a doctor with experience in treating anxiety disorders. This will allow the physician to rule out medical disorders that may

be contributing to the anxiety. Those with anxiety disorders should concurrently be referred to a counselor and engage in ongoing counseling as a part of their treatment program.

This handbook addresses some important issues relative to medication and Anxiety Disorders in the section titled, *Medications and Mental Health*. Please carefully read the section *Anxiety Disorders* to review some of the heightened risk factors associated with antianxiety medications.

## ANXIETY DISORDERS

We always hope that through prayer and healing, an individual will become free from anxiety. Often, however, we find that individuals who fall under the following categories also require professional and medical support.

- Generalized Anxiety Disorder
- Specific Phobia
- Panic Disorder
- Obsessive Compulsive Disorder
- Agoraphobia and Social Phobia
- Posttraumatic Stress Disorder
- Substance/Medication-Induced Anxiety Disorder

### Generalized Anxiety Disorder (GAD)

*Generalized Anxiety Disorder* can best be described as condition that involves chronic worry. Individuals with GAD have struggled with chronic worry for over 6 months and find it extremely difficult to overcome their worry. Frequently they will describe feeling worried about something for most of their life. They often struggle with feeling keyed

up or on edge, restlessness, have difficulty with concentration, experience muscle tension, irritability and sleeping difficulties. These individuals will often report a long history of using scripture, prayer and meditation as a means of addressing their anxiety but will report that, while helpful, these steps do not eliminate their chronic struggle with worry.

### Specific Phobia

A *Specific Phobia* is an irrational intense fear of an object that, in and of itself, is not dangerous. In order for this to be an actual phobia, it must significantly interfere with one's life. Single simple phobias often respond well to treatment. Individuals with multiple phobias or phobias combined with other anxiety disorders can be more difficult to treat.

### Panic Disorder

*Panic Disorder* can be debilitating to those who struggle with these episodes. A *panic attack* is an unexpected overwhelming sense of anxiety that isn't specifically connected to any object or situations. Individuals who experience panic attacks often fear that they are experiencing a heart attack. Symptoms include heart palpitations, sweating, trembling, dizziness, feelings of suffocation, fear of dying, nausea, fear of losing one's mind and a host of other symptoms of anxiety. Symptoms of this disorder often begin to manifest when individuals are in their twenties.

Those with Panic Disorder should be encouraged to seek medical attention in conjunction with professional counseling.

### Obsessive-Compulsive Disorder (OCD)

Briefly described, OCD involves the recurring presence of unwanted obsessions or compulsions. An obsession is an unwanted thought, and



a compulsion is an unwanted repetitive behavior. Individuals with *obsessions* may report that they have recurring thoughts such as going to hell, a child dying, someone being poisoned, germs, being in an accident and a virtually endless range of other disturbing thoughts. They often report that they have tried “everything to get the thoughts to stop”.

*Compulsions* are unwanted repetitive behaviors that can be extremely disruptive and in more severe cases make it impossible to sustain employment. Examples of repetitive behaviors include excessive hand washing, turning lights on and off, excessive cleaning, repetitive phrases and other disruptive behaviors.

For a diagnosis of OCD, the behaviors have to be disruptive to one's life and take more than 1 hour per day. Those with milder cases may be very functional and for the most part be able to conceal their disorder. For others the symptoms are extreme, and they render them unable to function normally relative to sustained employment, healthy relationships and taking care of domestic responsibilities.

Unfortunately, more serious cases of OCD can be highly resistant to treatment. Some with OCD have an excellent response to a group of anti-depressants in the SSRI family. Cognitive behavioral therapies can also be helpful for those with OCD.

## **Agoraphobia and Social Phobia**

*Agoraphobia* and *Social Phobia* both can result in an individual engaging in isolating behaviors. Individuals with agoraphobia fear being in situations where escape may be difficult. Examples include public transportation, cars, open places, closed places and being in a crowd. Social phobia may result in a person being homebound, but the fear is more specifically related to being under the scrutiny of others. It can be very difficult to get a person with Agoraphobia to engage in treatment.

