A Ministry OF

HOPE

Chaplains Of Hope

"LEVEL TWO"

HOPE HOPE HOPE HOPE HOPE HOPE

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Prayer

Matthew 16:24 (AMP)

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What is a Chaplain?

C Is for C_____
H Is for H_____
A Is for A_____
P Is for P_____
L Is for the L___ they carry
A Is for A R_____
I Is for I_ The Time of Need
N Is for N__ a Pipeline

We Begin Here!

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Mental Health Emergency Response (MHER) Level Two

CENTRAL FOCUS:

This course is designed to teach and train adults how to compassionately, safely, and effectively respond to common mental health emergency crises that will affect **20% - 25%** of the American adult population each year.

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Escalation of Mental Health on the Street

Students will:

- ✓ Learn value of developing MHER skills & of creating a personal resource guide for the application
- ✓ Learn how to recognize signs & stages of mental health issues
- ✓ Learn how to respond appropriately to common mental health issues encountered
- ✓ Become acquainted with a variety of common mental illness emergencies

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What Is "Mental Health"?

*"**Mental Health** … a state of well-being in which an individual realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a commitment to his/her community."*

World Health Organization (WHO)

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"What Is a Mental Health Crisis" or "Mental Health Emergency"?

"a collapse in a person's ability to solve problems or cope with a situation"

"a temporary state of upset and disorganization characterized chiefly by a person's inability to cope with a particular situation using current resources and problem-solving mechanisms"

(Dr. Curt Thompson)

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A Mental Health Crisis Is not the Same as Mental Illness

- The mentally ill are much *more likely to be the **victim** than the perpetrator.*
- Definitely, those who commit such crimes are "troubled" or at a **"point of personal crisis, even suicidal,"** and there is a need for proactive mental healthcare before they resort to such drastic measures.
- "A strategy of **'mental health first aid'** is needed at home, at school, in the workplace, and in our communities."

Dr. Jeffrey Lieberman, Columbia University psychiatrist

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A Mental Health Crisis Is Not the Same as Mental Illness

- A mental health crisis, tends to be a ***short, acute event*** to be passed through periodically along life's journey.
- If a person does not process and pass through a mental health crisis in a timely and healthy manner, mental illness may develop.

About 19% of the mentally ill also have an addiction to drugs and/or alcohol, which compounds their problems.

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NAMI

National Alliance on Mental Illness

Last updated: April 2023

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Having a Mental Crisis is not the same as having Mental Illness

- The National Alliance on Mental Illness (NAMI) now uses the term ***"mental health condition"*** interchangeably with the term ***"mental illness."***
- NAMI defines mental illness as a ***"physical condition, often requiring medical treatment."***

When present, the potential for a crisis is never far from mind.

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Mental Health Crisis according to NAMI

- Unfortunately, because of their poor coping and communicating skills, the mentally ill tend to live on the dangerous edge of crisis events and situations.
- They are exceptionally vulnerable to those who would take advantage of them or stigmatize and mistreat them. This includes law enforcement and healthcare professionals as well as family, neighbors, and friends.
- Because *mental health disorder/mental illness is invisible*, sufferers are often judged negatively and stigmatized as lazy, weak, unmotivated, uncooperative, or not really ill.

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According to NAMI

Each year:

- **1 in 5** U.S. adults experience mental illness
- **1 in 20** U.S. adults experience serious mental illness
- **1 in 6** U.S. youth aged 6-17 experience a mental health disorder

50% of all lifetime mental illness begins by age 14, and **75%** by age 24

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- **22.8%** of U.S. adults experienced mental illness in 2023 (57.8 million people). This represents over 1 in 5 adults.
- **5.5%** of U.S. adults experienced serious mental illness in 2021 (14.1 million people). This represents 1 in 20 adults.
- **16.5%** of U.S. youth aged 6-17 experienced a mental health disorder in 2016 (7.7 million people)

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Stats About Mental Illness/Mental Health Crisis

- About 7.7 million youth (6-17) experience a mental health disorder
- Suicide is the 2nd leading cause of death among people ages 10-34
- People with depression have a **40%** higher risk of developing heart and metabolic issues
- ***60%*** *of care givers die before the person they are caring for*
- Because mental health disorders start so young, they impact education, career, key social relationship, and establishment of health habits, which can lead to eventual disability and premature death

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Stats About Mental Illness and Mental Health Crisis

Approximately **20-45%** of adults in the US, both inside and outside the church and including pastoral leadership will experience a mental health crisis this year.

Top 3:

- Anxiety Disorder **19.1%**;
- Depressive Episode **7.2%**;
- PTSD **3.6%**

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Stats About Mental Illness/ Mental Health Crisis

Mental health disorders are the biggest health problem in North America, ahead of both heart disease and cancer.

- Depression is the most significant
- **50%** of mental health disorders start before age 14
- **75%** have started before age 24

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Mental Illness Among U.S. Adults, by Demographic Group 2023:

- Non-Hispanic **Asian**: **16.4%**
- Non-Hispanic **Native Hawaiian** or Other **Pacific Islander**: **18.1%**
- Non-Hispanic **Black** or **African American**: **21.4%**
- **Hispanic or Latino: 20.7%**
- Non-Hispanic **White: 23.9%**
- Non-Hispanic **American Indian or Alaska Native: 26.6%**
- Non-Hispanic **mixed/multiracial: 34.9%**
- **Lesbian, Gay or Bisexual: 50.2%**

Mental Health America

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There is an almost certainty you will experience a person with Mental Health Crisis and/or Mental Illness such as:

- ✓ Bipolar Disorder
- ✓ Post Traumatic Stress Disorder
- ✓ Major Depression Episode
- ✓ Anxiety Disorder

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Concerning Mental Illness By Condition

Annual prevalence among U.S. adults, by condition:

- Schizophrenia: **<1%**
- Obsessive Compulsive Disorder: **1.2%**
- Borderline Personality Disorder: **1.4%**
- Bipolar Disorder: **2.8%**
- Post Traumatic Stress Disorder: **3.6%**
- Major Depressive Episode: **8.3%**
- Anxiety Disorders: **19.1%**

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The PERSON:

- People with depression have a **40%** higher risk of developing cardiovascular and metabolic diseases
- **33.5%** of U.S. adults with mental illness also experienced a substance use disorder (19.4 million individuals)
- High school students with significant symptoms of depression are more than **twice as likely** to drop out
- **41%** of VA patients have a diagnosed mental illness or substance use disorder.

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The FAMILY:

- At least **8.4 million** people in the U.S. provide care to an adult with a mental or emotional health issue.
- Caregivers of adults with mental or emotional health issues spend an average of **32 hours** per week providing unpaid care.
- Approximately **20%** of people experiencing homelessness have Serious Mental Illness (SMI). 1 in 5
- **37%** of those incarcerated in prison have a diagnosed mental health illness.

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The COMMUNITY:

- **19.7%** of U.S. Veterans experienced a mental illness in 2020 (3.9 million people)
- **9.6%** of Active Component service members in the U.S. military experienced a mental health or substance use condition in 2021
- **70%** of youth in the juvenile justice system have a diagnosed mental illness.
- Across the U.S. economy, serious mental illness causes **$193.2 billion** in lost earnings each year

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The WORLD:

- Depression and anxiety disorders cost the global economy $1 trillion in lost productivity each year.
- Depression is a leading cause of disability worldwide

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Warning Signs & Symptoms of Mental Crisis in Adults:

- ❖ Confused thinking
- ❖ Prolonged depression (sadness or irritability)
- ❖ Feelings of extreme highs and lows
- ❖ Excessive worries, fears and anxieties
- ❖ Social withdrawal
- ❖ Dramatic changes in sleeping or eating habits
- ❖ Strong feelings of anger

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Warning Signs & Symptoms of Mental Illness/Crisis in Adults:

- ❖ Delusions or hallucinations
- ❖ Growing inability to cope with daily problems and activities
- ❖ Suicidal thoughts
- ❖ Denial of obvious problems
- ❖ Numerous unexplained physical ailments
- ❖ Substance abuse

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Symptoms of Someone in Crisis

These reactions fall into 6 categories:

1) physical
2) psychological
3) cognitive
4) Behavioral relational
5) spiritual

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Physical Signs of Mental Issues

- Using food, drugs, or alcohol to cope with difficult emotions.
- Inability to sleep, restlessness, sleeping too much, nightmares.
- Concentration problems that interfere with basic thinking and ability to recall.
- Feeling “blue” hopeless or helpless most of time.

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Cognitive Signs of Mental Issues

Disorientation – problems with thinking

Apathy – loss of desire to participate or follow directions; numbness

Over-stimulated sensitive to light, sights, sounds, crowds, touches, and smells; anger, irritability

Disconnection – sense of unreality; feeling disconnected from themselves or surroundings; disbelief

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Cognitive Signs of Mental Issues

Illogical thought – unusual or exaggerated beliefs about personal powers to understand meanings or influence events; regressive thinking

Nervousness – fear or suspiciousness of others; strong feelings of anxiety towards the unknown, intrusive thoughts

Unusual behavior –uncharacteristic of themselves, flashbacks

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Warning Signs & Symptoms of Mental Crisis in Preadolescents

- Substance abuse
- Inability to cope with problems and daily activities
- Changes in sleeping and/or eating habits
- Excessive complaints of physical ailments
- Defiance of authority, truancy, theft, and/or vandalism
- Intense fear of weight gain
- Prolonged negative mood, often accompanied by poor appetite or thoughts of death
- Frequent outbursts of anger

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Warning Signs & Symptoms of Mental Crisis in *Younger Children*

- Changes in school performance
- Poor grades despite strong efforts
- Excessive worry or anxiety (i.e., Refusing to go to bed or school)
- Hyperactivity
- Persistent nightmares
- Persistent disobedience and aggression
- Frequent temper tantrums

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COVID-19 Impact On Mental Illness

- Regardless of how we perceive the pandemic it is very real for some
- Association Between Prison and Mental Illness
- Impact on Rural COVID-19 Sufferers

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COVID-19 Impact On Mental Illness

We must recognize the significant impact of the pandemic on our mental health—and the importance of increasing access to timely and effective care for those who need it.

- **1 in 15** U.S adults experienced both a substance use disorder and mental illness
- **1 in 5** U.S adults report that the pandemic had a significant negative impact on their mental health
  - **45%** of those with mental illness
  - **55%** of those with serious mental illness

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Impact of the Pandemic

Among people aged 12 and older who drink alcohol, **15%** report increased drinking.

Among people aged 12 and older who use drugs, **10%** report increased use.

Among U.S. adults who received mental health services:

- **17.7 million** experienced delays or cancellations in appointments
- **7.3 million** experienced delays in getting prescriptions
- **4.9 million** were unable to access needed care
- **26.3 million** U.S adults received virtual mental health services
  - **34%** of those with mental illness/**50%** of those with serious mental illness

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Mental Health (MH) Impact from COVID-19

Youth and young adults experienced a unique set of challenges during the COVID-19 pandemic—isolation from peers, adapting to virtual learning, and changes to sleep habits and other routines.

Among U.S. adolescents (aged 12-17):

- **1 in 6** experienced a major depressive episode (MDE)
- **3 million** had serious thoughts of suicide
- **31% increase** in mental health-related ER visits

Among U.S. young adults (aged 18-25):

- **1 in 3** experienced a mental illness
- **1 in 10** experienced a serious mental illness
- **3.8 million** had serious thoughts of suicide
- **1 in 5** young people report that the pandemic had a significant negative impact on their mental health

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MH Impact from COVID-19 cont.

- **18%** of adolescents
- **23%** of young adults
- **Nearly ½** of young people with mental health concerns reported a significant negative impact
- **1 in 10** people under age 18 experience a mental health condition following a COVID-19 diagnosis

Increased use of alcohol among those who drink (COVID-19):

- **15%** of adolescents
- **18%** of young adults

Increased use of drugs among those who use (COVID-19):

- **15%** of adolescents
- **19%** of young adults

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MH - Impact on Prison

- People with mental illness deserve help, not handcuffs. People with mental illness are overrepresented in our nation's jails/prisons.
- About **2 million times** each year, people with serious mental illness are booked into jails.
- About **2 in 5** people who are incarcerated have a history of mental illness (**37%** in state and federal prisons and **44%** held in local jails).
- **66%** of women in prison reported having a history of mental illness, almost twice the percentage of men in prison.
- An estimated **4,000** people with serious mental illness are held in solitary confinement inside U.S. prisons.

