CLINICAL DISORDERS

Lifeline New Volunteer Training

DR. GEORGE HU, CLINICAL PSYCHOLOGIST

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About the Author

Dr. George Hu, PsyD is a licensed clinical psychologist from the United States. He is currently the Section Chief of Mental Health for Shanghai United Family Pudong Hospital. Previously, he was Director of Mental Health for Jiahui Health, Clinical Director at Octave Living, and Clinical Psychologist at Director of the Center for Cognitive Behavioral Therapy at Beijing United Family Hospital. Previous to China, Dr. Hu worked at such institutions in the United States as the San Francisco Veterans Affairs Medical Center (Posttraumatic Stress Disorders Clinical Team, and Integrated Care Clinic), Oakland Children's Hospital (Autism Intervention), and the Portia Bell Hume Behavioral Health and Training Center (Community Mental Health). Dr. Hu earned his Bachelor's degree in Clinical Psychology from the University of California at Berkeley, and this Master's and Doctoral degrees in Clinical Psychology from the California School of Professional Psychology at Alliant University. He is currently the Vice President of the Shanghai International Mental Health Association (SIMHA), and is a board member of many community and international organizations, including REACH Shanghai, Safe Haven Shanghai, and the International Council of Psychologists.

Introduction

The work of a hotline volunteer is a very particular one. In many ways, hotline volunteers need to act as a counsellor, confidante, friend, advocate, among other roles. The goal of this material is to present information regarding some common clinical disorders and symptoms that may present in a hotline context in order to equip you as a hotline volunteer to fulfil your role. This material will attempt to respect the fact that you do not operate as a treatment provider, but fulfil an important role to triage, identify appropriate resources, and even stabilize callers before they can access the next step. Generally, each section will contain the following portions:

a) A description of common symptoms and ways the disorder/symptoms may present themselves in callers
b) How a hotline volunteer can intervene to assist a caller presenting with that symptom/issue
c) What community resources may be appropriate for a caller with that symptom/issue

IMPORTANT NOTE: As a helpline volunteer, you would never label someone's concerns when they call. You are not a medical or mental health professional when you on the helpline. Instead, you follow their lead. For example, you would not use the words depression, anxiety etc. unless the caller said them already, and in this case, ask what this means to them and about their experiences.

General Guidance: Callers with Mental Health Concerns

A) Empathy

It is important to provide empathy by using empathic statements and active listening, as this allows the caller to feel understood and connected. Empathy can have the effect of "normalizing" emotions for the caller, as well as assisting them in managing distress and reducing the sense of felt isolation.

B) Caller's Emotional Expression

Allow the caller the time to express their emotions and their subjective experience. Indicate your empathy through the use of empathic statements and vocalizations, and encourage the caller to express further through the use of open questions like, "Can you tell me more about that?" or "Can you help me understand how that affected you?". The appropriate expression of emotion can assist the caller in reducing distress.

C) Uncover Healthy Coping Mechanisms and Supports

Our callers are the experts on their lives and, by asking these questions, we can uncover the many resources they have at their disposal. Ask the caller, what has helped before to ease their distress? What can the caller do right now to help themselves feel better? Who can help the caller? How can they get in touch with them?

It is also important to identify social resources, family and friends that can help reduce any feelings of isolation. You can ask questions like, "Who else knows?" and, "What does/would having the support of others mean to you?"

D) Identify Positive Aspects of the Caller's Life

Often, the 'problem' story, that is the one related to mental health concerns, seems to dominate the lives of those who call helplines, and tends to dominate our conversations with them as well. While it's important to discuss the biggest concerns people are facing, it is also important to help the caller identify positive aspects of their life so that they can begin to see a way through their difficulties. You can ask the caller, "What is going 'right'?" and, "What part(s) of their life are not 'bad'?".

E) Assess for Suicide and Self-Harm

It is critical to assess whether individuals with mental health concerns are considering/engaging in suicide or self-harm. This is covered in-depth during new volunteer training, and ongoing through your training at Lifeline.

