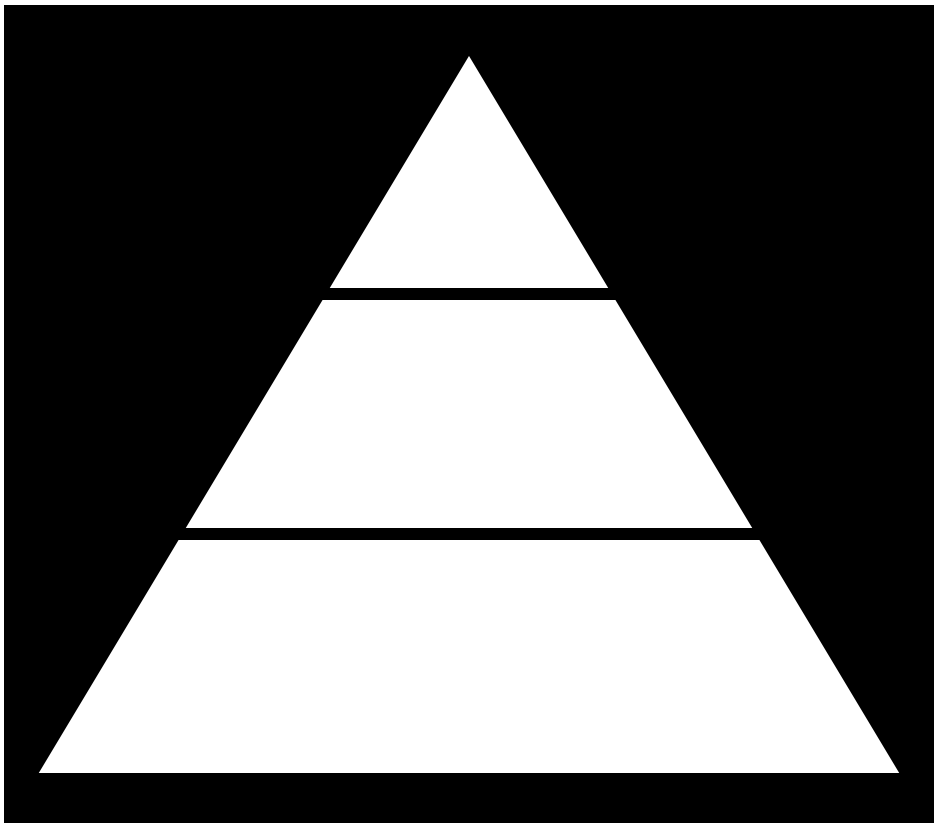

Heartland Alliance

Iraq Torture Treatment Project

Instructor Curriculum

Revised April 2005

Table of Contents

Page

Introduction

This curriculum was developed as part of Heartland Alliance for Human Needs & Human Rights' training and technical assistance program entitled "Integrated Torture Treatment Services in Rural Iraq". The purpose of this curriculum is to train Community Mental Health Workers in Iraq about the assessment of mental illness and the provision of mental healthcare.

The content and design of this curriculum were developed, in part, as a result of feedback from trainers and participants. This training curriculum is designed to be a practical, user-friendly and culturally appropriate resource in successfully developing and enhancing the skills of paraprofessional and professional staff in Iraq by helping them to identify their role in the treatment team and practice the skills needed in providing direct service.

Acknowledgments

This curriculum was developed in a collaborative effort between staff from Heartland Alliance for Human Needs & Human Rights and staff from the Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, with the assistance of several other individuals who offered their technical assistance and support in developing this curriculum. The following individuals participated in the development of this curriculum:

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About this Curriculum

This curriculum provides an introduction to the knowledge and skills needed to help individuals with mental illness and emotional distress due to trauma. The aim of this curriculum is to help direct service providers learn through a combination of lecture, visual aids, group participation and practice exercises.

The content of this curriculum is intended to provide trainers with insight into the rationale, processes and implications of providing direct service to individuals and their families. The companion participant workbook reinforces the content by reviewing key points covered in the lectures. In addition, several handouts and tip sheets are also provided for the participants' use with their clients.

The design of this curriculum offers specific text explaining the basic concepts of this curriculum, so that the trainer knows what needs to be presented in each lecture. The text is written in an easy-to understand dialogue style, so that the trainer may use the text as a lecture script, if desired. Italicized prompts provide the trainer with teaching tips and presentation notes, along with other helpful information and suggestions. The bracketed bold prompts provide information for the language translator or interpreter.