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MH - Impact on the Incarcerated

COMMUNITIES:

- **70%** of youth in the juvenile justice have a diagnosable mental health condition.
- Youth in detention are **10 times** more likely to suffer from psychosis than not.
- **50,000** veterans are held in local jails, **55%** report experiencing a mental issue.
- Among incarcerated people with a mental health conditions, non-white individuals are **more likely** to go to solitary confinement, be injured, and stay longer in jail.

ACCESS TO CARE:

- About 3 in 5 people (**63%**) with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons.
- Less than half of people (**45%**) with a history of mental illness receive mental health treatment while held in local jails.

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MH - Impact on the Rural

Compared to suburban and urban residents, rural Americans:

- Must travel **2x** as far to their nearest hospital
- Are **2x** as likely to lack broadband internet, limiting access to tele-health
- **25+ Million** rural Americans live in a ***Mental Health Professional Shortage Area***, where there are too few providers to meet demand

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MH - Impact on the Rural

Rural Americans: often experience unique barriers to managing their mental health.

Among U.S. adults in nonmetropolitan areas:

- **21%** experienced mental illness
- **6%** experienced serious mental illness
- **13%** experienced a substance use disorder
- **5%** had serious thoughts of suicide

Access to Treatment is Severely Limited

Among U.S adults in nonmetropolitan areas:

- **48%** with a mental illness received treatment
- **62%** with a serious mental illness received treatment

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MH - Impact on the Rural

Some Populations Face Additional Challenges:

53% of rural adults say the COVID-19 pandemic has affected their mental health

- **66%** of farmers and farm-workers
- **71%** of younger adults aged 18-34

Many rural states have a postpartum depression rate higher than the national average of 13%:

- **21%** in Alabama/**22%** in Mississippi/**23%** in Arkansas

Rural youth are at an increased risk of suicide, but highly rural areas have **fewer youth suicide prevention services**

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Mental Health Crisis Cycle

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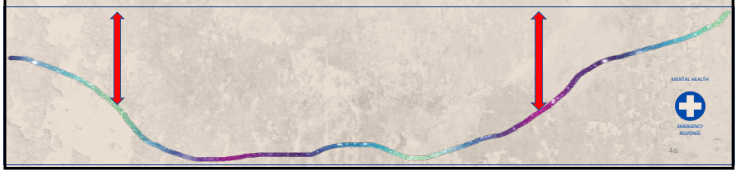
Mental Health Crisis Cycle

Stages of a Mental Health Crisis:
The ***average mental health crisis lasts 6-8 weeks but the average time for a person to regain his/her day-to-day coping skills is 36 hours,*** even if the crisis is not fully resolved.



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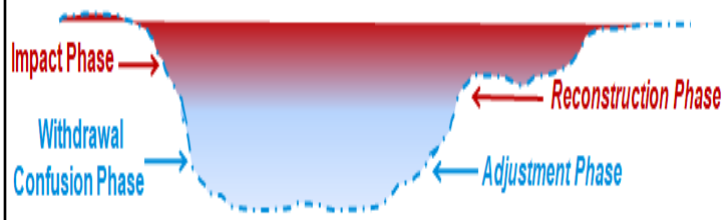
Mental Health Crisis Cycle



Note: "Reminding people that passing through these phases is normal and can be very reassuring to them!

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Mental Health - Impact Phase:

- ***Usually lasts a few hours to a few days.***
- Will tend to handle the crisis in "usual" way, which could be freeze, fight, or flight as brain switches to survival mode.
- ***Can make impulsive, unwise decisions. May not absorb facts and need assistance with simple things. Writing things down may help.***
- Needs to be listened to non-judgmentally.

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Mental Health Impact Phase:

Guilt feelings may or may not be justified (children causing parents' divorce, drunk driving accident, survivor's guilt, etc.); negative people and emotional people tend to exhibit more guilt, which is handled by:

- rationalization
- blaming others
- doing some kind of penance
- asking for and receiving forgiveness (1 John 1:9)

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Mental Health Withdrawal-Confusion Phase

- ***Typically lasts days to weeks.*** Surface emotions are in complete turmoil.
- Worn out emotionally; depressed; no more feelings to experience; tendency to deny one's feelings is strongest; feel as if they have died but their emotions haven't; ugliest feelings; intense anger produces more guilt and shame.
- Typical feelings: bewilderment, danger, confusion, impasse, desperation, apathy, helplessness, urgency, discomfort.

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Mental Health Adjustment Phase:

- ***Longest phase lasting weeks to months***
- Inconsistent down times; still need someone close and available
- Teachable
- ***More objective and insightful***

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Mental Health Reconstruction Phase:

- ***Months in duration***
- Person assumes the initiative for progress; reattachments are occurring; it is time for reconciliation if there are broken relationships.
- Despite the pain and heartache, a crisis can also be an opportunity to gain new:
  - strengths
  - perspectives
  - appreciation
  - values, and
  - a new approach to life

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The Lies We Tell Ourselves

These distortions in our thinking including:

1. **Black-and-White** - Thinking either/or
2. **Making Unfair Comparisons** – usually in the negative
3. **Filtering** – homing in on the negative, forgetting the positive
4. **Personalizing** - The Self-Blame Game

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The Lies We Tell Ourselves

5. **Mind-Reading** – thinking we know what others think (negatively)
6. **Catastrophic Thinking** – imagining the worst-case scenario
7. **Over generalizing** – "I always mess up…"
8. **Confusing Fact with Feeling** – "If I think or feel this way then my thoughts/feelings must be correct'.
9. **Labeling** – I'm a loser vs. I made a mistake.
10. **'Can't Stand this'** – being unnecessarily intolerant

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SAFER-R Model

This intervention model for responding to individuals in crisis consists of ***5+1 stages***.

They are:

1. **S**tabilize
2. **A**cknowledge
3. **F**acilitate understanding
4. **E**ncourage adaptive coping
5. **R**estore functioning or
6. **R**efer

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Basic Guidelines for Chaplains of Hope

Critical Incident Stress Disorder (CISD)

Critical Incident Stress Disorder differs from PTSD by lasting longer than four weeks after the event triggering the emotional, mental or physical response.

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Critical Incident Stress Information

- Trauma or Critical Events may have ***strong reactions*** in people.
- **Reactions** may occur soon after an event or be delayed for days, weeks or months later.
- Sometimes the **trauma/aftershock** may be so painful that professional counseling is needed.
- It doesn't mean the person is **crazy or weak**, they simply are overwhelmed by that event.
- Stress is ***cumulative*** and can build up over time and can overpower a person.

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Critical Incident Stress Information

- People react differently to a stress event.
- Some freeze on the spot, others deal with a situation but later have a delayed reaction.
- Some have almost no visible signs at the moment but may develop symptoms later
- Symptoms may be **physical**, **mental**, **emotional** and/or **behavioral**.

The charts on the following slides will list some symptoms.

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Signs of Stress Reaction – Physical

Chills	Headaches
Thirst	High blood pressure
Fatigue	Rapid heart rate
Nausea	Muscle tremors
Fainting	Shock symptoms
Twitches	Grinding of teeth
Vomiting	Visual difficulty
Dizziness	Profuse sweating
Weakness	Difficulty breathing
Chest pain	

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Signs of Stress Reaction - Cognitive (Mental)

Confusion	Poor attention/ decisions
Nightmares	Poor abstract thinking
Hyper vigilance	Poor concentration/memory
Suspiciousness	Poor problem solving
Intrusive images	Blaming others

Disorientation of time or place or persons
Difficulty identifying objects or people
Heightened or lowered alertness
Increased or decreased awareness of surroundings

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Signs of Stress Reaction – Emotional

Fear	Irritability
Guilt	Depression
Panic	Intense anger
Denial	Apprehension
Anxiety	Emotional outbursts
Denial	Felling overwhelmed
Agitation	Loss of emotional control

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Signs of Stress Reaction – Behavior

Withdrawal
Anti-social acts
Inability to rest
Intensified pacing of the room
Erratic movements, jerking
Change in social activities
Change in speech patterns
Loss or increase of appetite
Hyper alert to environment (patrol)
Increased alcohol consumption (self medication)
Change in communications with friends or family (cut off/avoid)

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Community Traumatic Events

- Fires (California) entire communities wiped out
- Floods (Katrina) in New Orleans
- Hurricanes (South East Asia)
- Earthquakes (Indonesia)
- Large Scale Disasters (Chernobyl)
- Terrorism and or acts of war (Middle East)
- Highly publicized crimes and rioting
- Mass migration of populations (Syria)
- Television and media saturation may even traumatize those who are watching from afar.

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Traumatic Television and Media

- TV, Radio, Face-book, email, smart phones have made information faster and unfiltered.
- Bloggers publish unedited graphic videos and pictures for all to see – the good, the bad and the ugly.
- Some pictures are "Photo shopped" to give a false depiction of a situation & publish untruths.
- People can feel traumatized, anxiety, insecure, scared, victimized even though far away.
- The closer they are to a situation/people, the more intense their response may become.

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Where a COH Can Apply Help

A COH should not being the first to hear all the details that may have criminal ramifications. Have the victim hold details and share with the appropriate authorities.

- Automobile accident, injury, property damage
- Industrial accident involving injury or death
- Sexual Assault, Abuse or Domestic Violence (see disclaimer)
- Robbery or violent crime
- Suicide or attempted Suicide
- Car bombing, rioting
- Homicide / murder
- Life threatening experience can do damage emotionally.

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How a COH Can Help With MHER

- Listen to them- not the disclaimer below
- **Disclaimer** - have them hold details that relate to a criminal offense.
  - Instruct them to hold the details for the appropriate authorities.
  - If you allow them to tell the details to you, you have now become involved at another level, adding a layer of legal custody.
- Talk is healing – allow them to discus what they need to **AFTER** they have told authorities and been released to share.
  - Verify this fact if you are late on the scene.
- Spend time with them. Don't be in a hurry. You may have to change your plans

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How a COH Can Help With MHER

- *Reassure them safe now*. Safe environment – calming effect
- DON'T take their anger *personally*, venting is normal.
- They may be mad at God. *Don't defend HIM*. God can handle people being mad at Him.
- Encourage getting back into a routine. *Help with everyday tasks*, cooking, cleaning, children, etc…
- *Give space* when they need it.
- *Encourage* them to pray, attend church, go with them.

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How a COH Can Help With a CISD

- Talk to them about *typical reactions* to CIS.
- Offer suggestion on *coping* with CIS and stress coping and survival and recovery.
- Discourage alcohol and drug use.
- Provide information and *helping agencies*.
- Get and give *contact information*.
- *Follow up* and check on them.
- Have them write a *daily journal* especially if sleeping is difficult- write your way to sleep.

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Critical Incident Stress Checklist

Introduction:

- I am (name)… this is my helper…(name).
- Explain the intent of the debriefing (CISD).
- Everything is confidential that does not require mandated reporting (criminal offenses).
- You do not have to talk if you don't want to.
- Everyone's experience is important.
- We are here to help you work through the matter.

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Critical Incident Stress Debrief (CISD) Checklist

Facts as you remember them:

- Who are you and what was your role in the incident?
- What happened from your viewpoint?

Thoughts:

- What were your first thoughts of the incident?
- Are there any thoughts that stick with you now?
- (Get them to **relive** and **release** the incident).

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Chaplains of Hope

Stages Of Counseling

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CRISIS COUNSELING DISCLAIMER:

- Chaplains of Hope *are not recruited for long term counseling or pastoral care* for individuals.
- However, they are the ***first level*** of care given to those they come into contact with whom are in need.
- Knowing how to become a "Demonstration of LOVE" and a "Depositor of HOPE"
- IS IMPERATIVE!

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*James Dobbins states, "**knowing crisis theory helps the Pastor [and Counselor] or Chaplain to avoid personal panic in the face of crisis and to learn how to manage the process better.***

The skilled crisis counselor will be rewarded by seeing critical moments in the lives of individuals and congregations become opportunity for creative change instead of disasters."

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Loss Counseling

Unless you are trained in mental health, remember you are providing/applying MHER, Pastoral Care, *not psychological or psychiatric care.*

Always be non-judgmental, supportive, and understanding.