F) Refer for Help

If you suspect that a caller is suffering from symptoms of a mental health concern, ask them if they have considered speaking to a medical profession. Make appropriate referrals using Salesforce. If there are no referrals for the caller's region or location, guide them to consider how they may find this themselves through searching online or through local networks.

Treatment Providers

There are many different types of mental health treatment providers in the community, including in China. Many different countries also use different terms to refer to the same profession. It can be confusing for individuals to decide which type of provider is appropriate for them. *While our job as a hotline counsellor is not necessarily to make this determination for the caller*, it can be helpful for us to have a basic understanding of the types of providers available.

Please note: We only make referrals to mental health and medical professionals who have had their credentials vetted by third parties Lifeline trusts. Only refer to those referrals listed in Salesforce. If you find there is no referral listed for the region in which a caller resides, remember to *them* to find support and remind them to check the credentials of the individual they contact.

1. (Psychological/Mental Health) Counsellors

These providers are individuals who have receive professional training in mental health counselling. Many jurisdictions have boards that govern the education, training, and licensing of these providers, and many require these providers to possess at least a Master's degree in a related field, along with a certain amount of supervised training hours. The Licensed Professional Counselor (LPC) in the United States is one such example of this.

2. Psychotherapists

These providers are individuals that need to be specifically trained in psychotherapy. Psychotherapy is a term used to refer to the variety of non-pharmacological techniques used to address psychological or mental health disorders, and is sometimes also referred to as "talk therapy" or "therapy". Many jurisdictions have boards that govern the education, training, and licensing of these providers, and many require these providers to possess at least a Master's degree in a related field, along with a certain amount of supervised training hours. The Marriage and Family Therapist (MFT) or Licensed Clinical Social Worker (LCSW) in the United States are examples of this.

3. (Clinical) Psychologists

These providers are individuals that are specifically trained in clinical diagnosis, psychotherapy, and usually psychological assessment. Many jurisdictions have boards that govern the education, training, and licensing of these providers, and most require these providers to possess at least a Master's degree in a related field, along with a certain amount of supervised training hours. Some jurisdictions may also grant psychologists medicine prescribing privileges, such as certain states in the US. Many

psychologists may also refer to themselves as “psychotherapists” or “therapists” because they primarily utilize psychotherapy in their practice. In the United States, those referring to themselves as Psychologists must possess a doctoral degree (PhD, PsyD, EdD, DSW, etc.) in a related field, along with up to 3000 hours of supervised training. The Licensed Clinical Psychologist in the United States is one such example of this. Often those who list themselves as a Clinical Psychologist are registered with their home country, and encouraging callers to check this registration may be helpful if they are uncertain.

4. Psychiatrists

These providers are individuals that usually have a medical degree (such as an MD). Psychiatry is a medical specialty (such as paediatrics, oncology, gynaecology, etc.). Most jurisdictions have boards that govern the education, training, and licensing of medical professionals such as psychiatrists. Though some psychiatrists may have also undergone training in certain types of psychotherapy, many psychiatrists in the hospital setting utilize pharmacology (medicines) as their primary treatment method. Some psychiatrists have chosen to receive training in further specialization, such as child and adolescent psychiatry.

5. Coaches

These individuals may have wide variation in their training and certification. Coaches may operate in many contexts, such as executive coaches, life coaches, etc. Coaches assist their clients in managing through life transitions, preparing for the future, optimizing performance, etc., and are generally not considered clinical mental health professionals. However, they can assist with the concerns noted above and can often be effective for shorter term or mild concerns.

6. Chinese professional counsellors (心理咨询师)

These individuals function similar to counsellors (see above), but may have been certified by the China Department of Labor (劳动部) as a professional counsellor. This certification system required individuals to pass a certification examination, but did not require individuals to hold any particular degree or type of degree, nor did it require individuals to accrue supervised training hours. However, this certification system was discontinued in 2016, as the China Department of Labor and the China Department of Health (卫生部, which governs medical practitioners) work toward a standard process that governs education, training, and licensing of mental health professionals.