Trainer Tips

It is important to personalize the training experience by offering or eliciting relative examples or anecdotes regarding the topic areas covered in this curriculum. By doing this you will keep training participants engaged and will help them learn from another.

Throughout the training sessions be sure to continually assess the needs of the training participants and revise the amount of time devoted to each specific topic in this curriculum according to their questions, interests and needs. For example, if some of the participants want to focus on training issues related to a particular problem, you should assess to what degree devoting extra time to discussing these problems would be instructive and helpful for the entire group.

You may also decide to tailor this curriculum in order to meet specific training needs. For example, if your training time is limited, you may choose to conduct several separate training sessions in order to complete one lecture. If so, you may find it helpful to end a training session at the point before a new topic are begins. New topic areas are indicated by bold headers. Also, supplemental reading materials are referenced at the beginning of each lecture and are recommended for individuals seeking a more comprehensive understanding of the topic being covered in the lecture. (We can provide copies of many of these materials written in English, if desired).

Module I Training Outline

DAY (DATE)	PARTICIPANTS	MORNING SESSION	AFTERNOON SESSION
DAY 1	Community Mental Health Workers	Welcome, Program Overview, Job Description, Job Roles and Expectations, Pretest	Maslow's Hierarchy of Needs, and creating access to resources
DAY 2	Community Mental Health Workers	Introduction to Mental Illness (mood disorders, anxiety disorders, thought disorders), psychological symptoms, physical symptoms and substance abuse	Stigma of Mental Illness, its consequences for people with mental illness; and how to eliminate stigma
DAY 3	Community Mental Health Workers	Communication and Active Listening; Empathy, Genuineness, and Unconditional Positive Regard; Barriers to Effective Communication	Building Trust and Confidentiality, The Confidentiality Oath, Consent for Release of Information
DAY 4	Community Mental Health Workers	Introduction to Stress, Crisis, and Trauma; Suicide, Aggression and Violence; Coping with Crisis	Hope, Empowerment and Recovery; Resiliency
DAY 5	Community Mental Health Workers	Intake and Assessment	Wrap-up, Posttest

Maslow's Hierarchy of Needs and Creating Access to Resources

Purpose of Training:
To teach community mental health workers about Maslow's hierarchy of needs and how it applies to mental health; and how to create access to resources for basic needs.

Learning objectives:
Participants will know different basic needs that Iraqis have
Participants will know why these basic needs are important
Participants will know the difference between lower needs and higher needs
Participants will know how needs apply to the understanding of mental health
Participants will know how to help create access to resources in helping people in their communities.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Recommended Readings:
Pratt, C.W., Gill K.J., N.M. (1999). Chapter 8, Case management strategies. In *Psychiatric rehabilitation*, (pp.122-133). San Diego: Academic Press.
Corrigan, P.W. & Garman, A.N. (1996). Case management and severe mental illness. In S.S. Blancett & D.L. Flarey (Eds.), *The handbook of nursing case management: Health care delivery in a world of managed care* (pp.334-353). New York: Aspen Publishing.

References:
Feist, J. & Feist, G. (2002). *Theories of Personality.* Fifth edition. New York: McGraw Hill. Publishing.

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

Agenda

We will begin this training with a general introduction of basic needs that people have in general. We will then talk about how people everywhere are motivated by the same basic needs. We will discuss lower and higher needs, what they are, and ways that we can use Maslow's Hierarchy of Needs to understand ourselves. Finally, we will talk about mental health, what type of needs people with mental illness may have, whether their needs differ from our needs, and what we can do to understand their needs.

Refer to the handout titled "Maslow's Hierarchy of Needs". Use the following questions to begin a group discussion. Be sure to write down the participants' answers on the board in order to further the discussion. The purpose is to help the participants begin to identify the different types of needs that we all have and how they don't differ from the individual with mental illness. This discussion is also aimed at building empathy. Be sure to thank participants for taking part in the discussion.

What are needs?
Possible responses include: things that are a necessity, things we want, things that our body wants.

What are the different basic needs that Iraqis have? *Solicit examples.*
Possible responses include: food, water, safety, security, housing, family, children, religion.

Are some needs more important than others? If so, which ones?
Possible responses include: safety, housing, security, jobs, water, and food.

Why are these basic needs so important?
Possible responses include: because they are important for living, make you feel good, we need them to feel happy

What types of needs are important for individuals with mental illness?
Possible responses include: An understanding family, friends, place to live, someone to love them, medication, doctors

Why do you think satisfying our basic needs are important to the person's well being?
Possible responses include: because it makes you happy, complete, loved, understood

As you can see:

- All of us have needs
- It is necessary to have these needs satisfied in order to feel physically and psychologically healthy.
- It does not matter if you are a man or a woman, a boy or girl, a father or mother, we all have needs and we are all motivated to make sure these needs are fulfilled.
- People with mental illness have needs that they can't always satisfy by themselves
- People with mental illness often need help from people like you in order to feel motivated in meeting their needs and in being active in life.