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Seven Stages of Counseling

1. **Introductory stage:** who you are, who they are
2. **Fact Finding stage:** who, what, whey, where, how
3. **Feeling stage:** explain emotions
4. **Reaction stage:** what happened with those emotions
5. **Review stage:** recount stories/memories
6. **Learning stage:** what did you discover about the other person and yourself
7. **Closure stage:** be sensitive here

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#1 Introductory Stage

- Who you are, establish your pastoral role
- Who he/she is
- Personable
- Establish confidentiality
- Comfortable, safe, and secure environment

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#2 Reaction Stage

- **What reactions did you experience then?**
  Nausea, dreams, concentration, depression, Isolation, grief, anxiety, fear of losing control…
- **What reactions are you experiencing now?**
- **How has this impacted relationships on the job, with parents, children, etc.?**

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3 Fact Finding Stage

- About facts, not feelings
- Re-create the event
- Who, what, when, where, how
- Circumstances
- Factors contributing to the death

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#4 Feeling Stage

- Non-judgmental, supportive, understanding
- Share the burden of feelings
- How did you feel then?
- How do you feel now?
- How is it you may feel some ownership?

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#5 Review Stage

- Recount personal stories or memories
- Lessens anxieties and tension

#6 Learning Stage

- New coping skills
- Recognizing destructive/construction outcomes, return to some pre-crisis equilibrium
- Avoid self-defeating or self-destructive behavior

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#7 Closure Stage

- Outstanding questions or issues
- Plan(s) of action that are life centered
- Give positive and spiritual direction
- Never condemning or judgmental

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Chaplains of Hope

MINISTRY OF

HOPE

Discussion

Q & A

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Dealing With A Narcissist:

Recognizing Narcissism

2 Types of Narcissists: ("Beauty and the Beast")

- **Grandiose –** Gaston: arrogant, vain, boastful, manipulative
- **Vulnerable** – the Beast: quiet, sad, sensitive

- Narcissists are often generous.
- They place everyone on a value scale above or below themselves.
- ***Family is below. Outsiders with power or wealth are above and get treated with respect.***
- Generosity will be extended to those above for the value it brings to the giver.

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Dealing With A Narcissist:

Recognizing Narcissism

1. What I want and what I have to say are all that matters when we talk. My opinions are always right and more important.
2. It's all about me. I know more; I know better; I am more interesting, so when you talk, I don't really care to listen, and I will jump back in to bring focus back around to me.
3. The rules don't apply to me; they exist for other people to follow.
4. Your concerns are really criticisms of me, and I don't like being criticized.
5. I'm right – you're wrong. So when things go wrong between us, it's your fault.
6. I may be quick to anger – but when I get angry, it's because of you. You made me mad, so it's your fault and you should apologize.

KEY INDICATOR:
How well or how poorly someone listens and values what other people say.

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Dealing With A Narcissist:

Narcissistic Personality Disorder (NPD)

NPD is a lifestyle habit that can be reduced to narcissistic personality style by uncovering the painful childhood root cause that created this defense system, receiving healing therapy, and working on listening and decision-making skills.

- Treatment can last months or years.
- Success stories include people who have gone forward to become talented performers, compassionate therapists, and charismatic leaders, etc.

If You Have To Deal with a Narcissist:

- **Be empathetic:** This person is not knowingly (consciously) being a jerk. In reality, they are desperately looking for love and acceptance.

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Dealing With A Narcissist:

Narcissistic Personality Disorder (NPD)

- Stay calm and good-natured– Arguing causes anger and anger only makes the situation worse. Refuse to engage in arguments, even if it means exiting the conversation or the room.
- To exit a space, stand, start walking, pleasantly excuse yourself to get a drink of water, return when you feel calm, initiate positive conversation on a safe topic before returning to the difficult issue.
- Don't confront the disorder directly or try to change the narcissist; However, if confrontation is unavoidable because of the seriousness of the conflict, choose a time when everyone is calm and self-controlled.

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Dealing With A Narcissist:

Narcissistic Personality Disorder (NPD)

- ***Listen for what you can agree with; train yourself to take others' perspectives seriously.*** Comment favorably before moving forward with your own perspective. Stop interjecting "but" into the conversation. Instead, try to link your thoughts with "and" or "and at the same time."
- Don't let attempts to bully, intimidate, or control you succeed. Set boundaries if necessary. Be assertive but not aggressive.
- Narcissists live in a black/white world of extremes: extremely good or extremely bad. Do not get dragged into that mindset. Stay centered on what you know to be true about yourself and others (biblical viewpoint).

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Dealing With A Narcissist:

Narcissistic Personality Disorder (NPD)

- When the narcissist won't listen to what you are saying – first digest aloud and validate their alternative perspective. Then put yours back on the table with an ***agree and add strategy*** something like, "Yes, I can see that you are tired, at the same time, I really want to see a movie. How about if we rent one and watch it here at home."
- ***Narcissists tend to get angry when their partner expresses negative emotions such as sadness or pain.*** (a) they may see the negativity as a criticism of themselves or (b) they may feel helpless when their partner is upset because they lack soothing responsiveness.

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Dealing With A Narcissist:

Narcissistic Personality Disorder (NPD)

- **Radiate sunshine**– we all relax when we feel loved and valued. Find ways to offer agreement, appreciation, smiles, and other positives, and you both will be happier.
- ***Important Note:*** Not all but some frustrated narcissists can become extremely dangerous and violent when challenges or "disrespected."

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Bipolar Disorders

Bipolar Disorders

1 & 2 (#1 formerly know as manic depression, is more severe and goes through all cycles).

Impact:

- ***2.6% adults (only 49% treated annually);***
- 11.2% are adolescents.
- Onset: teens to early 20's.
- Highs and lows are called "episodes"

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Bipolar Disorders

- Person experiences extreme mood swings from depressive lows to manic highs, but with possible normal periods in between.
- Periodic cycles, monthly, several times a year or only sporadically. Can cause psychotic episodes.
- Often co-morbid with alcohol and drug misuse.

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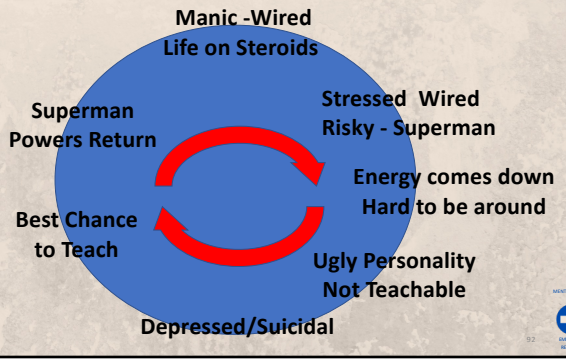
Bipolar Disorder Cycle – (SIMPLIFIED)



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Bipolar Disorders

At Risk Factors:

- Close relative with disorder (increase chance by 9%)
- Pregnancy/ obstetric complications / recently given birth
- Lower social situation
- Recent stressful events
- Brain injury
- Multiple sclerosis

Causes:

- Biochemical changes in the brain; a stressful triggering event, having had an episode prior.

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Bipolar Disorders

Manic State Symptoms:

- May include increased energy, rapid speech, subject switching, less sleep, risky behavior, grandiose ideas, sense of invincibility, sexual promiscuity, spending money and impulsivity.

Depression Symptoms:

- May include being extremely sad, hopeless, irritable, no interest in formerly enjoyable hobbies, fun activities, sleep / appetite changes, little to no energy, problems concentrating, overwhelmed by minor decisions, obsessing over feelings of loss, failure, guilt, hopelessness **– recurrent thoughts / talk about death / suicide.**

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Treatment of Bipolar Disorder

- Medications – mood stabilizers, antipsychotics, antidepressants
- Education designed to reduce relapses
- Psychological therapy: CBT – Interpersonal & Social Rhythm Therapy to work on problem areas in life
- Family Therapy
- May need short hospitalization to stabilize

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Facts to Know About Post Traumatic Stress Disorder (PTSD)

PTSD Occurs More Than You Think And Is Triggered By More Than You Think?

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PTSD - A COH Can Be Part Of The Answer

- PTSD – is a ***normal*** response to an ***abnormal*** situation.
- It is a natural emotional reaction to a deeply shocking and disturbing experience.
- May have symptoms **immediately**, **delayed** or have **chronic** problems for years.
- A healthy relationship is part of the cure
- Respect the person's boundaries
- Be sensitive and normalize and ask questions
- Keep the door open - Share the faith

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Post Traumatic Stress Disorder

To meet the criteria for PTSD:

- ❖ Symptoms must last more than 1 month.
- ❖ Symptoms must disrupt social, occupational, intimate relationships, spiritual or other areas of life.

- PTSD that lasts less than 3 months is acute.
- PTSD that lasts more than 3 months is chronic.
- Onset of PTSD for over 6 months is delayed onset PTSD.

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Post-Traumatic Stress Disorder (PTSD)

PREVALENCE:

- *10% of American women and 4% of American men will experience PTSD at some point in their lives.*
- Adults who are single, divorced, widowed, people in poverty and young adults who are socially withdrawn are more susceptible.
- Women are most affected by rape, assault and men by combat
- Veterans, First Responders, and EMTS are at higher risk.
- *Of those who did military duty in Afghanistan and Iraq 30% came home with PTSD.*

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PTSD (various) Symptoms

Symptoms may not show up immediately, but they can last for months/years.

- Nervousness, anxiety, chronic nerve pain created by traumatic events and memories
- Irrational or impulsive behavior
- Loss of interest
- Loss of ambition
- Inability to feel joy or pleasure
- Poor concentration
- Impaired memory
- Joint pains, muscle pains
- Depression/Low self-esteem

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PTSD (many various) Symptoms

- Hyper-vigilant, paranoid, particularly in crowds
- Exaggerated or easily startle response, tense, afraid, irritable
- Irritability sudden angry or violent outbursts
- Sleep disturbance, nightmares, restless leg syndrome, intrusive recollections, vivid memories involving the senses
- Triggers - sights, smells, sounds, activity
- Exhaustion and chronic fatigue
- Guilt feelings of detachment
- Phobias about specific daily routines, places, flashbacks
- Avoidance behaviors - people, objects that trigger a response
- Emotional / Physical numbness
- Out-of-body experiences -- world is not real

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PTSD – Physical Symptoms

- **Eyes** – pupils dilate
- **Mouth** – decreases saliva, dry mouth
- **Adrenal glands** – stimulate the secretion of nor-epinephrine
- **Lungs** – Increased blood flow
- **Heart** - pumps faster to increase blood flow
- **Liver** – Releases glucose
- **Bladder** – inhibits urination
- **Stomach** – slows digestion
- **Skin** – increases sweat production
- **Hands/extremities** – shake and tremble

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PTSD - What the Person is Experiencing

- Frustration with handling PTSD
- May feel guilt, embarrassment, shame
- May be avoiding dealing with it
- May see the world as a dangerous place
- May be acting out with violence/addiction
- May not understand it
- May not know where to go for help

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Encourage Them to:

- Learn about trauma and PTSD
- Talk to others for support
- Talk to your doctor
- Talk to God
- Practice relaxation methods
- Increase positive activities
- Take prescribed medication

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Post-Traumatic Stress Disorder (PTSD)

The (1) severity, (2) duration and (3) proximity of exposure will affect whether a person develops PTSD or not.

Typical Causes:

- ❖ Military combat/fatigue (Men)
- ❖ Violent crimes, assaults (witnessing as well as participating)
- ❖ Natural disasters (First Responders, police, firefighters, EMT)
- ❖ Serious accidents or frightening events ("being traumatized")
- ❖ Rape and sexual assault (**Women)**
- ❖ Of those who did military duty in Afghanistan and Iraq, 30% came home with PTSD.
- ❖ Natural disasters inflict PTSD on **50%-70%** of the survivors.

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Post-Traumatic Stress Disorder (PTSD)

4. Symptoms may not show up immediately, but they can include flashbacks, nightmares, frightening thoughts and can last for months.
5. *Avoidance of certain people, places, or objects that are certain reminders.*
6. Flashbacks and vivid memories involving the senses
7. Paranoid, particularly in crowds – hyper-vigilante
8. Easily startled, tense, afraid, irritable
9. Trouble sleeping, insomnia, nightmares, night terrors, night sweats, restless leg syndrome, lack of sleep, depression
10. Out bursts of anger/rage

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Post-Traumatic Stress Disorder (PTSD)

11. Chronic nerve pain – carrying traumatic memories creates a heightened state of hormone production, which can, over time cause chronic nerve pain. When the mind is focused on trauma, the entire endocrine (glands) system is affected.
12. Using alcohol or drugs to numb feelings
13. *Avoiding people and becoming isolated*
14. Changes in thoughts / feelings / beliefs
    a. feeling sad, anxious, afraid most of the time
    b. becoming emotionally numb, hopelessness
    c. losing interest in activities and relationships
    d. thinking of themselves as bad or guilty

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PTSD Treatment:

The earlier after the event that the treatment is offered, the better the results.