7. Treatment providers in public Chinese hospitals

Public hospitals in China may differ in their approach to mental health treatment than many Western jurisdictions. Public hospitals in China usually have a psychiatric

department (精神科), though some also have a psychological department (心理科). Generally, these two departments differ in the types of disorders they treat, and also by the types of providers present. In the Chinese system, there exists a distinction between “psychological disorders (心理疾病)” and “psychiatric disorders (精神疾病)”, though the difference between the two is not well-defined. Generally, depression, anxiety, trauma, adjustment, and others are considered “psychological disorders”, while bipolar disorders, psychotic disorders, and others are considered “psychiatric disorders”. For example, a typical psychiatric department (精神科) will have physicians treating more severe mental health disorders, while a typical psychological department (心理科) may have both psychotherapists and physicians using both psychotherapy and medications to treat disorders.

MENTAL HEALTH CONCERNS: Depression

A) Description

As with many of the issues we will discuss in this document, depression exists on a spectrum. Mental health experts, physicians, philosophers, artists, and others have tried for a long time to describe the experience of depression, but there are two common threads throughout most descriptions: hopelessness and "darkness".

Depression is what is called a "mood disorder". This means that the primary way that depression presents itself is with negative mood. **Negative mood** can present as sadness, anger, worry, fear, even boredom. It's important to realize that negative mood does not necessarily mean overly sad. Typically, though related, depression is separated from a grief/loss response. If a caller is experiencing symptoms as a result of grief or loss (e.g. death of a loved one, separation from home, loss of a relationship, etc.), it is considered an adjustment reaction and not depression per se (see below). It's also important to note that mood states can vary in length, meaning they can short (as in a few hours) or long (as in days to weeks). Additionally, mood states generally affect the caller's functioning in some significant way, such as their ability to work, attend school, do homework, function at their typical academic or performance level, affect quality of social relationships, etc.

Depression can also present itself in a variety of different ways. One common way is "**anhedonia**". Simply, this means that the caller does not presently derive as much pleasure from previously enjoyable/pleasurable activities. For example, the caller may have previously enjoyed her weekly racquetball games with her friends at the gym. However, in recent weeks she finds that these times are no longer as enjoyable, and she looks upon them as burdens rather than as times that are fun and pleasurable. Depression can also be linked to **changes in sleep and appetite patterns**. In general, healthy adults can vary in terms of how much sleep or food they need to maintain healthy and productive functioning. However, depression can be linked to changes in sleep or appetite that cannot be explained by another reason. For example, changes in diet can be the result of a person trying to fit into a particular weight class for an athletic competition, and this would not generally in itself be considered a clinical symptom. However, changes in sleep and appetite patterns can potentially start out in an appropriate manner (such as not sleeping enough in preparation for the SAT), but can lead to clinically significant symptoms as the person is sleep-deprived over time.

Commonly, those experiencing depressive symptoms will also experience a lack of or **decrease in socialization**. This can sometimes be difficult to assess, especially if someone was relatively socially isolated to begin with. It's also important to note that socialization may look different for different people. Socialization methods can include (but are not limited to) face-to-face meetings, meals together, shared activities (such as

team sports, hiking groups, knitting groups, etc.), online socialization (such as online support groups, online gaming communities, etc.).

Those suffering from depression can also experience a variety of **physical symptoms**, including (but not limited to) gastrointestinal problems, stomach pain, constipation/diarrhoea, joint/muscle pain, headaches, fatigue, changes in appetite, sleepiness, and difficulty sustaining attention.

It is also important to note that depressed mood can present itself as **irritability**, changes in temper (such as losing temper/becoming angry more easily), and even violence. It is especially important to be aware of this when speaking with male callers, as these issues can be easily neglected in men due to a social conception that men lose their tempers more "naturally".