Maslow's Hierarchy of Needs
According to Maslow's pyramid, there are a number of different types of needs. In addition, some needs must be fulfilled before the person can be ready to move on to fulfilling higher needs. Let us examine this further.

Refer to the handout titled "Maslow's Hierarchy of Needs". Review each item on the handout by conducting an open discussion. The purpose of this discussion is to show the students how important it is to make sure that the lower needs, which are the basis of the pyramid, are first satisfied before addressing the higher needs.

Maslow's Hierarchy of Needs indicates that lower needs (like physiological and safety) have to be satisfied before we can be motivated to seek higher needs

(like love and belongingness, esteem and self-actualization). Being hungry for example has importance over finding love and belonging. Lets talk a little more in depth about the various parts of this hierarchy of needs.

- Physiological Needs: Includes food, water, oxygen, etc..
- Safety Needs: Includes physical security, ability, dependency, protection, and freedom illness, fear, anxiety, danger, law and order.
- Love and belongingness: Includes friendship, marriage partner, children, family, and community.
- Esteem Needs: Includes self-respect, confidence, competence, reputation, and self-esteem.
- Self-Actualization Needs: Include self-fulfillment, and realization of all one's potential.

After reviewing the pyramid, use questions to continue the discussion:

Can you give me examples of how a lack of a need affects the individual's ability to function in his or her community, or with his or her family?

At the end of the discussion, be sure to debrief by asking questions like, "What do you think about this pyramid?"; "Are there things that are not included that may be important to include?"; "What do you think may be difficult needs for people here to satisfy?"; "Why do you think these needs are in the order that they are?."

How does Maslow's Hierarchy of Needs apply to Understanding Mental Health?

Write responses on the board and thank participants for their answers.

Let's discuss the relationship between Maslow's Hierarchy of Needs and mental health.

1. How would you feel if you had no water, or food? What would you do and can do to meet your needs?
2. Would this change if you had a mental illness? If yes how and if no how
3. What happens when you don't have friends? Or you feel isolated from the family?

Creating Access to Resources

This section is meant to show participants that there are many things that they can do within the community in order to lay a foundation for networking, community building and resource development. During this discussion the focus will be on helping individuals meet their basic physiological and safety needs.

Have participants refer to their Job Description in order to link specific job tasks to helping people meet their needs.

Can you tell me some of the needs that you will be helping your clients meet, based on your essential duties and responsibilities according to your Job Description?

Examples: help clients obtain employment, assess social service needs

One way to establish trust is to help people gain access to resources that they need. There are many things you can do to create access to resources in your community, even with limited opportunities.

1. Determine the types of services already available in your area. Some services are formal such as hospitals and government agencies. Other services are informal such as religious places, families, friends, and people in your neighborhood. What are some ways that you can determine what services are available in your area?
2. Establish and maintain positive relationships with community leaders. (Imam, doctors and other helpers in your community). Give me an example of how you would do this?
3. Foster trust with your religious leader by having genuine respect for their decisions and beliefs. Can you give me an example of how you could show respect for their decisions and beliefs?
4. Learn how to be skillful at working with agency bureaucracies to obtain the needed services. What is one way to learn how to be skillful in this area?
5. Learn how to advocate for the client, which can include making phone calls, writing letters, filling out forms, ensuring confidentiality is protected, and assuring that people are treated with respect. Can you give me an example of how you could accomplish this?
6. Identify their immediate needs and link them to resources that are already accessible in their community. Can you give me an example of a need and a resource in your community?

7. Continuously monitor the development of new opportunities and services in your area. What is a good way of keeping track of new services in your area?
8. Educate other helpers and community members about new resources that you discovered. How can you educate coworkers?
9. Negotiate with providers of resources to solve your client's problems. Are there particular tips that you have learned that help you in negotiating with service providers in your area?
10. Utilize your supervisor's knowledge to identify other potential resources. Do you know how to reach your supervisor when needed?

As you can tell from your new job description, much of your responsibility has to do with helping people meet their needs. The people you help will have different needs that may exist on different levels of Maslow's pyramid. You will find in time that one of the best ways to help people meet their needs is by first creating access to resources in your community.