Individuals with Agoraphobia may be highly resistant to seeking treatment and may require considerable support to assist them in seeking and engaging in counseling. Ideally family members should be involved in attempting to facilitate the counseling process.

Individuals with Social Phobias can be more open to seeking therapy and may need less direct support in scheduling and setting up their initial counseling appointment.

## **Posttraumatic Stress Disorder (PTSD)**

*Posttraumatic Stress Disorder* can develop when a person has experienced an extremely traumatic event which is outside the range of normal human experience. Individuals with PTSD may experience vivid flashbacks of the event, try and avoid situations that symbolize the event, have recurrent memories of the event, may feel distant from other people, struggle with sleep, startle easily, experience survivors' guilt and have difficulty concentrating.

There is a risk that those with PTSD may turn to substance abuse as a way of numbing their symptoms. This invariably increases their struggles and will even worsen their symptoms.

Men and women who serve in the military, law enforcement and fire departments often face events that can trigger PTSD. It can be difficult to get these individuals to engage in counseling to address their PTSD. Loving support and gentle encouragement from a pastor can help facilitate one who is struggling with PTSD to seek professional counseling.

## **Substance and Medication Induced Anxiety Disorder**

*Substance Abuse Withdrawal* can mimic the symptoms of *Generalized Anxiety Disorder* and *Panic Disorder*. It is important to rule out sub-

stance abuse in the process of developing an appropriate treatment plan for those dealing with anxiety. This is best conducted by a counselor with experience in anxiety disorder treatment and substance related issues. Often these individuals will need to participate in a substance abuse program in addition to individual counseling.

## *Trauma & Stress-Related Disorders*

CHRISTOPHER ROSIK, PhD

### **Adjustment Disorder**

An *Adjustment Disorder* occurs when a person develops serious emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). These symptoms create marked distress in the individual that is out of proportion to the severity or intensity of the stressor and/or results in significant impairment in social, occupational, or other important areas of functioning. These symptoms can include depressed mood, anxiety, and/or disturbance in conduct.

The stressor(s) leading to an adjustment disorder can be a single event (e.g., the termination of a romantic relationship, death of a loved one) or multiple events (e.g., marital struggles, work conflicts). The stressor(s) can also affect an individual, a family, or a community (e.g., natural disasters, crime infested neighborhoods). They may accompany specific developmental milestones (e.g., marriage, parenthood, or retirement).

### **Dissociative Disorders**

*Dissociative Identity Disorder* (DID) was earlier known as *Multiple Personality Disorder*. DID more accurately describes the psychological phenomena of an identity disruption involving two or more distinct personality states, each of which has their own sense of self and a unique



emotional and behavioral pattern. The origins of DID is believed to lie in severe and repetitive traumatic experience (i.e., sexual and/or physical abuse) in childhood where the child has no external means of escape and instead develops a subjectively separate identity to cope with or “take” the trauma. This appears to be an automatic capacity of the brain/mind to survive under extreme circumstances and is not a premeditated strategy.

DID is typically a disorder of secrecy in that sufferers hide what they are experiencing as it seems so odd or bizarre, even and especially to themselves. Very few cases of DID present in a florid or easily detectible manner. Most diagnoses of DID are made from the often-subtle symptoms common to this disorder, including significant gaps in one’s recall of everyday events, “coming to” and not knowing how one got where they are, finding evidence of having done something one does not remember doing, out-of-character behavior, and the experience of internal voices (fearful childlike voices and angry, critical voices are common). Reports of external voices (e.g., emanating from the radio or the man on the moon) are generally associated with other disorders, such as psychosis or substance abuse. By contrast, internal voices (identified by sufferers as coming from inside of their head) are suggestive of DID.

Christians suffering from this disorder may be particularly frightened and assume that the voices are demonic. Discernment is critical for effective pastoral care, as treating a personality state as if it were a demon can result in increased shame, hopelessness, and spiritual discouragement when the voices later reemerge following an attempted exorcism or deliverance prayer. When the presence of DID is suspected, a good rule of practice is to seek consultation with a therapist familiar with the assessment and treatment of this disorder.