- ❖ Meditation, yoga, relaxation techniques, service dogs
- ❖ Antidepressants such as serotonin reuptake inhibitors
- ❖ Spiritual ministry
- ❖ Group / family therapy
- ❖ Exposure Therapy
- ❖ Hypnosis
- ❖ Cognitive Behavior Therapy
- ❖ Eye Movement Desensitizing and Reprocessing Therapy

PTSD is a diagnosis: It is not meant to be a life long label!

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Post-Traumatic Stress Disorder (PTSD)

- Believing the world is scary, dangerous places and people can't be trusted
- Symptoms can become severe enough to lead to suicide.
- Suicide is especially high in people who have experienced physical trauma
- Self-harm dangerous, risky hobbies, taking chances, cutting, etc.

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Post-Traumatic Stress Disorder (PTSD) - Suicide

- Symptoms can become severe enough to lead to suicide.
- The VA reports 22 daily suicides from both active and non-active military persons including reservists.
- Suicide is especially high in people who have experienced physical trauma. Self-harm – dangerous, risky hobbies, taking chances, cutting, etc.
- Impact **3.5%** of adults (7.7 million)/**4%** of children
- More women than men

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WHY DO PEOPLE FEEL SUICIDAL?

"Because their problems seem overwhelming with no hope."

THE MAIN CAUSES OF SUICIDAL FEELINGS ARE STRESSORS AND SYMPTOMS THAT LEAD TO FEELINGS OF:

Hopelessness

Helplessness

Worthlessness

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Suicide Intervention

- Statistics
- Warning Signs
- Myths and Facts
- Do's and Don'ts
- Talking to a Possible Attempter

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STRESSFUL SITUATIONS THAT CAN INITIATE SUICIDAL FEELINGS…

- Multiple failures; relationships, promotion, finances, etc.
- Death of a loved one
- Sickness, illness, loss of body parts and/or body function
- Financial problems
- Loss of "support systems" or "emotional safety"
- The compounding and disorienting effects of drugs and/or alcohol

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STRESSFUL SITUATIONS THAT CAN INITIATE SUICIDAL FEELINGS…

- Leaving old friends
- Humiliation/rejection
- Being alone with concerns about self and family
- Disciplinary action
- Renewal of bonding with family on return from long field training or an isolated tour
- Suicide is the Leading Cause of death for people held in local jails.

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Suicide: Some Current Statistics:

- More than 50,000 Americans died by suicide in 2023 — more than any year on record.
- This equals **1 death every 10.5 minutes** or about **137** persons a day.
- **12.3 million** consider suicide; **3.5 million** make a plan; **1.7 million** attempt it.
- Men are **3.9 times** more likely to succeed at suicide (firearms and suffocation) but women are more likely to attempt (poison).

Men are about 50% of American population but about 80% of suicides.

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Suicide: Some Current Statistics:

- Suicide is the **2nd leading** cause of death among people aged 10-14 and the 3rd leading cause of death among those aged 15-24 in the U.S.
- **46%** of people who die by suicide had a diagnosed mental health condition
- **90%** of people who die by suicide may have experienced symptoms of a mental health condition, according to interviews with family, friends and medical professionals.

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Suicide: High Risk Populations:

- **U.S. Adults: annual average 4.8%**
  - Native Hawaiian/Other Pacific Islander: **7.4%**
  - Mixed/Multiracial: **8.2%**
  - American Indian/Alaska Native: **8.5%**
- **Youth Populations:**
  - Young adults aged 18-25: **13%**
  - High school students: **22%**
  - LGBTQ youth: **45%** - Lesbian, gay and bisexual youth are **nearly 4x** more likely to attempt suicide than straight youth:
- **Transgender adults** are **nearly 9x** more likely to attempt suicide at some point in their lifetime compared to the general population

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BE ALERT OF SIGNALS AND SYMPTOMS

They can be written, verbal, or behavioral.

- Hopelessness/Despair
- Lack of interest in activities
- Lack of energy
- Sudden change in weight
- Sleep disturbance/deficit
- Intrusive thoughts
- Giving Away Possessions

MENTAL HEALTH EMERGENCY RESPONSE

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BE ALERT OF SIGNALS AND SYMPTONS

- Disregard for any positive experience
- Substance abuse
- Social media, poetry
- Passive language
- Recognize negative feelings or emotions that last several days.
- Be aware of unusual plans; going away, etc.

MENTAL HEALTH EMERGENCY RESPONSE

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Do's:

- Do let them know you are concerned
- Do listen seriously to show care
- Do listen seriously for signals and clues
- Do let them ventilate
- Do check on feelings:
- Do make empathetic statements: "It must be awful feeling the way you do. Tell me more."
- Do ask what might be helpful
- Do discuss family and network support
- Do encourage to seek professional help

MENTAL HEALTH EMERGENCY RESPONSE

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Don'ts:

- Don't leave the person
- Don't show surprise or shock
- Don't judge or condemn or shame
- Don't lecture on the value of life
- Don't argue
- Don't make statements you can't back up
- Don't offer ways to fix problems
- Don't dare or dare give up
- Don't minimize problems
- Don't struggle for right words
- Don't be sympathetic if you have never been suicidal

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Myths and Facts

- **Myth:** People who talk about wanting to die by suicide are just trying to get attention. They don't mean it!
  - **Fact:** People who die by suicide usually talk about it first. They are in pain and oftentimes reach out for help because they do not know what to do and have lost hope.
- **Myth:** Suicide always occurs without any warning signs.
  - **Fact (Suicide):** There are almost always warning signs.

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Myths and Facts

- **Myth:** Once people decide to die by suicide, there is nothing you can do to stop them.
  - **Suicide Fact:** Suicide can be prevented. Most people who are suicidal do not want to die; they just want to stop their pain.
- **Myth:** Suicide only strikes people of a certain gender, race, financial status, age, etc.
  - **Fact:** Suicide can strike anyone.

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Myths and Facts

- **Myth:** People who attempt suicide and survive will not attempt suicide again.
  - **Fact:** People who attempt suicide and survive will oftentimes make additional attempts.
- **Myth:** People who attempt suicide are crazy.
  - **Fact:** They are in pain, and probably have a chemical imbalance in their brain.

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Myths and Facts

- **Myth:** You should never ask a person if they are thinking about suicide or if they have thought about a method, because just talking about it will give them the idea.
  - **Fact:** Asking people if they are thinking about suicide does not give them the idea for suicide. Hear them out, you will learn more about their mindset, intentions, and allow them to diffuse some of the tension that is causing their suicidal feelings.

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Myths and Facts

- **Myth:** There is little correlation between alcohol or drug abuse and suicide.
  - **Fact:** Oftentimes people who die by suicide are under the influence of alcohol or drugs.
- **Myth:** Young people never think about suicide, they have their entire life ahead of them.
  - **Fact:** Suicide is the third leading cause of death for young people aged 15-24. Sometimes children under 10 die by suicide.

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Suicide:

Mental Health Emergency Response (MHER)

Covered in General MHER Section

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Absolutes!

Stay with the person and call for help...don't leave them alone.

Unless you are trained to do so, don't try to determine if someone is or is not suicidal.

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Handling a Potential Suicide CALL

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Handling a Call from a Suicidal Person

1) ***Be yourself.*** The right words are unimportant. If you are concerned, your voice and manner will show it.
2) ***Listen***. Let the person unload despair, ventilate anger. If given an opportunity to do this, they will feel better by the end of the call. No matter how negative the call, the fact that it exists is a good sign.
3) ***Be sympathetic.*** Non-judgmental, patient, calm, and accepting. The caller has done the right thing by getting in touch with another person.

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Handling a Call from a Suicidal Person

4) **If the caller is saying,** "*I'm so depressed, I can't go on*,"
   Ask the question, *"Are you having thoughts of suicide?"*
   You are doing a good thing by showing that you care.
5) **If the answer is "yes,"** you can begin asking questions:
   - "Have you thought about how you would do it? **(**PLAN**)**
   - "Have you got what you need? (MEANS**)**
   - **"**Have you thought about when you would do it? (TIME SET).

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Handling a Call from a Suicidal Person

Approximately **95%** of all callers will answer "no" at some point in this series of questions or indicate that the time is set for some time in the future. This will be a relief for both of you.

6) **Avoid arguments,** problem-solving, advice giving, quick referrals, belittling, and making the caller feel that he/she must justify his/her suicidal feelings.

It is not how bad the problem is, but how badly it is hurting the person who has it!

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Handling a Call from a Suicidal Person

7) **Simply talking about their problems** for a length of time will give suicidal people relief from loneliness and pent-up feelings.
   - They also get tired - their body chemistry changes.
   - These things take the edge off their agitated state and can help them get through a bad night.

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Handling a Call from a Suicidal Person

8) **If the person is ingesting drugs,** get the details (what, how much, alcohol, other medications, last meal, general health) and call Poison Control at 1-800-222-1222.
   - A partner can call while you continue to talk to the person, or you can get the person's permission to do it yourself on another phone while the caller listens to your side of the conversation.

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Handling a Call from a Suicidal Person

9) **If Poison Control recommends** immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance.
   - In a few cases, the person will initially refuse needed medical assistance.
   - Remember that the call is still a cry for help and stay on the line in a sympathetic and non-judgmental way.
   - Ask for address and phone number in case he/she changes his/her mind. (Call the number to make sure it is busy.)

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Handling a Call from a Suicidal Person

10) **Your caller may be concerned about someone else** who is suicidal.

- Just listen, reassure them that they are doing the right thing by taking the situation seriously and sympathize with their situation.
- In the rare case that the third party is really the first party, just listening will enable you to move towards his/her problems.

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988 versus 911

- **988** established in 2020
- National 24/7 helpline
- For people who may be: Suicidal and Experiencing a MHE OR experiencing Substance Use Disorder (SUD).
- In multiple languages
- Free and confidential.

- **911** is an emergency number to call requesting immediate on-site assistance. Police, EMTs, and fire dept.

When police or law enforcement arrive, they assume full authority and command of the situation regardless of the wishes of family or friends.

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Basic Guidelines for Chaplains of Hope

Hospital Visitation is Necessary

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ALWAYS REMEMBER:

- Call ahead of time if possible.
- Be mindful of visitation hours.
- Dress appropriately.
- Pray before you go and depend on God for guidance, understanding, and direction.
- Identify yourself at the nurse's station.
- Make the visit friendly and causal, not stiff and formal.
- Knock and identify yourself.

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ALWAYS REMEMBER:

- If possible, visit because you care and not as an expected obligation.
- Keep visit confidential.
- Make visit uplifting, bring comfort, hope, and encouragement.
- Wash/clean hands before entering and leaving.
- Stand or sit where the patient has good eye contact. Sitting is preferred.

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ALWAYS REMEMBER:

- Do not sit on the bed or touch equipment.
- Ask permission before you touch the person.
- Be an active listener for cues and concerns. Don't ask many questions.
- Do not be afraid of silence or tears. Theirs and yours.
- Never say, "I know how you feel," because you don't.

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ALWAYS REMEMBER:

- Use care and discernment in asking questions. Questions can be tiring to a patient, and they may appear imposing.
- Use questions that prompt storytelling and healing.
- If you get there and find you can't visit, leave a card or note and that you are planning on returning.
- Be prepared to leave reading materials.

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ALWAYS REMEMBER:

- Do not give false hope or promise things.
- Do offer hope in what God can do.
- Do not wake the patient without permission.
- Do ask what condition brought them to the hospital and what's the latest from the doctor.
- Do not give medical advice.
- Move conversation to faith or spiritual background questions.

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ALWAYS REMEMBER:

- Discuss how prayer, scripture reading, journaling, relaxation bring your peace?
- Excuse yourself when a hospital staff enters the room unless the patient or family asks you to stay.
- Limit the length of your visit. Not more than 10 minutes is ideal.
- Close the visit by reading a scripture passage and have prayer.