Self-harm (also called "**self-injurious behaviour**") is sometimes associated with depression. However, it is important to note that the two do not always need to go together. Obviously, it is very possible to suffer from depressive symptoms and not be engaged in self-harm. It is also very possible to be harming oneself, but not meet criteria for depression. Generally, self-harm is found more commonly in adolescents, though can also present in adults or younger children. Self-harm can include behaviours such as:

- Cutting oneself
- Scratching oneself (with finger or object)
- Burning oneself (e.g. with cigarette butt or lighter)
- Injuring oneself (e.g. by hitting or punching something such as a wall)
- And more…

Self-harm (or "self-injurious behaviour", also referred to as "SIB") is a complicated phenomenon that can occur and be sustained in an individual for many reasons. Many individuals who experience self-harm report that they are undergoing intense emotional pain that finds expression and release in self-harm.

Additionally, if you suspect that a caller may be suffering from depressive symptoms and/or self-harm, you should refer to caller to a medical professional.

B) Guidance for Your Calls

In addition to the wealth of general questions you can ask someone, and those on page 4, here are some specific questions that can help you better understand how someone with low mood or depression is functioning:

1. Sleep

It is important in our context to ask about how much sleep the caller is getting, or about any recent changes in appetite/eating patterns. Asking about these issues can assist

the caller in becoming more cognizant and aware of their relationship to their mood, and help the caller identify concrete steps to improve their sleep or eat in a healthy manner.

2. Socialisation

In the case of expatriate callers, or callers who have recently moved or had a significant change in situation (changing employers, moving to a different city for school, etc.), it may be important to ask about their level of socialization before they moved or changed situations.

3. Self-Harm

If you encounter a caller that experiences self-harm, you may want to try the following:

a) Provide empathy and understanding through empathic, reflective statements and active listening
b) Assist the caller in expressing their emotions verbally
c) Assist the caller in expressing their emotional reactions, difficulties, and emotional pain (also called “psychache”) regarding any aspect of their lives, even if the caller feels it’s not necessarily related to the self-harm
d) Refer to a medical professional

4. Suicide

When depressive symptoms are noticed, it is important to assess for self-harm and suicidal ideation (separate training provided). Where this is confirmed by the caller, you should also refer the caller to a medical professional.

5. Social Supports

People who are experiencing depression need the support of others, whether they are friends, family, co-workers, and/or mental health professionals. Ask them about who else knows they are having a difficult time, or guide them to consider how this may be useful to support them.

C) Resources / Referrals

Please see Salesforce for most up-to-date referrals for mental health professionals. It is ideal to provide 2-3 referrals where available. If there are no referrals for the caller’s region or location, guide them to consider how they may find this.

MENTAL HEALTH CONCERNS: Anxiety

A) Description

Anxiety is a cluster of symptoms that are often closely related with depression. These can include symptoms of panic, generalized anxiety, and phobias. In some mental health classification systems, obsessive-compulsive symptoms/disorders and even trauma disorders are also considered as part of the anxiety spectrum.

Frequently (though not exclusively), anxiety symptoms present as **excessive worry**. This can be worry about several different aspects of a person's life throughout the day, or can be worry during circumscribed periods of time (such as before important meetings). Anxiety symptoms can also present frequently as a variety of **physical symptoms**, such as headaches, muscle aches, rapid heartbeat, shortness of breath, itchiness, sweatiness, changes in sleep and/or appetite patterns, tremors, nausea, diarrhoea, etc. It is important to note that oftentimes, callers may endorse or describe physical symptoms without applying an emotional label (e.g. describing how uncomfortable an incident was or how difficult it was for them to breathe before calling it "worry" or "anxiety). This may be due to a variety of reasons, including that the caller may not realize that what they were experiencing is in fact anxiety, or because they do not have the emotional vocabulary at their disposal.

Generally, anxiety can be separated into two broad types. **Baseline anxiety** is the level of anxiety that is felt throughout the day, while **situational anxiety** is the level of anxiety felt in response to a particular stimulus/stressor. The two are not necessarily mutually exclusive, and either or both can rise to such an extent as to be bothersome, clinically significant, and affect the caller's functioning.

Panic is a sense of felt anxiety that usually occurs as a type of situational anxiety, and can feel sudden and profoundly uncomfortable. Callers experiencing panic may describe increased heart rate, shallow breathing, sense of fear, tingling or numbness in joints or limbs, narrowing vision, weakness in limbs and muscles, difficulty talking, difficulty standing or sitting, choking sensations, or even loss of consciousness or memory.