### *Depersonalization and Derealization*

These disorders are considered to be on the *dissociative spectrum* but without the subjective sense of separate personality states. *Depersonalization* refers to the experience of unreality, detachment or being an outside observer of one’s thoughts, feelings, sensations or actions. This can include perceptual alterations, a distorted sense of time, or emotional and/or physical numbing. *Derealization* is the experience of unreality or detachment with respect to one’s surroundings, where individuals or objects are felt to be unreal, dreamlike, foggy, or visually distorted. It should also be noted that the symptoms of any dissociative disorder need to occur apart from any drug or alcohol use to confirm the diagnosis.

## *Substance Abuse*

In general, *substance abuse* occurs when a person is using a substance in a manner that significantly interferes with their functioning. For some, substances take over their lives to a degree that leaves them unable to function at work. In addition, the substance abuse often creates significant problems within their family.

Physiological addiction occurs with a variety of medications and substances. With physiologically addictive substances, one's tolerances increase in a manner that requires more and more of the substance to get the desired effect. In the absence of the substance the person will experience withdrawal symptoms that can be extremely uncomfortable. Withdrawal symptoms can include extreme anxiety, nausea, shaking, sweating, craving the substance and irritability.

In some cases, withdrawal can be fatal. In cases of extreme alcoholism, a person may require inpatient detoxification to manage the withdrawal symptoms. Opiate abuse and benzodiazepine abuse are additional categories of medications that may require inpatient services for detoxification.

There are individuals who use substances to excess, while being able to maintain their jobs and family life. A common example of this is the functional alcoholic. These individuals drink in excess but continue to perform their job responsibilities and may maintain good family relationships. In many cases, however, the functional alcoholic does experience family problems and negative physical effects of the substance. It can be

difficult to get “functional” substance abusers to seek help. First, they must reach a place where they admit they have a problem. This may not occur until a person has a life-changing event, such as a DUI, loss of a job, health crisis, relationship problem or other significant event. These moments can provide an opportunity to encourage the person to seek help.

### **Prescription Medication Abuse**

The addiction to prescription medication is an ongoing challenge. In some cases, individuals with severe chronic pain will become addicted to their pain medications without ever abusing the medication. Patients under the care of chronic pain programs may be given increasing doses of medications due to the tolerance that occurs with many pain medications. These individuals may have never misused their medication, but still require a medical detoxification to go off of their medication. Without proper medical supervision the immediate cessation of high levels of pain medication can be life threatening.

Individuals with a propensity of substance abuse may intentionally misuse prescription medications. Often this is in combination with alcohol abuse, which can be extremely dangerous. Alcohol can have a synergistic effect with some pain and anxiety medications resulting in a multiplicative effect of the two substances combined.

It is important that all prescription medications be securely stored and disposed of. Parents should be aware that there is a serious problem with the abuse of prescription medication by adolescents. Most of these medications are stolen from parents who have saved old medications or have not properly secured their medications.

### ***Methamphetamine***

Methamphetamine abuse has become a public health crisis in the United States. It is critical that the church do anything possible to educate their youth about the dangers of Meth. The effects of Methamphetamine abuse are dramatic. The early signs of methamphetamine abuse are signs of high energy, distractibility, rapid speech and little sleep. The active intoxication can look very similar to a person experiencing a manic episode. Later signs of abuse include rapid weight loss, premature aging and tooth loss. Methamphetamine abusers can become psychotic and develop bizarre and even dangerous delusions.

Methamphetamine is considered highly addictive, and some report that they felt they were hooked after the first time they tried it. While this is not a physiological possibility, the rush of meth for some has an intensely addictive effect.

In this handbook, we will not cover the wide range of substances that are dangerous and being abused. It is noteworthy however, that heroin abuse is rapidly increasing in the United States. Cocaine also continues to be a major problem and there are high numbers of prescription medications getting into the hands of young people for abuse.

### **Substance Abuse Program**

#### ***Referral Information***

In the previous section a review was provided regarding various categories of substance abuse. That information can be important when making a referral to a substance abuse treatment program. For example, someone who is a functional substance abuser may do fine with a referral to a ministry like Celebrate Recovery and AA. Many do extremely well with the support of these programs. In more serious cases, a person will need

an inpatient detoxification program or intensive outpatient treatment program. The following are agencies and programs that can assist those with substance abuse issues. Individuals should contact their insurance company for inpatient programs covered on their plans.