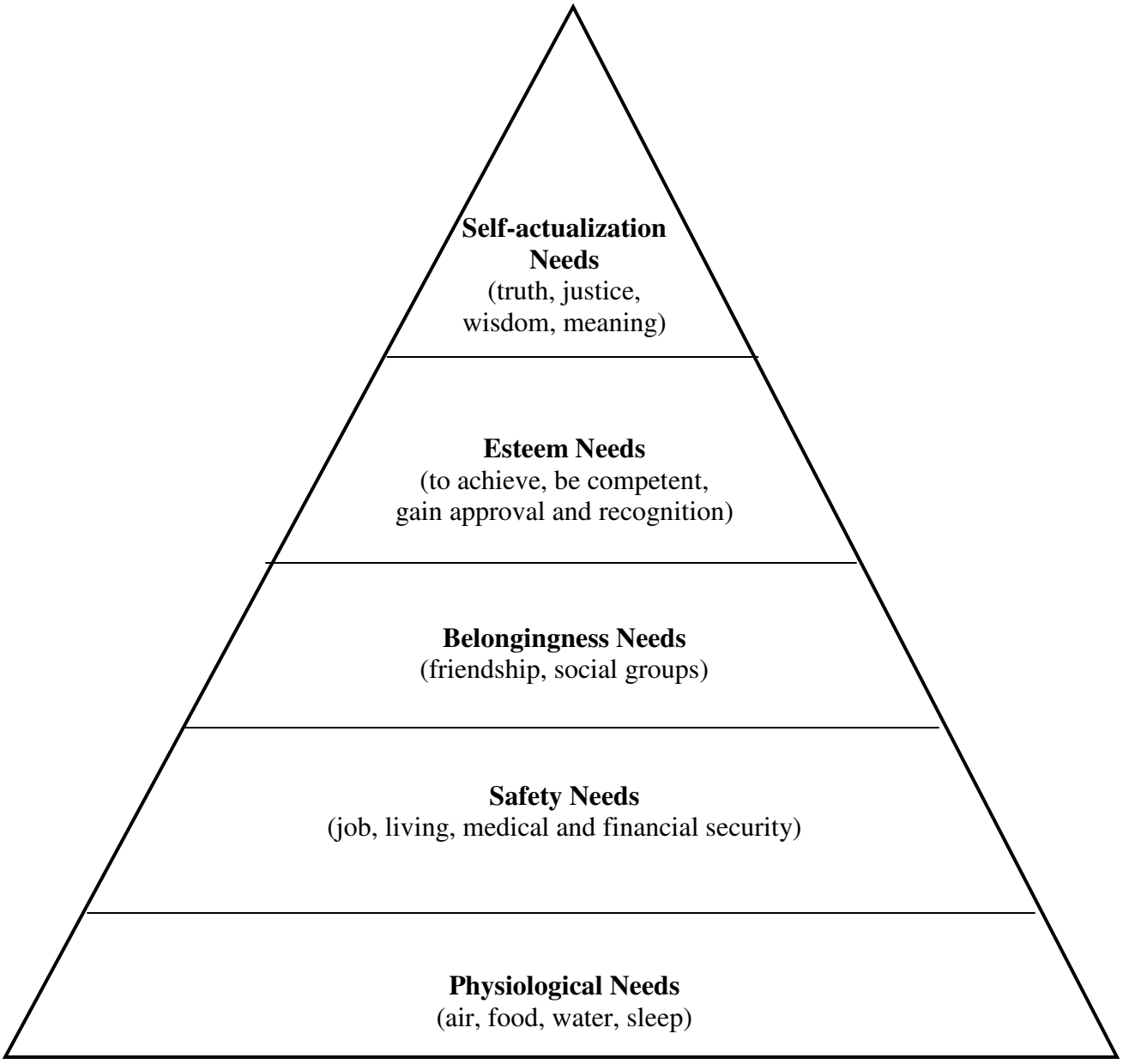
Do you have any questions?

Keep Points to Remember

1. Everyone has needs and it is necessary to have our needs satisfied in order to feel physically and psychologically healthy.
2. People with mental illness have the same types of needs as everyone else.
3. People with mental illness have needs that they can't always satisfy by themselves.
4. We can help people with mental illness meet their needs by motivating them to be more active in life.
5. We can also help people with mental illness meet their needs by helping them to access the resources in their community.

HANDOUT

Maslow's Hierarchy of Needs



Introduction to Mental Illness

Purpose of Training:
To teach community mental health workers about the nature of mental health and mental illness and about the relationship of environmental stressors to mental health.