Generalized anxiety is a type of baseline anxiety or mixture of baseline and situational anxiety regarding a variety of domains of the caller's life. A caller with generalized anxiety may describe anxiety regarding such things are their marriage/relationship, children, job status, social status, etc. Often, the caller may endorse a certain degree of debilitating anxiety toward many different aspects of his/her life.

A **specific phobia** is a persistent and excessive fear of an object or situation. This can lead to strong avoidance of the feared object/situation, or profound distress when it cannot be avoided. There are also some phobias which are not as specific, such as

social anxiety disorder, which is an intense fear of being scrutinized by others. Individuals with this disorder may avoid things like speaking out in front of others, going to social events, or will be tremendously uncomfortable when doing so.

In some mental health classification systems, obsessive-compulsive disorders are also categorized as anxiety. Certain classification systems (most notably the DSM-5 system used in the US) have moved **obsessive-compulsive disorder (OCD)** to its own category, due to the particularities of this disorder. OCD typically contains **obsessions**, which are repeated thoughts, urges, or mental images that cause anxiety for the caller. Some examples of obsessions are: fear of germs, aggressive thoughts toward self or others, fear of things being out of place/order. **Compulsions** are repetitive behaviours that the caller may feel compelled to do as a response to an obsessive thought, such as excessive cleaning/handwashing, or order/arranging things in a particular way.

Anxiety disorders often coexist in a person alongside depressive symptoms. This phenomenon is called "**comorbidity**". This means that it is very common for people who suffer from depression to also suffer from anxiety, and vice versa. In fact, many depressive symptoms can first appear as anxiety in a caller.

B) Guidance for Your Calls

In addition to the wealth of general questions you can ask someone, and those on page 3, here are some specific questions that can help you better understand how someone experiencing worry or anxiety is functioning:

1. Physical Symptoms

As callers will not always associate their physical sensations with worry, it can be beneficial to ask the caller if in fact they were feeling "worried" or "stressed" at the time they described having a specific physical sensation (e.g. headache, stomach ache etc.), or to ask the caller how they would describe their emotions in that moment. You can also ask questions about what was happening just before their physical sensations, to help the caller identify better what may be related to their worry. These questions can help them to better understand the impact of worry or anxiety on their functioning.

2. Understand the Caller's Anxiety

As there are many types of anxiety disorders, and therefore many different ways it might affect a caller's life, it is helpful to ask the caller to describe what their experience of worry or anxiety is like. For some people, there can even be some aspects of their anxiety that they appreciate (e.g. pushes them to achieve more or work harder). Ask them questions like, "How does *your* experience of worry/anxiety affect your life?", "Is it helpful, unhelpful, or a bit of both?", and, "In what ways do you find worry or anxiety getting in the way of things?"

C) Resource / Referrals

Please see Salesforce for most up-to-date referrals for mental health professionals. It is ideal to provide 2-3 referrals where available. If there are no referrals for the caller's region or location, guide them to consider how they may find this.

MENTAL HEALTH CONCERNS: Trauma

A) Description

IMPORTANT NOTE: NEVER ask a caller to recount a traumatic experience or to elaborate. Always follow their lead. If a caller volunteers details about a traumatic event, utilise empathic listening and provide space for the caller, but do not ask for details. Instead, allow the caller to express freely to the extent that they are comfortable.

Traumatic disorders exist along a spectrum, defined by different factors including time since traumatic event(s), severity, chronicity, and impact on life functioning. However, all traumatic disorders involve a debilitating reaction to an event or events. The table below arranges the types of traumatic incidents into grid form.