**NO COST SUBSTANCE ABUSE SUPPORT PROGRAMS**

**Celebrate Recovery Program**

<https://www.celebraterecovery.com/>  
<https://locator.crgroups.info/>

**Alcoholics Anonymous Group Locator**

<http://www.fresnoaa.org/gfaia/wp/>

**INTENSIVE OUTPATIENT TREATMENT | *Call for costs***

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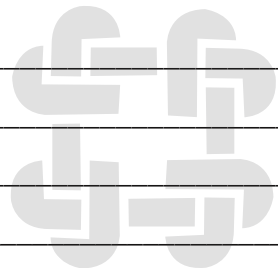
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**RESIDENTIAL SUBSTANCE ABUSE PROGRAMS | *Extended Length***

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LINK CARE CENTER

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## *Medication & Mental Health*

### **TO MEDICATE OR NOT MEDICATE?**

This is by no means a simple question. The internet is full of horror stories about the effects of psychotropic medications. Unfortunately, there are those who have had poor medication management and have become addicted to prescription medications with tragic outcomes. It is important to acknowledge that all medications can carry some risk and negative side effects, but for many the proper administration and use of mental health related medications can produce positive life-changing outcomes.

*The following sections briefly address some of the issues relative to psychotropic medication. No information in this section is intended to be used or interpreted as a specific medical recommendation.*

*All issues and questions regarding medication should be discussed with a physician.*

*Diagnostic groups that should be considered for a full medical & medication evaluation.*

- Bi-polar Disorder

- Major Depression & Dysthymia
- Psychosis
- Sleep Disturbance, Insomnia
- Anxiety Disorders

## Bi-Polar Disorder

Individuals who have *Bi-Polar Disorder*, will likely require a mood stabilizing medication for the remainder of their lives. Without mood stabilizing medications, many with this disorder will eventually re-experience a Bi-Polar episode. It is common for individuals with Bi-Polar to dislike the side effects of the mood stabilizing medications, and frequently they will discontinue their medications during times when they feel they have stabilized. The result of this is a cycle of repeated active episodes of mania or extreme depression.

It is not unusual for individuals of faith who suffer from this disorder to genuinely believe that they have been healed from the disorder leading them to discontinue their medications. Unfortunately, in many cases these individuals suffer a return of manic or depressive symptomology as a result of going off of their medications which can result in great personal and family disruption and even hospitalization.

If a person believes that God has healed them from this disorder, it is wise to encourage careful medical monitoring and education regarding potential signs of the re-emergence of the disorder. This should be no different than a person who believes they have been healed from cancer. The cancer patient would, of course, be encouraged to see their oncologist to get verification of the healing.

## Major Depression and Dysthymia

When a person is struggling with *depression* they should always be

referred for a full medical evaluation to determine if there is a physiological contributor to their depression. There are many medical conditions that can contribute to depressive symptoms and good medical assessment is important in the treatment.

Research shows that exercise and cognitive therapies can have a major impact on reducing depressive symptoms. Most literature indicates that to achieve the greatest benefit from exercise, it needs to be an aerobic exercise that elevates the heart rate for at least 30 minutes a minimum of 5 times per week. In some studies exercise has been shown to help as much as antidepressant medication. This is a viable option, but in many cases a person who is struggling with intense depression will not engage in an intensive exercise regime.

As with all issues around mental health and medication, there are strong debates around the use of medication to treat depression. When a person is depressed there are reduced levels of neurotransmitters in the brain and antidepressant medication can help normalize the neurotransmitter levels which can significantly reduce the symptoms of depression. Contrary to some opinions, the antidepressants for most do not produce any high or immediate feeling at all. In most cases all that is noticed is a gradual lessening of depressive symptoms.