Learning objectives:
Participants will know that mental health and mental illness are on a continuum with many levels.
Participants will know that mental health and mental illness are the result of an interaction of biology and environment.
Participants will know symptoms that affect mood, thinking, understanding of reality, physical health, and behavior.
Participants will be able to identify some common symptoms of mental illness.
Participants will be able to use the Symptom Questionnaire to ask questions about their client's symptoms.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings and References:
Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation
American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorder, 4th Edition-Text Revision. Washington, D.C.: APA.

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

What is mental illness?

Ask participants "what is mental illness?" Write responses on the board.

Mental illness is associated with:

- distress,
- emotionally or physically painful symptoms, and
- impaired functioning in one or more areas of life.

Exercise 1: The Mental Health/Mental Illness Continuum.

A good way to view mental illness is to use a continuum to show that there are different levels or different degrees of mental illness or mental health.

Let's do an exercise to demonstrate that mental health and mental illness are not opposites of each other. Rather, mental illness and mental health are on a continuum. This continuum will be used throughout the training to show how people can move back and forth along the continuum at different times in their lives.

Draw a long line on the board or paper. Above the line, write the words "great", "normal", "distressed", and "severe". (If there are difficulties with translation, reduce the list to 3 distinctions: "great", "normal" and "severe").

This line represents the mental health/mental illness continuum from optimal health on one end and severe mental illness on the other.

As participants give responses to your questions, write their responses under the relevant word on the continuum. For example:

GREAT	NORMAL	DISTRESSED	SEVERE
Elated	*Okay*	*Sad*	*Suicidal*
Very Happy	*Content*	*Depressed*	*Hallucinating*
Excited	*Happy*	*Worried*	*Psychotic*

I am going to ask you a series of questions. Please give me words to describe the conditions listed on this continuum: Great, Normal, Distressed, or Severe. *(Provide an example, if necessary).*

How do you know when someone feels **great**? (What are signs and symptoms of feeling great?)

How do you know when someone feels **normal**? (What are signs and symptoms of feeling normal?)

How do you know when someone feels **distressed**? (What are signs and symptoms of feeling distressed?)

How do you know when someone feels **severe**? (What are signs and symptoms of feeling severely mentally ill?)

As you can see from the way that I have arranged the words (or signs and symptoms) that you have given me, we can think of mental health and mental illness as being on a continuum.

There are several important points to remember about this continuum:

1. Each of us exists somewhere on this continuum.
2. We may exist at different places on this continuum at different times in our lives.
3. The different places on this continuum require different types of treatment and interventions.
4. As conditions become more severe, they also become more disabling for the individual.
5. As conditions become more severe and more disabling, they also become harder for the individual to recover.

Exercise 2: Mental Illness and its Affects on Functioning

The purpose of this exercise is to help demonstrate how people with mental illnesses may be unable to function in some areas of their lives for some periods of time, although they may be able to function very well at other times. It is also meant to show how treatment or the discontinuation of treatment can affect symptoms of mental illness. Refer to the continuum as necessary.

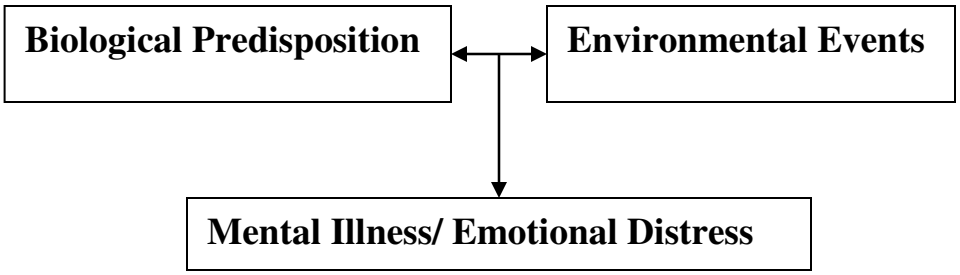
I am going to tell you a story about a woman named Miriam and then I will ask you some questions about how well you think she is functioning according to this continuum.

1. Miriam is a 40-year-old female who is happily married to a good man who works hard to take care of his family. They have a good home and Miriam's husband loves her. Miriam is a good wife and cares for her home and children. Based on this information alone, where do you think Miriam may be on the continuum?
2. Miriam's oldest son dies in a car accident. Now Miriam has difficulty sleeping, she cries constantly, and she is unable to eat. Where on the continuum do you think Miriam may be now?
3. Miriam gets help from her doctor at the hospital who gives her some medication for her symptoms. She meets with a community mental health worker who listens as Miriam talks about her son and how much she misses him. Miriam begins to feel better. Now where do you believe Miriam is on the continuum?
4. Miriam refuses to continue treatment. She stops seeing her doctor and stops speaking with the community mental health worker. She no longer takes care of her other children or her home. She begins saying that she just wants to die. Soon she begins seeing her son's spirit in the house and talks with the spirit. Based on this new information, where do you think Miriam is on the continuum?