Table 1: Types of traumatic incidents

	Personal	**Impersonal**
Single Incident	Single Incident, Personal (e.g. one-time rape)	Single Incident, Impersonal (e.g. earthquake, plane crash)
Multiple Incident	Multiple Incident, Personal (e.g. chronic child abuse)	Multiple Incident, Impersonal

Some common traumatic disorders include the following:

a) *Acute stress reaction*: This diagnosis is used to describe symptoms that arise within 30 days of a traumatic event. Generally, if the symptoms last more than 30 days, a diagnosis of Posttraumatic stress disorder (PTSD) is considered.
b) *Posttraumatic Stress Disorder (PTSD):* This diagnostic label is used to describe a variety symptoms that result from direct or indirect exposure to a traumatic event(s).
c) *Adjustment Disorders*: This diagnosis is typically applied when symptoms do not meet criteria for PTSD, and is generally limited to 6 months in duration. Adjustment disorders will be further discussed in a separate section below.

The traumatic disorders are typified by the below symptom clusters, and these are things you should be listening out for / may hear a caller talking about on the helpline:

A) Exposure to a **stressor**(s). This can be a variety of things, such as death, the threat of death, actual or threatened serious injury, actual or threatened sexual violence, etc. Additionally, stressors may also include witnessing a trauma occur to someone else, learning that a relative or close friend was exposed to trauma, or indirect exposure to details of trauma in the course of professional duties (e.g. first responders, medics, etc.). As indicated above, exposure to stressor(s) can either be

direct or **indirect**.

B) **Intrusion** symptoms. These can include, **nightmares**, **flashbacks,** intrusive thoughts, emotional distress, and **physical symptoms** (e.g. trembling, shaking, feeling "paralysed", etc.) that result from a **re-experiencing** of the traumatic event(s).
C) **Avoidance** symptoms. Including avoiding thoughts, places, people, situations, or any other physical or non-physical reminder of the traumatic event(s).
D) **Negative changes** in thoughts and mood. These should either have begun or worsened after the traumatic event(s), and can include inability to remember key parts of the trauma, overly negative thoughts/beliefs about oneself or the world, exaggerated blame of self or others for the trauma, anhedonia (decreased interest in activities), feelings of isolation, difficulty feeling happy, etc.
E) **Hyperarousal/hyper-reactivity**. This can include irritability, aggression, risky or destructive behaviour (towards self or others), hypervigilance (overly sensitive to perceived risk/ "paranoid"), exaggerated startle reaction (overly sensitive and exaggerated reaction to noises or sounds), difficulty concentrating, and sleep disturbance.

It is also useful to note that recent research has identified a phenomenon termed *"complex trauma",* which refers to the types of symptoms that present when a person is repeatedly exposed over a long period of time to severe interpersonal trauma, usually beginning in childhood. For example, this term can be used to refer to the symptoms arising in child victims of sex trafficking, or children who have been repeatedly or chronically sexually abused. The symptoms of complex trauma are usually more severe and profound, and may affect the victim's core personality structure given that the traumatic events usually begin in childhood.

Community trauma is a term that refers to the phenomenon when entire communities or groups of people are exposed to collective trauma, whether at the same time or separately. For example, victims of the Khmer Rouge violence in Cambodia may experience traumatic symptoms individually, but also the Cambodian community as a whole may experience reactions to the violence.

B) Guidance for Your Calls

1. Combatting 'False Truths'

In many ways, the "power" of traumatic symptoms is that it sells the victims certain "lies", or false truths. These include:

a) The trauma defines you.
b) The trauma will happen again, and danger lurks around every corner.
c) You are the only person this happened to.
d) Your life as you know it is now over, and will get worse and worse.

Therefore, the way you talk to the caller is really important so that you do not lend support to any of these false truths. You can do this by:

a) Providing empathy and "normalising" the caller's experience
b) Actively listening with verbal responses to indicate listening
c) Asking about hope for the future
d) Asking about / encouraging connection with others
e) Encouraging professional support

2. Managing Distress

The biggest part of your role as a helpline volunteer is to sit alongside someone else's distress. It is important to be mindful of a caller's emotional reaction as they are sharing stories, and to check in with them about how they are feeling. Set up safety by reminding them they do not have to recount their story or details unless they choose to, and make sure you leave time at the end to discuss things unrelated to their traumatic experiences and how these are impacting them.

If you find that a caller is becoming distressed while sharing their story, ask if they are comfortable to continue and let them know they don't have to. You can also ask them to pause to take some deep breaths or to get a drink of water.