For many people antidepressants have little or no immediate noticeable effects and take approximately two weeks to produce the needed elevation in the neurotransmitter levels. Many clients report that they notice a slow and progressive reduction in their depressive symptoms. For many individuals the use of antidepressant medication is an extremely helpful adjunct to their counseling process and can greatly reduce the amount of time that they are struggling with depression.

As with any medication, antidepressants can produce negative side effects. A variety of negative side effects can be associated with



antidepressants such as weight gain, agitation, nausea, suicidal ideation, headache, anxiety, dizziness and other negative symptoms. They should report any negative side effects immediately to their physician. In addition to side effects, approximately 10% do not show a benefit from the use of antidepressants.

We conducted an informal survey of our clinical staff at Link Care which is comprised of psychologists, marriage and family therapists, a social worker, pastoral counselors and MFT Associates and Trainees regarding negative outcomes with antidepressant medications. One senior staff member estimated that approximately 60% of clients have a favorable reaction to antidepressants with 30% having no reaction and 10% having a negative response. Another therapist estimated that as high as 80% of her clients experienced a positive benefit from antidepressant medications with no negative side effects.

### CAUTIONARY STATEMENT!

*Antidepressants may increase the risk of suicide especially in adolescents. Ironically, the risk of suicide can increase as a person begins to move out of a major depressive episode, subsequently, any person who starts an antidepressant medication should be in counseling and monitored for suicidal risk. In some the antidepressant medication can increase feelings of agitation. Feelings of agitation combined with depression further heighten the risk of suicide.*

### *Antidepressants in Many Cases are Helpful in Treating Depression*

To summarize, antidepressants help many individuals move out of their depressive episode without complications. If a person is depressed, it is

important that there is a wholistic approach to their healing which addresses medical, spiritual and psychological issues. Medication can be an extremely helpful adjunct to this process. It is also important to have careful follow up which monitors side effects and suicidal risk.

### Psychosis

When a person experiences psychotic symptoms such as delusions or hallucinations, they will have to be medically stabilized before talk therapy will be helpful. The medications for treating psychotic patients can have severe side effects and potential outcomes to treatment vary greatly depending on the diagnosis.

In the case of *drug-induced psychosis* the individual will need to be medically detoxed and likely given antipsychotic medication. These individuals, once sober, may return to normal functioning with family and community support. They may require the short-term use of antipsychotic medication during the initial time of stabilization, but they should not have to continue with the antipsychotic medication for long-term care.

Individuals with *schizophrenia* often do not respond to talk therapy until they have been stabilized on an antipsychotic medication. Schizophrenia is often a progressive illness which will require antipsychotic medication to treat the symptoms. Legally a person cannot be forced to take any medication so in the case of schizophrenia, many go untreated and due to their illness wind up homeless. Family support can be critical in helping an individual continue on medication which can help prevent active psychotic episodes.

There are times where individuals with *bi-polar disorder* may reach a manic phase that includes psychotic symptoms. These individuals may be



treated with an antipsychotic medication as well as a mood stabilizer and then transitioned to only a mood stabilizer which does not have the same side effects as antipsychotic medication.

While there have been some improvements in antipsychotic medications, the side-effects of these medications can be devastating. The longer a person is on antipsychotic medication the greater the potential for negative side effects. The most serious side effect is *Tardive Dyskinesia* a serious, and in their extreme, debilitating movement disorder that can include uncontrollable movements, tongue thrusting, involuntary blinking and stiff jerky movements. The newer generation of antipsychotics have a lower rate of incidence of this condition. Other side effects include things such as weight gain, sexual problems, drowsiness, constipation, dry mouth, blurred vision, restlessness and other uncomfortable symptoms. Unfortunately, those with schizophrenia often are not able to lead a normal life without consistent treatment with antipsychotic medication and are left with no choice other than to accept the negative side effects of the psychotropic medications.

### **Sleep Disturbance, Insomnia**

Individuals facing an acute crisis who are unable to sleep often can benefit from a sleeping medication to help them sleep. There are times when such medications can be an important adjunct to other treatment when dealing with acute insomnia.