As we can see from Miriam's story, it is possible to feel good one day and then something happens in life (such as trauma, war, or rape) that can make a person move to being severe. Once they get treatment, they can begin feeling better and can move back to feeling good again.

Why do people develop mental illness?
Write responses on the board. This section discusses the role of environment and biology in the development of mental illnesses and emotional distress.

Draw the following diagram on the board or paper to illustrate the point that you are making about the interaction between biology and environment.



An individual may be born with a certain biological predisposition to illness. Can you give me an example of a biological predisposition? *Example: inherited gene for a certain disease*

Can you give me an example of environmental events that can lead to illness? *Example: if an infant's mother were malnourished, infected with illness, or had come into contact with toxic chemicals prior to birth*

Trauma is one of the best-known types of environmental events that can change an individual's biological predisposition. It is widely believed that experiencing torture, rape, war, or natural disaster can change the biological structure and functioning of a person's nervous system. These changes can increase a person's predisposition to experiencing symptoms of mental illness.

Let's refer to Miriam again. Perhaps she comes from a family that has a lot of depression in its history. Perhaps Miriam already had a biological predisposition for depression long before her son died. And although she had this predisposition she did not become depressed until after the environmental event occurred, which was her son's death.

Do you have any questions?

Symptoms and Disorders of Mental Illness
Mental illness can be experienced in a number of different ways. Symptoms of mental illness and emotional distress can be divided into different groups. Let's discuss these different groups.

Mood Disorders. Mood disorders are characterized by emotional disturbances that affect the way that a person acts and thinks.
Examples: Depression, Bipolar disorder
Symptoms:

- Depression: sadness, emptiness, tearfulness, apathy, loss of hope, loss of faith, pessimism, a sense of loneliness, and feeling helplessness.

- Mania: an elevated mood, out of control with happiness.
- Irritability: sudden or unexpected anger for no reason, homicidal rage, out of control anger.
- Apathy: a lack of feeling, emotion and interest.
- Fatigue/loss of drive: low energy levels and/or the inability to start a task.
- Hypersomnia: an increase in time spent sleeping, or sleeping too much.
- Insomnia: the inability to sleep restfully or not sleeping enough.
- Suicidal ideation: thoughts of death and killing oneself.
- Psychomotor retardation: a slowing of activity or movement.
- Psychomotor agitation: an increased level of activity and jitteriness.
- Anhedonia: the loss of pleasure in things that used to be pleasurable.
- Impaired memory: problem with attention and concentration, and ability to make decisions.

Anxiety Disorders.
Anxiety disorders are characterized by feelings of excessive worry that are not attributable to real danger, and occur either in panic attacks or a constant state of worry.
Examples: General anxiety disorder, Posttraumatic stress disorder (PTSD)
Symptoms:

- Phobia: an unnatural, irrational fear of an item or situation, which the person realizes is not really dangerous, but the person still takes steps to avoid.
- Compulsion: an irresistible impulse, urge or desire to perform an irrational act that relieves worry for the person, such as repeatedly washing hands.
- Obsession: a repetitive or unwelcome thought, idea, emotion or impulse that provokes worry, such as a constant urge to wash hands or count objects.
- Panic: a sudden, overwhelming worry that produces terror and/or fear of death, and results in physiological and psychological changes.
- Agoraphobia: the fear and panic of leaving home, or being in public places, crowded spaces, or locations where help cannot be reached.

Thought (Psychotic) Disorders.
Thought disorders are characterized by loss of insight and reality.
People with thought disorders experience false beliefs and are unable to interpret external stimuli correctly. They are not aware that their thoughts are abnormal.
Examples: Schizophrenia
Symptoms:

- Psychosis: lost touch with reality; experiencing delusions.
- Illusion: an incorrect perception.

- Hallucination: false sensory perception such as hearing things, seeing things or tasting things that are not really there.
- Delusion: a false belief that isn't really true, such as someone believing that they are Allah.
- Paranoia: excessive or irrational suspicions, distrust, such as a person believing that they are a secret agent or that someone is following them.
- Disordered thinking and disordered speech: Disorganized thinking or expressing themselves in ways that don't make sense. They make speak in a jumble of unrelated words; they may make up nonsense words, or they may senselessly repeat words or phrases.