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Additional Points to Consider

- Reaction to loss, trauma and critical incidents is not an exact science. Reacting to trauma is normal.
- Most individuals will respond to people helping them get through the event. Don't take their anger personally, venting is normal.
- Two ears and one mouth is a good formula.
- They may be mad at God. Don't defend Him. God can handle people being mad at Him.
- Police and emergency workers often see tragedy. They also may need someone to talk with.

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General Mental Health Emergency Response (MHER)

There is an almost certainty you will experience a person with Mental Health Crisis and or Mental Illness as a COH.

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Attitude Makes the Difference

A crisis is an opportunity for a person to gain new:

- *Strengths*
- *Perspectives*
- *Appreciation*
- *Values*
- *Approach to life*

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Why Get Involved in COH

Have you ever used any of these reasons/excuses to avoid doing something?

- ❑ It's too dangerous for me.
- ❑ I'm too busy.
- ❑ I have more important things to do.
- ❑ This is a hopeless case.
- ❑ It's not my problem.
- ❑ He/she probably won't even appreciate my efforts.
- ❑ He/she is not that important.
- ❑ I haven't been asked to do this/It's not my job.

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COH are an Army of Chain-Breakers!

- ❖ **Captives** – those imprisoned because of something that happened to them (enslaved, kidnapped, etc.) battlefield events, assaults.
- ❖ **Prisoners** – those who have made bad choices out of their pain or rebellion.
  - **Left unhealed, they will pass their pain on to others.**
- ❖ **Co-morbidity** (strong connection) between trauma and addictions.

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Chaplains Need A 3-fold Heart For Those In Need:

What is a proper biblical response to someone in need?
(I John 3:17, John 15:2-3)

- ❖ Willing to lay down our lives for others
- ❖ Willing to share our material possessions with those in need
- ❖ Willing to love each other as Jesus has loved us

Often Used But Never More True:

"People don't care how much we know until they know how much we care…"

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Simply Put COH Can Do MHER:

- **Ministry of Presence:** Chaplains carry into painful and difficult situations *the very presence and peace of Christ.*
- **Ministry of Compassion:** Jesus' compassion always moved Him to act to heal the broken-hearted. So too, His compassion can move us to action today.
- **Ministry of Silence:** Whether by words or by silent support, chaplains can bring comfort to the crushed and hopeless.
- **Do you remember any time when you felt assaulted/overwhelmed by someone or by life and could have used the services of a Christian Chaplain?**

What did/would have helped you the most?

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Why is being a MHER So Important?

Mental health problems are very common and increasing.

- ***Many people do not understand mental disorders/mental crisis/mental illness, which puts those suffering at risk of being misunderstood by:***
  - **Family**
  - **Friends**
  - **Health professionals**
  - **Law enforcement**

Sufferers need an Advocate!

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Why is being a MHER So Important?

- The mentally ill are 16 times more likely to be killed in an encounter with law enforcement!
- Many people with mental health issues do not seek help or delay seeking help because of:
  - Stigma
  - Transportation
  - Expense
  - Unawareness of need

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Why is being a MHER So Important?

- Professional and other support services are not always available when a mental health problem arises, especially in rural areas.
  - *More than 130 million Americans live outside of areas that offer mental health services.*
- What sources are available in your community to assist the mentally ill.

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Being Prepared and Properly Trained

- Well-meaning but untrained people can make things worse instead of better. *If you can't help them, don't hurt them!*
- You need to have some understanding between the stress of a critical incident and mental safety issues, while preventing escalation of other mental health crises.
- *You will be viewed as a professional, especially if you carry or wear anything that labels you as a chaplain or first responder.*

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Why Do I Need to Be Prepared and Properly Trained?

- *You need to know who to call as the next step up for further treatment (police, EMT, family, pastor, social worker, etc.).*
  - It is your job to pass the person on for continuing or long-term care of professionals.
  - *You need to know how to be a helpful team player rather than a nuisance or hindrance.*
- *Know when you have done your job, and now it is time to yield.*

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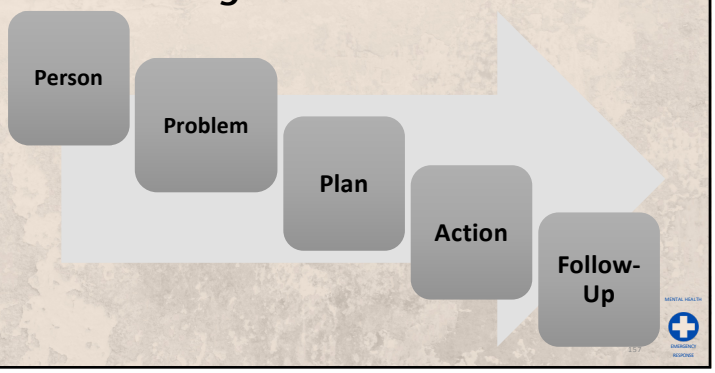
Understanding the PPPAF model for MHER



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Understanding the PPPAF model for MHER

- There is a person in my path who has a problem.
- I need to approach, access, and build rapport to help them develop a plan and then act on it.
- I will follow-up if appropriate.

1. A (approach)
2. A (assess)
3. B (build rapport)
4. H (Help Them)

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P = Person - Approach

- Act and speak calmly, kindly, confidently, empathetically.
- Do not display any inner motions you may be experiencing. Introduce yourself and explain why you are approaching.
- Example:
  - *"Hello, my name is COH John Doe.*
  - *I am a COH from CHC of Amarillo (organization or community).*
  - *I am here to check in with you and see if you are okay.*
  - *What name do you prefer to go by?*
  - *Please tell me what's going on."*

159

P = Person - Approach

- Use the person's name when you speak to them.
- Use a slow cadence, brief phrases, and repeat as necessary. *Watch Body Language.*
- Be upbeat and confident.
- If necessary or appropriate, take person to safe quiet place away from danger

BUT… *Always stay visible to other team members or responders!*

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P = Person - Assess

- Assess for risk of suicide or harm to self or others.
- If you have suicidal concerns, ask direct questions such as:
  - Are you thinking about committing suicide?
  - Do you have a plan to kill yourself?
  - Do you have the things you need to kill yourself?
  - Have you picked a time or date to kill yourself?

Talking about suicide *will not make a person more likely to act*

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P = Person – Build Rapport (Relationship)

- Practice active, nonjudgmental listening.
  - Give social cues such as head nodding to let them know you are listening.
- Adapt to speaking style of person by listening carefully and observing body language: loud versus quiet; very detailed versus short answer; introvert versus extrovert; linear thinking versus tangential (all over).
- AVOID any *phrase or opinion that is overused.*
- Use repetition and empathetic responses such as "It sounds as if you are feeling…"

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P = Person Build Rapport (Relationship)

- Be a team player and do your part to help solve the current situation. ***Go out of your way to assist.***
- Always be courteous ***and genuine.***
- Explain in good detail what is being done to aid and assist and ***give only the FACTS you have about the current situation.***
- If the person is in psychosis, acknowledge that the person is really experiencing the images and voices they are sharing with you. ***"I believe you really see ?_____?, but I don't see it."***
- ***Don't patronize or lie!***

MENTAL HEALTH EMERGENCY RESPONSE

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P = Person – Help Them Use Motivational Interviewing (MI)

- Express empathy through reflective listening (paraphrase back what person is saying).
- Develop discrepancy between client's goals and current behavior.
- Avoid arguing and confrontation.
- Adjust to client resistance rather than oppose it directly; invite new perspectives without forcing them.

MENTAL HEALTH EMERGENCY RESPONSE

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P = Person – Help Them Use Motivational Interviewing (MI)

"In relationships, the person with the widest range of responses will have the greatest amount of influence and control"

(Dr. Norman Wright)
"The Complete Guide to Crisis & Trauma Counseling"

MENTAL HEALTH EMERGENCY RESPONSE

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P = Problem

- *Assess situation as quickly and accurately as possible.*
- If the person represents harm to themselves or others: call law enforcement and emergency services (911).
- If the person is actively suicidal, dangerously self-injuring or suffering effects of withdrawal/opioid overdose: immediately call emergency services.
- Person has not slept or eaten in several days because of mental health condition: get to hospital.

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P = Problem

- Person is experiencing severe mania, prolonged psychosis, or severe depression: get to hospital.
- Person is physically hurt: get to hospital or call for emergency services. (Watch for signs of possible internal injuries, changes in mental/physical state, sudden disorientation.)
- Does person have immediate needs for food, water, clothing, or shelter? (Clothing and not showering are important for evidence gathering in assault cases.)

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P = Plan

- Give *reassurances*, information from your *Resource Notebook*, practical help, a glass of water, cup of coffee, arm to lean on, blanket, etc. A *reassuring word* of encouragement, hope or a *hand-shake*.
- Never promise what you can't deliver! *Don't promise confidentiality if a person is at risk of self-harm or harming others. Don't leverage the truth to gain insight.*
- Allow the person to be as self-sufficient as they are able and to make their own decisions regarding care, if possible. Help them find their strengths (personal resources) and how to use them.

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P = Plan

- **Have person identify** family, friends, peers who can offer support.
- **DO NOT try to diagnose**, offer professional counseling or summarize what you may or may not be seeing.
- **NEVER ASSUME ANYTHING!** (including that people are traumatized when they may not be)
- **If you can't answer a question**, admit it, but say that you will try to find the answer and then follow through.

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Follow Up: Encourage self-help & other strategies

- Document incident, involvement, response and resolution; include times, dates, locations, and who else was present.
- If possible, connect the person's loved ones to medical or mental health resources in the community.
- ***Establish boundaries*** *but be available if you are able to, for continued support;* ***HOWEVER, you are not the long-term caretaker – you are the first responder.***
- Maintain confidentiality when appropriate and necessary.
- Always act respectfully and professionally: Be polite, sensitive, patient, and responsive.
- ***Don't take anything personally!***

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Follow Up: Encourage self-help & other strategies

- Encourage appropriate professional help.
- Stay with person until other professional(s) arrive and take charge. **NEVER leave alone!**
- When reporting to professionals, ***stick to facts and keep information simple, clear concise and free from opinion.***
- Be firm but respectful if disagreeing. Offer encouragement.
- Do not speculate as to what will happen next.
- Document interaction for future reference and protection.

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Supporting the Person in Need With MHER

With practice, *any mentally healthy, well-trained person* can learn how to better help support others in their time of crisis.

- Responding quickly and motivating others to act swiftly, you may literally save a life someday.
- Transferring the person in need to the appropriate professionals – don't hold back the correct care.

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Summary: Supporting the Person Experiencing a Mental Health Crisis

Use Motivational Interviewing (MI):

- ❖ Express empathy through reflective listening.
- ❖ Develop discrepancy between goals/values and behaviors/Avoid arguing/confronting
- ❖ Adjust to resistance; invite new perspectives
- ❖ Support self-efficacy and optimism by helping person identify strengths and strategies

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Summary: Supporting the Person Experiencing a Mental Health Crisis

Guidelines:

- ❖ Be clear and concise in words, body language, etc.; always upbeat.
- ❖ Deliver communication ASAP and keep individual informed.
- ❖ Encourage person to participate in decision making process.
- ❖ Be patient, tolerant, and understanding, even in respectful disagreement.
- ❖ *Don't argue; be courteous; build rapport; be genuine; repeat back.*
- ❖ Be a team player. Go out of your way to assist.

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Active Listening Skills - Compassionate Conversation

- **Paraphrase.** *Once the other person has finished expressing a thought, paraphrase what he or she said to make sure you understand and to show that you are paying attention.* Helpful ways to paraphrase include "What I hear you saying is…" "It sounds like…" and "If I understand you right…."
- **Ask questions.** When appropriate, ask questions to encourage the other person to elaborate on his or her thoughts and feelings. ***Avoid jumping to conclusions about what the other person means.*** Instead ask questions to clarify his or her meaning, such as, "When you say_____, do you mean_____"?