#### *Chronic Insomnia*

Sleeping medications for more chronic sleep disorders often result in a dependence on medications and result in individuals increasing dosages of medications over time to get the desired effect. Even over-the-counter

medications can result in reported feelings of being dependent on the medication and being unable to sleep without it. Most individuals who feel they are dependent on over-the-counter medications will experience periods of extreme insomnia upon cessation of the medication. It may take a few weeks for them to return to more normal sleeping patterns. Some report that Melatonin helps them to have a more normal sleep pattern. Melatonin does not appear to have the same addictive properties of other sleeping medications, but the efficacy of Melatonin is questionable.

Stronger prescription medications like Ambien and prescription antianxiety medications from the benzodiazepine family, when used as a daily long-term treatment for insomnia can potentially develop into a dependency that includes a tolerance for the medication (need for increasing dosages to have the same effect) and *withdrawal symptoms*, (extreme discomfort in the absence of the medication). These medications should only be used as short term or intermittent methods of treatment for insomnia. Persistent insomnia should be addressed by other treatment approaches.

For some cases, the antidepressant Trazodone is used as a treatment for some patients with sleep issues. Antidepressant medications and other therapies can be a safer alternative to treating sleep disorders. It would be important to discuss with one's doctor whether Trazodone and other medications might provide a safer alternative than more addictive sleeping medications.

*\*Discuss the use of any medication with your doctor prior to use.*

### **Anxiety Disorders**

The use of antianxiety medications is a highly complex issue and with improper treatment, the solution (medication) can ultimately result in

an addiction that greatly compounds the initial symptoms of anxiety.

Prescription anxiety medications can have a powerful and immediate effect on reducing anxiety. However, these medications must be carefully prescribed and utilized. The benzodiazepine family which includes Xanax (Alprazolam) and Valium (Diazepam) when taken, can result in an immediate reduction of anxiety which may be helpful for individuals experiencing intense and overwhelming episodes of anxiety.

When these medications are used in excess, they can create feelings of euphoria. Unfortunately, due to this euphoria, benzodiazepines when used alone as a solution for anxiety **may** result in drug dependency. When used in excess, individuals will develop a tolerance to the medication and immediate cessation from high doses of the medication can be extremely serious, even fatal. Individuals on high doses also may experience withdrawal when they stop taking the medication. Ironically, a central withdrawal symptom from these medications is anxiety. As a result, the individual who has used these medications as a long-term treatment and gradually increased their dosage may have to detoxify from the medication, which can result in extreme anxiety. Unfortunately, because of this, clients can easily develop an addictive cycle that is very difficult to break, with the addiction becoming a greater problem than the initial anxiety disorder. Combining these medications with alcohol is exceptionally dangerous in that alcohol and benzodiazepines can have a synergistic effect which greatly increases the euphoric effect of both medications.

When properly managed benzodiazepines can be useful in the treatment of anxiety, however most recommend that they be used as a short-term alternative, or adjunctive treatment for episodic episodes of high anxiety.

There are some antidepressants which can help reduce anxiety

without the addictive side effects related to the Benzodiazepines. A physician can discuss whether medications like Paxil or Lexapro might be a safer method of helping reduce anxiety symptoms. No anxiety disorder should be treated by medication alone. Individual counseling should be a part of any treatment program for anxiety.





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LINK CARE CENTER



*How do I manage an acute mental health emergency?*

*Who do I contact? What is a safety plan?*

*Who do I call for which service?*

*What are the major symptoms of Depression?  
Psychosis? Suicidality?*

## WHAT CAN I AS A MINISTRY LEADER DO?

*Here in one slim volume, Link Care Center has tried to put together many resources the church can use in navigating mental health emergencies. In addition to resources, this handbook includes a brief description of many common mental health disorders and contact information for supportive services.*

### ABOUT PHIL COLLIER, PhD

Dr. Collier is the Clinical Director and CEO of Link Care Center. He leads a team of therapists who each year provide almost 10,000 hours of counseling and pastoral care. He has been involved in clinical training, supervision, teaching, and local church ministry.

### ABOUT LINK CARE CENTER

For over 50 years Link Care Center has provided almost 6,000 pastors, missionaries and their families counseling, education and training.

**CHANGING ONE. HELPING MANY.**  
*Transform their world.*