3) Identifying Impact of Trauma

It is not your job to label symptoms as they are described by a caller. However, you can help a caller reflect on the impact of the trauma on their lives. You can do this by asking more questions about what their experience has made more or less possible, what they hope for the future and if it interferes with this, and how they are dealing with the ongoing effect of the trauma in their life.

C) Resources / Referrals

For individuals who have experienced a traumatic event, they are likely to need professional support to help manage their experience. Ask them if they have considered support and what kind of support may work best for them. Encourage them to ask mental health professionals about their experience working with survivors of traumatic experiences, so that they can get the most appropriate care they need.

MENTAL HEALTH CONCERNS: Adjustment Disorders

A) Description

Adjustment disorders are a class of disorders along the trauma spectrum, but for the purposes of this document will be separated into its own section. In sum, adjustment disorders describe a **difficulty adjusting to a situation**, change in circumstance, or event that has caused a **decline in functioning** and usually a change in mood. Adjustment disorders are usually time-limited to 6 months from the event or change in circumstance, and has four types:

a) With depressed mood
b) With anxiety
c) With mixed anxiety and depressed mood
d) Unspecified

Adjustment disorders are not uncommon in individuals undergoing significant change or disruptions in their lives, including:

- Being diagnosed with an illness
- Moving to a different country/city
- Changing schools or jobs
- Death or major illness in the family
- Divorce, breakup, or other significant change in social or family relationships
- And more…

Adjustment disorders can present similarly to depressive symptoms and anxiety symptoms, but are classified as adjustment disorders due to the presence of an **identifiable event or circumstance** that the individual is having difficulty adjusting to, or at times due to a difference in degree of severity.

Typically, an individual experiencing an adjustment reaction may report that they have usually adjusted to changes in circumstance without a problem, but for some reason are having difficulty with the present change in life circumstances. For example, a foreign expatriate employee may have previously adjusted to foreign placements without significant problems, but is now experiencing difficulty having moved to China 2 months ago, to the degree that they have been having difficulty sleeping and are experiencing social isolation and depressed mood.

B) Guidance for Your Calls

In addition to the general guidance, here are some specific things to be mindful of when speaking to a caller having difficulty with adjustment:

1. Normalise the Caller's Experience

As is common, one of the most effective interventions in the hotline context can by the provision of empathy, and a "normalisation" of the caller's experience. It can be helpful to state to the caller how common it is for individuals to have difficulty adjusting to a foreign context, even if they have previously managed successful transitions to foreign countries.

2. Draw Out Their Previous Successful Adjustments

Help the caller to recall previous times they have dealt with change or difficult transitions in their life. Ask them what made them more or less successful, how long it took to adjust, and what helped them at that time. These questions help the caller to understand what resources or strengths they can draw on.

3. Identify Social Supports / Social Interests

It can also be helpful to assist callers experiencing adjustment difficulties to identify a social circle with whom they can share common interests, express their experiences, and experience validation. You can ask what they enjoyed doing in the past or what community groups/events they enjoyed participating in.

Some callers may need some concrete guidance in exploring ideas for social connections, including those available online. Do not recommend using "I think you should" language, instead ask them gently if they have considered sources like:

- WeChat or Facebook groups
- Churches or places of worship (if this is something they express interest in)
- Taking classes or tours (such as Mandarin classes or city tours such as the ones organized by Community Center Shanghai and other organisations where they can connect with others in the same context)
- Fellow parents, such as other parents in their children's school
- Psychotherapy or support groups
- Meetup or Community groups organized around a common interest (e.g. biking, or a book club)

C) Resources / Referrals

For those listed above, there are many resources listed in Salesforce. If you suspect an adjustment disorder in a caller, or the caller describes significant difficulty in functioning, refer them to a qualified medical professional.

MENTAL HEALTH CONCERNS: Eating Disorders

A) Description

Statistically, eating disorders are noticed more commonly in younger females (e.g. adolescents and early 20s). However, recent research has highlighted the fact that these disorders are increasingly being noted in boys and men. Most researchers theorize that this is not necessarily because these disorders are now occurring more commonly in males, but rather that we are paying more attention to how males can suffer from eating disorders, and also how the symptoms of eating disorders can be masked in males.