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Active Listening Skills - Compassionate Conversation

- **Express empathy.** If the other person voices negative feelings, strive to validate these feelings rather than questioning or defending against them.
- For example, if the speaker expresses frustration, try to consider why he or she feels that way, regardless of whether you think that feeling is justified or whether you would feel that way yourself were you in his or her position
- Possible response, *"I can sense that you're feeling frustrated," "I can understand how that situation could cause frustration."*

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Active Listening Skills - Compassionate Conversation

- **Use engaged body language.** Show that you are engaged and interested by making eye contact, nodding, facing the other person, and maintaining an open and relaxed body posture.
- ***Avoid attending to distractions in your environment or checking your phone (or watch).***
- **Be mindful of your facial expressions:** Avoid expressions that might communicate disapproval or disgust.
- **Avoid judgment.** Your goal is to understand the other person's perspective and accept it for what it is, even if you disagree with it.

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Active Listening Skills - Compassionate Conversation

- ***Try not to interrupt*** with counterarguments or *mentally prepare a rebuttal* while the other person is speaking.
- **Avoid giving advice.** Problem-solving is likely to be more effective after both conversation partners understand one another's perspective and feel heard.
- **Moving too quickly** into advice-giving can be *counterproductive*.

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De-Escalating a Situation

- **Aggression** has two forms:
  - Emotion-driven and based on Fear. Individual wants to be heard and understood.
  - A response to not getting one's way. Individual wants an audience or a stage.
- Take all warnings and threats seriously especially at first.
- Never put yourself at risk. Do not make threats – Period!
- If you are fearful, remove yourself from the situation and seek help immediately.
- Make sure to let other responders know whether a person is armed or unarmed, if you know for sure!

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De-Escalating A Situation Process:

- Get into rapport quickly by being respectful, receptive, and helpful to sensitivities and needs.
- Upon approach, give name and affiliation.
- Use non-threatening body language: feet shoulder-width apart. Legs relaxed, arms uncrossed, hands unclenched
- Keep a safe and clear distance (1-2 arm's length)
- *Speak softly, clearly, simply, and calmly and in a soothing manner with body language that reflects calmness.*
- Be relaxed and unflustered.
- Use short sentences and slow breathing.

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De-Escalating a Situation

- Never argue or debate in a hostile, disciplinary, challenging manner.
- Replace negative statements with positive ones.
- You may need to repeat yourself until person understands.
- Stand or sit at a slight angle rather than directly in front of so that you do not appear to be confronting.

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De-Escalating a Situation

- ***Set boundaries up front***: You will be in charge, and you will be understanding their needs and concerns. Never respond impulsively because you are shocked or offended.
- ***Give the person enough space/room*** as desired so that he/she won't feel trapped or boxed in. Do not restrict movement.
- ***Do not let yourself get trapped or boxed in***. Stay near exit or window in case you need to get away quickly.
- ***Remain positive*** and provide acceptable options.
- If you must disagree, ***try to empower*** with positive information to motivate them by focusing on their positive qualities.

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De-Escalating a Situation

- Never make promises you can't keep!
- Help the person identify healthy, safe behaviors that will not get him/her into trouble.
- Use breaks of silence to allow person to cool down. When you don't know what to say, silence can be useful.
- Debrief your experience to review what went well and what did not.

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De-Escalating a Situation – what NOT to say or do during a Mental Health Crisis

- Don't judge, moralize, or admonish – this may keep person stuck in crisis.
- Don't confront inappropriately – Some problems cannot be fixed immediately.
- Don't force or use pressure tactics such as prodding, browbeating, threatening with negative consequences if they don't respond quickly, etc.

WATCH YOUR WORDS, especially when dealing with people who are experiencing great physical, social, emotional, or spiritual pain.

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What NOT to Say or Do During a Mental Health Crisis

- Don't be passive interacting
- Don't become dominant by interrupting, showing impatience, changing the subject, lecturing, attempting to persuade, etc.
- Don't self-disclose too much. It is not about YOU!
- Don't interrogate—not too many questions.
- Don't give false reassurance or be premature or without justification.
- Don't emotionally detach.

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HELPFUL CONVERSATION STARTERS

- *Are you okay? How are you, really*? Say sincerely and show concern.
- *Are you thinking about suicide?* Ask only if you are concerned that person is having suicidal ideations.
- *Do you want to take a walk, sit and chat?* (Doing some activity together can make talking less uncomfortable.)
- If violence is a concern, *do not leave*.

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HELPFUL CONVERSATION STARTERS

Instead of saying:	Say:
Keep a stiff upper lip.	I can see you are hurting.
It's for the best.	Wow! That's really hard.
I know how you feel.	How are you really feeling?
God doesn't give you more than you can handle	Can I pray for you?
It's God's will.	I'm so sorry that happened to you.
You should do _____.	How can I help?
You'll get over this in no time.	Give yourself time to heal.

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HELPFUL CONVERSATION STARTERS:

Instead of saying:	Say:
You'll be fine. /Get over it.	I'm here for you.
I understand.	I can appreciate that…
Stop acting crazy	Ex. When you don't clean up…
Just don't worry about it.	This is hard/I'm here for you
Therapy/drugs are for the weak	I will support your choices
Things will be better in the morning	I'm here to listen, support, be with you, etc.

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Chaplains of Hope

MINISTRY OF

HOPE

Discussion
Q & A

HOPE HOPE HOPE HOPE

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Dealing with an Angry Person

"Anger was designed to be a visitor, never a resident in the human heart."

Why We Get Anger:

- experiencing pain (flight, freeze of flight response)
- experiencing fear or a "weaker" more vulnerable, uncomfortable emotion such as anxiety, shame, guilt, hopelessness or grief

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Dealing with an Angry Person

Why We Get Anger:

- A response to not getting what we want
- *A tool to bully, intimidate, manipulate, and control*

❖ Being angry is not a sin; our behavior when we are angry could be. How do I behave when I am angry?

Staying angry is like swallowing poison and waiting for the other person to die."

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Scripture - Dealing with an Angry Person

"In your anger do not sin; do not let the sun go down while you are still angry and do not give the devil a foothold." Eph. 4:26-27

"But now you must also rid yourselves of all things as these: anger, rage…" *Col. 3:8*

"Fools give full vent to their rage, but the wise bring calm in the end." *Proverbs 29:11*

"Do not be quickly provoked in your spirit, for anger resides in the lap of fools." *Eccl. 7:9*

"Human anger does not produce the righteousness that God desires." *James 1:20*

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Dealing with an Angry Person

If You Are Dealing With an Angry Person:

- Do not assign blame, argue, or confront
- Never threaten or lose your own temper
- Acknowledge their frustration.
- Show **empathy** – Invite them to share/explain what is happening and how they are feeling. Practice reflective listening.
- *Ask what they wish to achieve and how you can help that happen.*
- Appeal to the healthy side of their personality; ***use humor carefully.***

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Dealing with an Angry Person

If You Are Dealing With an Angry Person:

- Keep yourself safe – Take all threats and warnings seriously. In extreme cases, you may need to step away from the person, ask for assistance, or call for help (law enforcement).
- ***Stay calm*** and ***non-confrontational*** on the outside:
  - Low voice, slow speech, confident, up-beat
  - Economy of body language, imitation, non-threatening stance
  - Do not crowd person or make them feel trapped
  - Stay in sight of others

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Dealing with an Angry Person

If You Are the Angry Person:

- Acknowledge that you have a sin problem in this area.
- Keep a hostility log – What/who keeps making you angry and why.
- Let the people you respect and care about know that you are trying to make changes; they can become your support group.
- Use techniques to interrupt anger cycle: deep breathing, counting to 20, praying, etc.
- Use imagery and positive thinking (Scriptures) to interrupt negative thought patterns.
- See the situation from other person's perspective.

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Dealing with an Angry Person

If You Are the Angry Person:

- See the humor in situation – Laugh at yourself.
- Relax – Work on maintaining a calm, healthy lifestyle (walking, exercising, enough sleep, good diet, etc.)
- Build trust with friends and colleagues.
- Listen effectively – Use active listening skills.
- Don't destroy relationships over small matters.
- Forgive and release.
- Seek counseling if you need further support.

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Are alcoholism or drug addictions a result of disease or moral failure?

- This question has been a struggle for Christians for generations. The Bible is clear in both the Testaments that drunkenness is not to be condoned.
- While this sin can be forgiven, practicing drunkards will not inherit the Kingdom of God. (1 Cor. 6:10,11) Notice that it is excessive drinking that is specifically condemned.
- When a person develops a pattern of heavy drinking or consuming certain drugs that mimic brain chemicals, the brain will respond by creating different neural pathways and declaring a "new normal."

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Helping Someone With Substance Use Disorders (SUD)

Understanding the Effects of Substance Use Disorders:

- By continuously over-stimulating portions of the brain that control the pleasure and reward centers they will now begin to act irrationally, including in their treatment of those around them.
- Their brains have changed, and you must remember that you are dealing with a mental health disorder and/or even emergency.
- For most people, walking out of an addiction to **any** mind-altering substance is usually a long and difficult journey.

The good news is that there is no trap so strong or hole so deep that God cannot find that person and bring them out into new life!

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Weakness of some Self-help

"If you are using a drug (legal, illegal, over the counter, alcohol) and are made aware that it is causing you problems"

Primary Symptoms of a Substance Use Disorder (SUD):

- Loss of control
- Preoccupation with the drug/substance
- Mental
- Behavioral

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Important Things for Helping Someone With SUD

Always meet the person in a public place so that:

- Others can be present during the meeting (you never know the intentions of someone that is suffering from addiction.)
- Accountability can be established.
- *Most people will not act as irrationally when there are people around that could be possible witnesses.*
- Depending on their condition they may have no regard for yours, theirs, or others' safety.)
- When possible, work as a team.

"And He summoned the twelve and began to send them out in pairs, and gave them authority over the unclean spirits;" Mark 6:7

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Important Things for Helping Someone With SUD

NEVER bring someone with substance abuse disorder to your home or give out your address:

- Sometimes you will be in a situation where the person you are trying to help will have no options for living arrangements because of the relational damage they have caused by their actions.
- Your home is not equipped to handle or facilitate recovery and never should be used as such. ***(Temporary exception for family)***
- If you and a spouse are both working in ministry, establish an agreement that your home will never become the answer for someone else's issues brought on by substance use disorders.

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Important Things for Helping Someone With SUD

Exception: For those dealing with SUD within the family:

- You must understand that your loved one is suffering from a SUD and may take advantage of your love for them.
  - A supervised emergency overnight stay may work if you have arranged for the family member to begin recovery the very next day.
  - Do not allow extended stays which can often enable the SUD and put your family at risk.

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Important Things for Helping Someone With SUD

- If possible, try to use a **second phone number** for those that you are helping battle with substance use disorder.
- This will help prevent the late-night phone calls and the occasional inappropriate phone calls.
- Using a different number for dealing with SUD will also let you know the purpose of incoming calls
- There are apps on Google Play and Apple Store that you can use to obtain a second number for free. (Example: TextNow, Talkatone, Freetone, Talk)

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Spotting the Symptoms of *Someone With SUD*

- Too often, people miss the **signs and symptoms** that could make the difference between early intervention and long-term SUD.
- **Never assume** that the person is currently using such substances. Such presumption can cause you to lose your ability to evaluate the person and the situation objectively.
- Automatically jumping to conclusions and accusations **WILL** push that person away.
- **Active listening** and **Motivational Interviewing** techniques can help you find the answers you seek.

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Spotting the Symptoms of *Someone With SUD*

- While **missing work or school** can be a sign of drug use, sometimes spending **too much time working** can ALSO be a sign of occurring drug abuse.
- It is not unusual for some adults to start using drugs as a way to add more awake time to the day, so suddenly working nearly non-stop can point to a substance problem.
- **Friends** at school or work may also change if there is a new drug problem. Your loved one may no longer want to see anyone socially due to fear of being caught. Or, they may have made new friends who share the same habit.

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Spotting the Symptoms of *Someone With SUD*

- Consider your loved one's **money habits**. Sudden changes in spending or missing money can be a sign of a hidden drug problem.
- Even small changes like not being quite as open as they have been in the past about money can mean there is something to hide like a drug or alcohol issue.
- Changes in money habits can also include a **sudden use of credit cards** or obtaining new lines of credit when that was not something they did in the past.
- **Overdue bills** are another sign that money is being spent on things that are out of the ordinary.

