Mental Health Concerns on Wilderness Expeditions

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When we venture into wilderness we bring with us our medical and our mental health history. Illness, injury and mental health concerns that can present back in our urban lives may also present in the wilderness. Outdoor leaders and expedition physicians will tell you that they see mental health issues on Denali, at Everest base camp, on treks, outdoor programs and personal trips. No one talks much about this in public, but mental health issues ranging from heightened stress to episodes of anxiety, depression, mania, psychosis, or drug reactions can and do occur on wilderness expeditions. More serious episodes will need to be treated by a skilled mental health professional in a more controlled setting. Anxiety, mild depression, some post traumatic stress responses and mild drug reactions can often be defused without having to end the camping experience.

We don't expect Wilderness First Responders to be mental health professionals, but awareness of some of the more common mental health conditions, application of our patient assessment system and thoughtful, compassionate care can help diffuse these concerns in the field.

STRESS RESPONSES
Stress occurs whenever the mind or body has to adjust to a change in the external or internal world of that individual. Substantial increases in stress typically result in heightened physiological and emotional states. This can exacerbate pre–existing physical conditions (e.g. change in blood pressure, greater risk of a cardiac event), and generate symptoms related to anxiety and depression. Stress can also exacerbate chronic mental conditions such as psychotic disorders.

ANXIETY RESPONSES
Anxiety responses can include an acute anxiety disorder (also known as panic attacks), phobias, obsessive-compulsive thoughts/behaviors and Post Traumatic Stress Disorder responses. Anxiety often accompanies and can interfere with an accurate assessment of the physical injury. Symptoms may include feelings of fear, apprehension, loss of control and loss of sanity. Signs, which can mimic a heart attack, include heart palpitations, rapid, irregular heart beat, rapid breathing, pale skin and sweating.

First aid for stress and anxiety responses is to calm the patient, try to ally their fears and complete a PAS to try to rule out physical causes. Patients whose responses abate might be able to stay in the field. An anxiety or stress response that is unpredictable or persistent may be a hazard to the patient and others, and may dictate an evacuation.

DEPRESSION
Depression typically manifests itself in withdrawal, isolation, crying, diminished interest in most activities, fatigue or loss of energy, trouble making decisions, feelings of helplessness and hopelessness, and/or a change in eating or sleeping patterns. These are not occasional blue moods. This is a deeper, persistent affective disorder. Depression can also present with agitation, increased motor activity, ruminating thought processes, and compulsive behaviors. If the depression affects other group members, or the ability of the person to participate in the trip, or focus on essential risk management tasks, they may need to be evacuated.

MANIA/PSYCHOSIS
Mania and psychoses are generally more serious than anxiety or depression and are more likely to require field consultation with a mental health specialist if available and/or evacuation. Psychotic symptoms can be brought on by heightened stress, change in environment, use of drugs, and/or going off prescribed medications. Individuals experiencing mania or psychosis are out of touch with reality in some way (e.g. hallucinations, delusions, heightened energy

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levels, which means that the person suffering from psychotic symptoms cannot distinguish internal reality from external reality. Thus, they are more difficult to manage. Both can be dangerous if they occur in terrain with risk of a fall, or during an activity requiring focus and precise actions, such as paddling a rapid.

SUICIDAL BEHAVIOR

Suicide is the 3rd leading cause of death among individuals 15 – 24 years of age in the United States. Females tend to have more suicide gestures than males, but males are more likely to complete their attempt to end their life. If someone talks about suicide, pay attention.

If suicidal thoughts are suspected, perhaps the patient is very depressed, feeling hopeless or helpless, or actually talking about harming themselves talk to the patient. It may be challenging to open this conversation, but talking about suicide does not cause people to commit suicide. Ask the following five questions:

- Are you thinking of harming or killing yourself?
- Do you have a plan how you would do this?
- Do you have the means with you now to carry out this plan?
- When are you thinking of doing this?
- Do you have a history of past suicide attempts?

The more of these questions that are answered in the affirmative, the higher the risk to that person

The policy of an outdoor program may dictate what is to be done if an individual demonstrates any suicidal thoughts or behaviors, but in most cases these individuals ought to be evacuated.

Signs/Symptoms (boxed summary)

Anxiety Responses

- RR and HR increased
- SCTM: PCC
- Trouble focusing,
- Dizziness, trembling,
- Stomach distress
- Chest pains
- Tingling sensations
- Excessive fear reactions
- Possible fight/flight/freeze response
- Catastrophic thoughts of dying, losing control or going crazy (with panic episodes)
- Compulsive rituals/thoughts (with obsessive-compulsive disorder)

Depression

- Persistent feelings of helplessness, hopelessness, despair. Agitation and anxiety may also be present.
- Symptoms of withdrawal, isolation, crying, diminished interest in most activities, fatigue or loss of energy, trouble making decisions, irritability, and/or change in eating and sleeping patterns
- LOR A+Ox4, HR, RR, SCTM normal for patient

Mania/Psychosis

- Mania: pressured speech, flight of ideas, high energy, decreased need for sleep, and/or altered sense of reality or inability to distinguish internal from external reality.
- Psychosis: hallucinations, delusions and an altered sense of reality.

TREATMENT PRINCIPLES

Complete your patient assessment (PAS). There may be a physical cause to the problem. Psychological problems can have physical causes such as brain tumors and infections, brain injury, substance abuse, hypoxia, hypoglycemia, hypo or hyperthermia, to name a few.

Is the patient on any medications? Might they be influencing the problem? Does the patient have any history of this problem? If so, what has made it worse, what has made it better?

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Listen carefully. Use a calm voice, slow breathing, eye contact and patience. Keep questions simple, honest, direct, respectful. You may need to repeat questions if patient has trouble tracking. Ask the person if they know what led to their feelings/reactions.?

Remain calm and reassure the patient. Focus on patient's strengths. Discuss what they have done in the past to help correct these feelings/thoughts/reactions, and see if some of these things can be done now. Try to instill hope that they will get better

Evaluate the risk to yourself, the patient and others. Inform, don't surprise the patient. Decide if you can manage this patient. Is there danger to self, patient or others?

EVACUATION CRITERIA

We don't need to fully understand the problem. We can make a decision based on simple principles used by many field instructors and wilderness trip leaders.

- Does the harm to the expedition outweighs the benefit to the patient?
- Is the mental health condition beyond our ability to manage in the field?
- Is the patient requiring a level of attention or monitoring that is already adversely affecting the cohesion, function or safely of the group?
- Is the patient a danger to self or others?
- Does the patient believe they are unsafe or unable to continue?

Answering any of these question in the affirmative gives you reason to evacuate the patient and seek a mental health professional.

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