Can Mental Illness Affect a Person's Physical Health?
We've just discussed several psychological disorders and their common symptoms. Now we are going to discuss how many people express their mental illness through physical problems. Mental illness does not only affect our psychological health, but also our physical health as well.

Vignette:
Let me tell you a story about a man named Mustafa. He is 55 years old and married, with 5 children. Today he is seeking help from the doctor due to nausea, vomiting and abdominal pain. He says he feels terrible and cannot eat. He says he had good health until about 3 weeks ago when he began experiencing abdominal cramping. He thinks he has lost 10 pounds since these symptoms began. He has tried medication, but nothing seems to help. The doctor performed an extensive medical check up and could not find anything physically wrong with Mustafa. There is no medical explanation for why Mustafa continues to have abdominal pain, nausea, vomiting and weight loss. During a conversation with the community mental health worker, Mustafa said that the symptoms developed shortly after he lost his job. He has not been able to work since then because the abdominal pain keeps him in bed most days. And he fears that if he cannot get rid of the symptoms, he will not be able to keep a job in the future.

What do you think may be causing Mustafa's abdominal problems?

What are some other ways that psychological symptoms or illness can affect a person's physical health? *Examples:*

- Physical Pain: Headaches, or aches and pain in any other part of the body. It can stay in one place or move to different locations. The pain may be steady or it can increase and decrease.
- Sleep problems: terrifying dreams, fear of falling asleep, difficulty sleeping, excessive sleeping, difficulty staying awake during the day, lack of need for sleep. Terrifying dreams are often associated with having experienced trauma. Sometimes in these dreams, the individual relives the traumatic experience. This can lead to fear of falling asleep. Lack of need for sleep, that is feeling rested after only three or four hours of sleep, may be associated with mania.
- Eating: Losing interest in food or eating more than usual. Increased or decreased weight.
- Chest problems: palpitations, pains in the chest, sensation of racing heart, pounding sensations in the chest. People with these symptoms often go to the hospital believing that they are dying.
- Stomach and bowel problems: upset stomach, gas, cramps, fluttering feeling in the stomach or intestines, diarrhea or constipation, loss of appetite or increased appetite, nausea and vomiting.

Mental Illness and Substance Abuse

Mental illness can contribute to problems with securing and maintaining housing, keeping a job, or caring for oneself or family. These problems can become even worse when a person also suffers from substance abuse.

There are three important things to remember about mental illness and substance abuse:

1. Mental illness can contribute to a person using alcohol or other drugs.
2. Substance abuse behaviors may be associated with a number of different mental illnesses and emotional problems.
3. Alcohol and drug abuse are also mental illnesses.

You will receive more information on substance abuse in a later training, but for now do you have any questions about mental illness or the symptoms that we have discussed today?

Key Points to Remember about Mental Illness and Physical Health

1. Mental illness can result in a wide variety of physical symptoms
2. These symptoms can look like a number of medical problems.
3. Similarly, medical problems can mask mental illnesses.

4. It is important for the doctor to do a careful evaluation and diagnosis in order to distinguish between mental illnesses presenting with physical symptoms versus medical conditions.

Stigma of Mental Illness

Purpose of Training:
To teach community mental health workers about stigma of mental illness and the barriers that people with mental illness face in Iraq.

Learning objectives:
Participants will know to identify and discuss barriers that people with mental illness face
Participants will know to identify how stigma hurts people with mental illness, their families and friends, and communities
Participants will know to describe myths of mental illness and the corresponding correct information for each myth.
Participants will know to identify ways to eliminate stigma

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings:
Corrigan, P.W., & Lundin, R. (2001). *Don't call me nuts*. Tinley Park, IL: Recovery Press.
Corrigan, P.W. & Watson, A.C. (2002). The paradox of self-stigma and mental illness. In *Clinical Psychology: Science and practice*. (9)35-53.
Pratt, C.W., Gill, K.J., Barrett, N.M., & Roberts, M.M. (1999). Residential services and independent living. In *Psychiatric Rehabilitation*, 215-239. San Diego: Academic Press.

References:
Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

Agenda

We will begin this training with a general introduction to the barriers that people with mental illness face; and then we will discuss stigma, what it is, and ways that you can help eliminate it. Let us begin with an open discussion.

Use the following questions to begin a group discussion. Be sure to write down the participants' answers on the board in order to further the discussion. The purpose is to help the participants begin to identify some of the barriers that are created for the individual with mental illness. This discussion is also aimed at building empathy. Be sure to thank participants for taking part in the discussion.