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Spotting the Symptoms of *Someone With SUD*

- Look at their physical appearance. Significant changes in both the physical body as well as mannerism may be a sign of drug use.
- Depending on the drug of choice, users may also suddenly seem like they have endless energy and more movement due to **"nervous energy."**
- Beyond the physical body, you may also start to notice **poor hygiene** and the **same clothes** being worn for a longer amount of time than usual. If the drug use includes the use of needles, you may also notice that they often wear **long-sleeved clothing** year-round to hide their arms**.**

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Spotting the Symptoms of *Someone With SUD*

- Watch for the signs of drug addiction. **Things disappearing at home** may be a sign that property is being sold or traded for drugs. They may need more and more money to fund drug use.
- Other signs of a problem may include family members noticing **missing prescription drugs** like painkillers, attention-deficit meds, or a variety of other drugs.
- Major **changes in sleep patterns** including either not sleeping for days on end or excessive sleeping can mean drugs are in play.
- Certain drugs can cause one to stay awake for several days at a time and then cause a crash that sends one into days of sleeping.

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Spotting the Symptoms of *Someone With SUD*

It is wise to be knowledgeable about the effects of using specific drugs. Use of these drugs may result in the following signs and symptoms:

- **Marijuana:** increased appetite, euphoria, dry mouth, memory impairment , and paranoia
- **Cocaine:** increased agitation, hyperactivity, cold symptoms, and lowered expectations
- **Ecstasy:** lowered inhibitions, heightened sexuality, increased energy, tightness in mouth/jaw, increased heart rate, and muscle tension.
- **Methamphetamine:** affects central nervous system causing increased body temp, jaw clenching, insomnia, loss of appetite, sweating, and paranoia.

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Spotting the Symptoms of *Someone With SUD*

- **Amphetamine:** synthetic drug often used to treat ADHD (example: Adderall, Ritalin, Dexedrine) by releasing dopamine. Also used in weight loss and "stay awake" situations.
- **Heroin:** short term feelings of euphoria, well being and pain relief. High and rapid risk of dependence.

Finding Resources:

- As a community Chaplain, your most valuable assets are your resources!
- Don't just recommend a professional or facility without vetting it first.
- Adequately research, otherwise you risk damaging God's ministry through you.

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Understanding the Risks of *Helping Someone With SUD*

Always remember that when you are dealing with someone who is currently abusing alcohol or drugs that you are at risk of ***mental, physical, and spiritual attacks.***

- **Mental** – Understand that you will experience stress when helping someone and it must be handled appropriately.
  - If you personally are having a mental health emergency, you are not helpful to others. If you are in recovery yourself, remember that ***the most important person's recovery is your own.***
  - If you feel like your recovery is in danger remove yourself from the situation. ***Don't be afraid to say, "I can no longer help you because I too am in recovery." Honestly is your best practice in recovery!***

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Understanding the Risks of *Helping Someone With SUD*

- **Physical** – When dealing with people who have altered their brain chemistry, you have to remember that at any moment, they can choose you to be their next target to get what they are craving.
- **Spiritual** – While there are wonderful testimonies of miraculous deliverances from the stranglehold of addiction, for many others, recovery is often a long, hard, and painful road, not just for those with an SUD, but for the people trying to help them recover.
  - The occasional deaths of those you so desperately want to help will be a sad but inevitable part of your life if you choose recovery as your focus. Relapses will happen too often.

You MUST prepare spiritually for the battle and journey ahead.

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Important Things for Helping Someone With SUD

Recently:

- More people are using prescription opiates than are smoking tobacco.
- The death rate from using illegal opiates such as heroin and illegal fentanyl have tripled.
- Every 16 minutes an American will die from opioid use.
- Many of those taking heroin, started out on prescription opioid.
- The National Institute of Health estimates that nearly 52 million people/**20%** of the population have used prescription drugs for non-medical reasons.

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The Secret to Successful Recovery Involves

- Removing oneself from the places, people, and things that triggered and supported those strong desires is essential.
- ***12-step and other recovery programs can be invaluable in maintaining sobriety. Celebrate Recovery is a Christian version with proven results.***
- Supportive family, church, and social network can greatly increase the opportunity for success.

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The Secret to Successful Recovery Involves

- For many, the decision to stay sober requires a daily acknowledgement and a constant deliberate choice for sobriety.
- ***That former drug or drink can never be part of the recovering addict's lifestyle.***
- It is always heartbreaking to see someone fall back into the trap of addiction after months or even years of successful abstinence.
- In some cases, doctors have unwittingly prescribed addictive medications to those who should have never been given access to them because of their mental health or former SUD struggles.

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MHER:

Substance Use Disorders (SUD)

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MHER Treatment

Important Things for Helping Someone With Substance Use Disorders (SUD)

Creating Boundaries:

- As a Community Missions Chaplain, you must create boundaries for both your protection and the welfare of those you are trying to help.
- People with a substance use disorder (SUD) **don't always understand that their mind has been depleted of chemicals that would normally prevent them from irrational thinking and actions.**
  - In fact, for the person desperate for more drugs or alcohol, ***you may be a potential target.***

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MHER for Medical Emergency for Alcohol Abuse

All of the following 3 conditions can lead to a medical emergency:

1. **Intoxication** – Significantly high levels of alcohol impair person's thinking and behavior.
2. **Poisoning** – Toxic levels of alcohol in the bloodstream; could cause death(0.250 – 0.399%)
3. **Withdrawal** – Adverse symptoms from stopping drinking or cutting back greatly; without medications can cause seizures.

Recovery Position –

When unconscious, you must keep the airway open. Turn from back to side (prone) to keep from suffocating on vomit or tongue blocking the airway.

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MHER for Medical Emergency for Alcohol Abuse

If Person is Conscious:

- Stay **Calm**
- **Communicate** appropriately (respectfully, clearly, without laughing at or provoking
- **Monitor** for danger – Assess for potential danger and ensure everyone is safe. Ask if any other drugs or medication have been taken in case a medical emergency arises as conditions deteriorates.
- Ensure the person's **safety** – Do not leave alone; keep away from dangerous objects and machines as well as access to bikes, motorcycles, boats and vehicles, etc.
- ***If you are unable to keep safe, call for law enforcement.***

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MHER for Medical Emergency for Alcohol Abuse

If you determine a person is at risk of medical emergency:

- ❖ Call ambulance or 911
- ❖ Do not leave alone
- ❖ Place in Recovery Position: monitor airway, breathing, and circulation
- ❖ Kick out of the way any broken glass or sharp objects before rolling into prone position
- ❖ Do not give food as they may choke if not fully conscious
- ❖ Cover to keep warm and avoid hypothermia
- ❖ Alcohol consumption can mask pain from injuries
- ❖ If vomiting and conscious, sit them up
- ❖ If breathing stops, apply expired air resuscitation (EAR)
- ❖ If pulse stops, apply cardiopulmonary resuscitation (CPR)
- ❖ If helpful, take a family member or friend to hospital to supply important info.

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Basic Guidelines for Chaplains of Hope

Immediate Grief Counseling Death Notification

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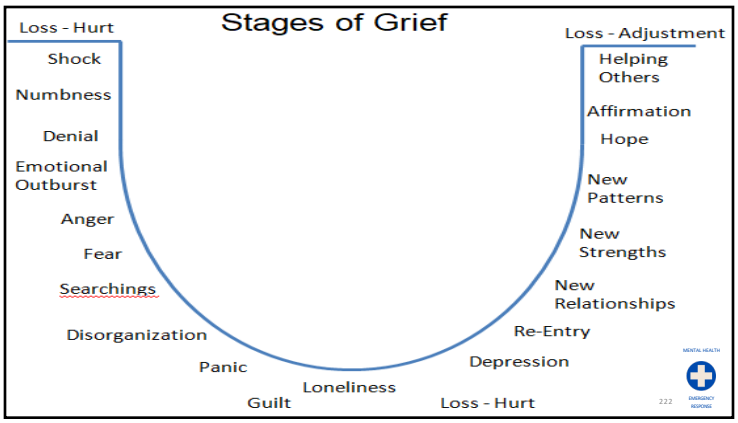

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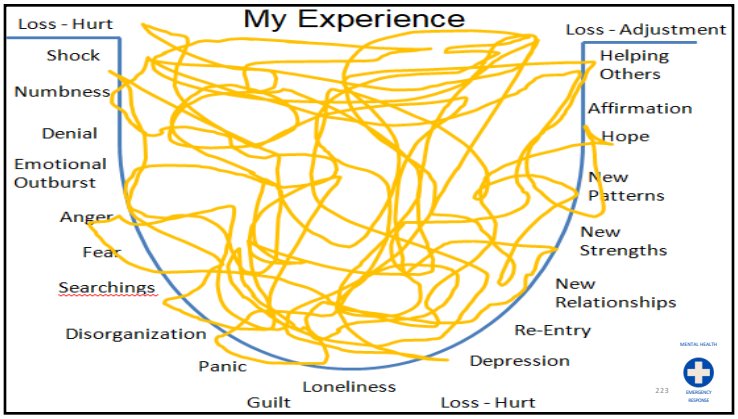

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The Elisabeth Kubler-Ross Stages of Grief

in her 1969 book, *On Death and Dying*

- **Denial**: "This cannot happen to me!"
- **Anger**: "Why did this happen to me?
- **Bargaining**: "Yes me, but…".
- **Depression**: "Oh no, why bother with anything".
- **Acceptance**: "So be it. Let it be".

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- Dr. Kubler-Ross later stated that she had never meant for the 5 stages of grief to "help tuck messy emotions into neat packages".
- There is no single pathway or progression through grief, and that is the main fault of any attempt to stage grief like this.
- Even the different Kubler-Ross stages can be experienced multiple times, at the same time, and in any order.

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5-Stage Kubler-Ross Model

1. **Denial** is the brain's way of pacing itself and helping you survive the initial loss. Being forced to confront difficult grief-related emotions all at once can be extremely painful and overwhelming. Denial becomes unhealthy when it is unshakeable.
   - **The only way to get beyond grief is to go through it.** Occasional distractions from the process can be beneficial.
2. **Anger** – For some, allowing themselves to truly feel anger is a natural response. It is something to grasp onto as a natural, healing step. The anger may be directed at oneself, others, the deceased or even God. It is a temporary stage that will pass.

Coping with Grief and Loss

3. **Bargaining** – Life isn't always fair, and people don't always get what they want, ask for, or think they deserve…even from God.
   - Death is neither fair nor unfair. It is simply the reality of living in a fallen world.
   - Bargaining with God doesn't usually work, and isn't generally, a good idea. (Zephaniah, 2 Kings 20, Louis Zamparelli -- if God would save him from the sea, he would serve Him.)

Coping with Grief and Loss

4. **Depression** is the result of deep, continuing sadness. It is even more profound if it shakes one's faith.
   - Grief takes time – there are no shortcuts on this dark journey through the "valley of death."
   - Moving forward requires accepting the loss, not only of the loved one, but also of certain roles; it involves redefining ourselves.
   - Comfort comes from those people/traditions/routines that remain stable.

Coping with Grief and Loss

5. **Acceptance** – accepting the inevitable cannot be rushed or forced or short circuited. The person may temporarily lose interest in what is going on around him/her and become less talkative.
   - Memories will not disappear, but the crippling pain will eventually fade. The time frame will be different for each person, but acute grief usually lessens within a few months.
   - **Do not give the person any kind of time limit, even if you are asked. Some will simply give up and wait to die.**
   - The majority will eventually accept their new condition and resolve to live each remaining day as best they can.

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Encountering Death

- Each family member and friend ***will grieve in a different way*** based on the ***closeness*** and ***nature*** of their particular relationship with the deceased
- Each feeling is equally real and will require individual assistance.
- Those who refuse to grieve openly and emotionally may soon start exhibiting ***physical ailments*** as their body responds to suppressed grief.

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Deaths You May Encounter

- **Death of a parent** – Level of grief depends on age of parent and age of child as well as the closeness of the relationship.
- **Death of a sibling** – ***Sibling bonds are the longest human relationships***. Losing a sibling may be more painful than losing a parent, child, or spouse.
  - ***Sibling deaths tend to be minimized by others as not as significant***. Sibling deaths, if experienced as a child, may affect the surviving sibling's future.
- **Death of a friend** – Friends of the deceased may be dismissed by family members and minimized by other friends and family. However, friends may be strongly impacted and should be given the freedom to grieve.