Generally, eating disorders are typified by a **maladaptive relationship with food or eating patterns**, and can also include **body dysmorphia** (an obsessive idea that some aspect of one's body/appearance is severely flawed and therefore warranted excessive measures to hide or fix that aspect, such as with drastic changes in eating or exercise patterns, purging, etc.).

There are many ways in which one's relationship with food or eating patterns can be maladaptive:

a) **Restricting**: this can occur in a variety of ways, including limit the variety or amount of food that an individual eats, sometimes severely. Restricted eating can sometimes be hard to identify as it can be "masked" by a seemingly appropriate goal, such as to lose unwanted weight, or to fit into a certain weight class for athletics.
b) **Binging**: overeating/gorging on food in a certain episode or period of time. Often, this looks like severe overeating of "junk food", such as eating three cartons of ice cream in one sitting. Binge eating behaviour is often accompanied by feelings of guilt or regret, which can lead to purging (see below. Additionally, binge eating can be preceded by a significant amount of emotional distress, such as depression or anxiety.
c) **Purging**: the activity to compensate for overeating, such as (but not limited to) after a binge eating episode. Purging activities can include inducing vomit, taking laxatives or diuretics to induce diarrhoea, excessive exercise, etc.

Anorexia nervosa (also referred to as "anorexia") is an eating disorder that typically begins as a diet to achieve weight loss. Statistically, most of those diagnosed with anorexia are adolescents, and 9 out of 10 are female. Typically, people with anorexia are significantly below normal weight, but still feel fat and/or heavy. About half of individuals with anorexia also display a binge-purge cycle.

Bulimia nervosa (also referred to as "bulimia") may also be triggered by a weight-loss diet but can be punctuated by binge eating episodes. Most individuals diagnosed with

bulimia are female and in their late teens or early 20s. Bulimia is unlike anorexia in that weight fluctuations occur within normal ranges, making this disorder easier to hide. Those suffering from bulimia can cycle between restricting and binging/purging.

Research has identified links between eating disorders and perfectionistic tendencies, negative self-esteem, negative self-evaluation, and obsessive/compulsive symptoms. There is also high comorbidity (co-occurrence) between eating disorders and depression, anxiety, trauma, self-harm, and suicidal ideation.

Contrary to popular belief, eating disorders are the deadliest class of mental health disorders. Most people who die from a mental health disorder die from an eating disorder (not suicide). Eating disorders are also notoriously resilient and difficult to treat.

B) Guidance for Your Calls

In addition to the general guidance, here are some specific things to be mindful of when speaking to a caller describing difficulties with their eating behaviour:

1. Develop Discrepancy

Ask the caller about what they like and what they like less about their current eating/exercise/body-related behaviours. Asking them what they like less second, helps them to consider what is potentially unhelpful about their current behaviour. You can ask about what their behaviour makes more difficult, and what they hope for the future.

2. Discussing Self-Care - Eating / Drinking / Exercise

Often, callers will be reluctant to commit to an action to eat or drink or to avoid exercise, and this can make it more difficult for you to engage them in self-care behaviours. Ask them about what self-care is for them, what they do to look after themselves, and if/how they show themselves appreciation. You may also gently remind them that one way to do this would be to get a drink of water or have a small snack (granola bar, apple, grapes), but do not push this on the caller.

3. Take a Non-Judgemental Stance

You are not required to agree with a caller's choices, but your role is to provide them with an empathetic and reflective space to share. You do this by not judging their choices, but guiding them to reflect on the impact of their choices on their lives.

C) Resources / Referrals

Given how difficult eating disorders are to treat, and that they rarely involve spontaneous recovery, if you suspect that a caller may have an eating disorder, please

refer them to a qualified medical professional. It is often helpful for individuals with disordered eating to have their treatment managed by a medical doctor *and* a mental health professional, so that their physical safety is being monitored.