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Deaths You May Encounter

- **Death of a pet** – Missing, lost, stolen, lost in a custody battle, or dead. This loss can be as painful as the loss of a close relative! Choosing to euthanize a pet can be extremely difficult and traumatic.
- **Death of a spouse** – an endless goodbye
- **Death of a child** – ***19% of parents will experience the death of one of their children,*** most commonly through accidents and miscarriages.
  - The grief will be more disabling and last longer than any other form of grief. It is the **"ultimate bereavement."**

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Deaths You May Encounter

- **Parents of "special needs" children** *may need to grieve the loss of the "normal" child they were expecting to love and raise before they can truly accept their new baby.*
- **Shadow grief –** an emotional dullness experienced across all normal activity that includes a feeling of sadness and mild anxiety.
  - Grief over items not living – Job, House, etc - Expecting one's own death

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Coping with Grief and Loss

- **Grief** is a reaction to a change or loss that is significant to the individual.
  - A strong, uncontrollable emotion that includes feelings of hopelessness and passivity. It is a necessary part of the recovery process.
- **Feelings usually include sadness, anger, guilt, anxiety, loneliness, fatigue, shock, yearning, emancipation, relief, and numbness.**
- **Physical sensations** include weakness, breathlessness, dry mouth, decreased energy, tightness, oversensitivity to noise.
- **Cognition difficulties** include confusion, disbelief, hallucinations, a sense of the deceased person's presence.

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Coping with Grief and Loss

- **Behavior** can include sleep/appetite disturbances, absent mindedness, social withdrawal, dreams of the deceased, sighing, crying, restless over activity, focusing on remembering, talking constantly about the deceased.
- *During the **grieving period**, there is an increased susceptibility to illness, problems with memory and concentration, despair, depression, and loss of pleasure.*

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Coping with Grief and Loss

Grief/mourning is a necessary process that leads us back to a normal, balanced state.

It involves:

- Accepting the reality of the loss
- Working with the pain of the grief
- Adjusting to the environment without the deceased
- Emotionally relocating the deceased and moving forward with life

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Coping with Grief and Loss

Each person's journey is unique and messy.

- Experiencing grief is not a nice, neat package that works neatly through the **5-stage Kubler-Ross model,** although the process can be described with this model.
- Those who grieve may experience many or only one of these stages in no particular order – a roller coaster of emotions is more typical.

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How Long Do the Grieving Need Assistance?

- Prayer support and direct contact for **2-3 weeks.**
- Show concern in tangible ways for **2-3 months.**
- Regular attention and acknowledgement for **up to 2 years.**

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Death of a Spouse

- **Approximately 800,000 spouses die each year.**
  - 600,000 are men **(75%)**
  - 200,000 are women **(25%)**
  - **7%** of U.S. population is widowed.
- Death of a spouse changes the **identity** of the widow/widower.
- Sense of self and security are disrupted.

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Death of a Spouse

People may think these kinds of thoughts:

- "I have lost my best friend."
- "I am angry." OR "I feel relieved."
- "I feel guilty for what I did/didn't do."
- "I think about my own death more often."
- "I feel old now." - "I feel sick all the time." "I am afraid."
- "I worry about money."
- "I don't know who I am anymore."

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Death of a Spouse

- There may be unpleasant memories and consequences to deal with.
- There may be hallucinations for up to **18 months.**
  - Person may not share because doesn't want to appear "crazy."
- What to do with the deceased person's belongings?

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Surviving and Rebuilding Requires Steps

- ***Bridge the past*** – Loosen ties to the deceased and accept his/her death. Shared experiences must become memories.
- ***Live in the present***
  - Role changes for parents with young children – Work at being a better parent rather than trying to be both parents.
  - Housing arrangements – Avoid making significant financial changes: selling the house, moving, remarrying, etc. for at least a year.
  - **Good decisions are often not made during times of intense emotion!**
- ***Find a new path*** – Operating independently and looking to the future.

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Responding to a Grieving Person

- **Begin where the grieving person is** – not where you think he/she should be. No judgment on your part.
- Practice **active listening**, even if the person is repetitive,
- *Saying "I'm sorry" or "I can't imagine how painful this must be for you" is honest. Saying, "I know how you feel" is probably not.*
- An appropriate **hug or touch or hand holding** (all physical touch requires permission) communicates caring, but only if the person is comfortable being touched.

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Responding to a Grieving Person

Be sensitive to his/her feelings:

- Don't offer faulty assurances such as "You'll feel better in a couple of days."
- Be extremely careful about offering advice, quoting Scriptures or "admonishing" the grieving person.
- *Being quietly present is usually better than talking too much, which can seem like noise and be very bothersome to any person experiencing deep emotions.*

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Responding to a Grieving Person

- Empathize
- Reassure that whatever feelings are being experienced are normal:
  - crying is normal, not crying is also normal; expressing anger is normal; feeling empty and numb is also normal; brain fog, not being able to make decisions, being forgetful are all normal, feeling scared or hopeless is also normal…

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Legal Issues For COH

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Ethical/Legal Issues Affecting MHER

- Ethical Issues / Ethical conduct grows out of:
  - Character
  - Values
  - Professional training

As Chaplains of Hope we should strive to meet or exceed both the professional standards and those of the community we serve.

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Ethical/Legal Issues Affecting MHER

Our ethical principles will be based on our moral principles.

- **Autonomy** – clients are allowed to make their own decisions.
- **Non-maleficence** – do no harm
- **Beneficence** – move others toward the goal of good
- **Justice** – treat all equally
- **Fidelity** – Demonstrate trust and faith; keep commitments
- **Veracity** – Demonstrate truthfulness

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Ethical/Legal Issues Affecting MHER

- Highest ethical standards are critical especially because of the vulnerability of the client in crisis.
- As people-helpers, we must be self-aware.
- Confidentiality -
  - Personal information is not to be shared without written permission. Privileged information offers some legal protection for client in working with certain professionals.
- HIPPA laws are very protective.

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Ethical/Legal Issues Affecting MHER

- **Documentation** –
  - Accurate and detailed record keeping protects both the helper and the client. The goal is to show your decision-making and choices in a way that another professional can follow.
- Increase the amount of details in high-risk situations (ex. suicidal) during crisis.
- Keep notes on collateral resources (family, friends, relevant professionals).
- Note refusals to treatment, hospitalization, etc.

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Ethical/Legal Issues Affecting MHER

- **Duty to Report –**
  - While volunteer chaplaincy is currently a grey area in terms of mandated reporting, teachers, members of the clergy, social workers, medical professionals, and career chaplains are just a few of the professionals who are mandated reporters. You must have a reasonable belief that abuse has happened, but you do not necessarily have to have absolute proof.
- **Duty to Report –**
  - If wearing chaplaincy clothing, you will be regarded as a professional by both clients and other first responders, especially if you behave in a professional manner. Consequently, you may also be considered responsible and held legally accountable in this area.

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Ethical/Legal Issues Affecting MHER

- If you **observe** or **suspect** that a member of a vulnerable population (children, mentally or physically disabled adults, or the elderly) are being abused or suffering from severe neglect, take notes and immediately report the incident(s) to your pastor who may know more about the situation/people involved than you do and will therefore be able to make the best decision for the good of the client.
- In any case, you will have reported the situation, and it will now become the responsibility of your pastor.

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Ethical/Legal Issues Affecting MHER

- Mandated reporting is a serious responsibility with jail time and fines for those who ignore it. (a $500 fine and/or 6 months in jail is possible for this misdemeanor.)
- Reporting can also be done anonymously to law enforcement or APS / CPS if the abuser of a child is a parent or guardian or someone else responsible for the child's welfare.

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Resources: *Lab For Level Two*

Developing my personal Resource Guide:

- ✓ What is it?
- ✓ Why do I need It?
- ✓ What should be in it?
- ✓ A personal, tested, directory of local resources.
- ✓ Possible local resources of need already in my community – "211 Texas" OR Equivalent

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Resources In Your Area

- Start by establishing **resources in your area**.
- **Don't** try to start a **duplicate program** in your community if someone is already actively working with God on the issue. Especially if they are being successful
- **Helping oth**ers that are working on the need you have selected, moves the effort forward faster than starting from scratch.
- **Build a team** around your resources – Find people in the ministries or businesses that you can speak with personally when an SUD issue arises.
- Having more people on your "Team" will help you be more productive in finding hope for those in crisis. Helps **avoid burnout**.

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Appendix

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LEAP Model for Helping Someone with Mental Illness - Accept Treatment

- ***Goal #1*** – To repair damage already done to relationships by "doctor knows best approach."
- ***Goal #2*** – Help your loved one find their own reasons for accepting treatment.
- **"L" - Listen** – Reflective Listening.
  - The goal is to understand the other persons point of view and reflect your understanding back to them. Do not comment on what is said, point out mistakes or ways in which he is wrong, judge or react in any way.
  - Really listen to understand, then reflect back in your own words what you think you heard. Do it without commenting, disagreeing, or arguing. You need to understand the person's perception of his illness, taking psychiatric drugs and hopes/expectations for the future, (even if unrealistic).
  - Build relationship and trust.

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LEAP Model for Helping Someone with Mental Illness - Accept Treatment

- **"E" – Empathize –**If you want someone to seriously consider your point of view, he must first be certain he feels you have considered his point of view.
- Not the same as agreeing. Especially empathize with any feelings connected to delusions.
- "I don't see that snake slithering across the floor and swearing at you, but I believe you do. That must be really scary!"

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LEAP Model for Helping Someone with Mental Illness - Accept Treatment

- **"A"** - **Agree –**Find common ground and nail it down. Perhaps you have common ground in motivation to change.
- There is always common ground somewhere. Look for places where you can make observations together – identifying facts upon which you can ultimately agree.
- Ask lots of questions, particularly about what happened to gather information and find common ground.
- Try to uncover the person's motivations (through understanding their short-term and long-term goals) to accept treatment (ie. sleep better, get a job, etc.) Do not mention "mental illness" at any time.

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LEAP Model for Helping Someone with Mental Illness - Accept Treatment

- **"P" – Partner –**Make an explicit decision to work together to achieve shared goals: teammates striving for the same goals.
- You may be thinking "recovering from illness" while loved one is thinking "get a job" but the names are irrelevant to arriving at a shared plan that will include accepting treatment and services.

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Cognitive Behavioral Therapy (ABC Model)

"Could be described as, "As I Think, So I Feel, And I Do!"

- **Activating Event** – the actual event and the client's immediate interpretations of the event
- **Beliefs about the Event** - this evaluation can be rational or irrational
- **Consequences** - how you feel and what you do or other thoughts

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A – Activating Event
- Actual Event
- Client's immediate interpretations of event

B – Beliefs
- Evaluations
- Rational
- Irrational

C – Consequences
- Emotions
- Behaviors
- Other Thoughts

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From counselingresources.com

✓ How one interprets an event affects how one feels, thinks and behaves.

Negative Event (A)
↓
Rational Belief (B)
↓
Healthy Negative Emotion (C)

Negative Event (A)
↓
Irrational Belief (B)
↓
Un-healthy Negative Emotion (C)

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A-B-C Methodology

(Dr. Howard Stone)

+ **A**chieve contact with the client
+ **B**oil down the problem to its essentials
+ **C**ope actively through an inventory of the client's ingenuity and resources
+ **D**evelop a plan of action

(Dr. Howard Clinebell adds "D")

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Pity:
I acknowledge your suffering.
Sympathy:
I care about your suffering.
Empathy:
I feel your suffering.
Compassion:
I want to relieve your suffering.
Engagement

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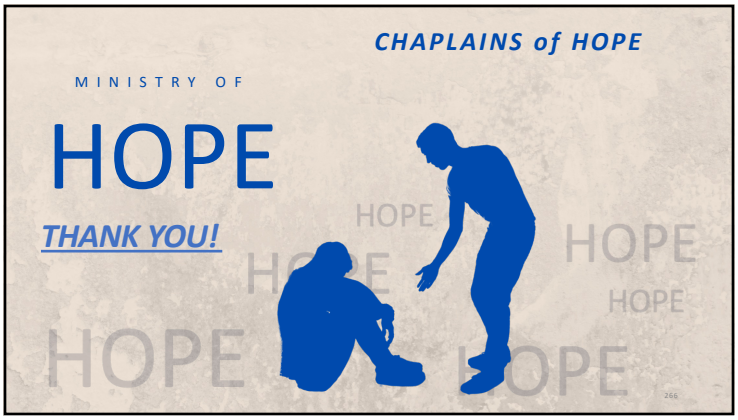
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