What are some common beliefs about mental illness?

Possible responses include: demon possession; the person is crazy; God is punishing the person for something his/her parents have done; mental illness doesn't go away, it is terminal

How is a person with mental illness viewed in Iraq?

Possible responses include: punishment from Allah, it is something bad; there is a lot of guilt around it; flawed; dangerous; having a weak or no character; crazy; stay away from them; seen with pity

What happens with people who have mental illness?

Possible responses include: ignored; isolated; put away in mental institutions; kept away from the public; most live with family but are viewed as being a burden to their family and once their family can no longer take care of them, they become homeless.

As we can see, the individual with mental illness is often treated poorly. Furthermore, as we can see from this list, there are numerous misconceptions about mental illness and about the people who have mental illness. Let us examine this further.

Exercise 1: Myths about Mental Illness
Refer to the handout titled "Myths about Mental Illness". Review each item on the handout by conducting an open discussion. At the end of the discussion, be sure to debrief by asking questions like, "What surprised you most about these myths?", "Which of these myths do you think creates the biggest problem for people with mental illness?" etc.

Definition of Stigma
Stigma is a mark of shame, disgrace or disapproval that is placed on a person who is rejected or shunned by others as a result of prejudice.

Minority groups and their members are often stigmatized. Examples include people with physical disabilities or illnesses, people in certain cultural or ethnic groups, and people who have a particular income or occupation.

Have you or anyone you have known ever been the victim of prejudice caused by stigma? *(Wait for responses and thank participants for their answers).*

Today we are going to focus on stigma due to mental illness, but keep in mind that many of the people who you will be helping actually belong to several different stigmatized groups. For example, someone may be in a wheelchair and may also developmentally disabled, which could likely lead to stigmatization based on the physical disability and stigmatization based on the mental disability. So, in your role as a community mental health worker you will need to be sensitive to the several different types of stigma or shame that they experience.

Why do you think they may be afraid to tell others about their illness? *(Wait for responses and thank participants for their answers).*

Types of stigma

There are three types of stigmatizing attitudes that people have about individuals with mental illness:

1. fear and exclusion. It is the belief that persons with mental illness need to be feared and excluded from society much like the way that a dangerous criminal is excluded. An example would be, if you know that a man has schizophrenia or talks to himself, then you choose to stay away from him because you fear that the man may become violent.
2. authoritarianism. It is the belief that people with mental illness are incapable of taking care of themselves and therefore they need an authority figure to make decisions about them. An example would be, if you think that a woman who has a mental illness is unable to make her own decisions because of the mental illness, so you make all of her decisions for her.
3. benevolence. It is the belief that people with mental illness are like young children and need to be taken care of as we would our children. An example would be, if a man has depression, and you believe he cannot take care of himself so you must take care of all his daily needs as if he were a child.

You may be asked how stigma is perpetuated. If so, lead a brief discussion about some ways that stigma appears in society:

1. *Television and movies often portray individuals with mental illness as being dangerous*
2. *News media over-represents dangerous acts by persons with mental illness.*
3. *People use loose terms like "crazy" that attribute negative thoughts about individuals with mental illness*

Consequences of stigma

Stigma can lead to:

1. a loss of opportunity. Can you give me an example of how stigma of mental illness can lead to a loss of opportunity for the individual with mental illness? *Every community has what it considers to be "normal" about how people should behave in a given situation based on what the established rules of conduct exist for that situation. For example, a person with mental illness may lose his or her opportunity to socialize, by becoming isolated from the community or because of a lack of friends.*

2. discrimination. Can you give me an example of how stigma can lead to discrimination? *Example: People with mental illness who don't have family to take care of them and don't work, have limited housing opportunities. Since many people don't think that individuals with mental illness can take care of themselves, options for housing are limited and often lead these individuals to become homeless.*
3. additional limitations for treatment and opportunities. Can you give me an example of how stigma can lead to additional limitations or barriers? *Example: People with mental illness tend to view themselves negatively and may not think they are capable of doing things*

Vignette:
Sima, who is 18, has depression about the death of her brother and seems to cry whenever she is around other people. Many times she chooses to isolate herself because she feels unhappy and unable to socialize with her friends and family in the way that she used to. Some people might see her behavior as being not normal and might start looking at her as being crazy, weak, or different, which might limit her opportunity for marriage. Rumors begin to spread that Sima is going crazy and that she is bringing shame to herself and to her family because of her constant crying and isolation. Sadly, her friends and family begin to shun Sima, which causes her to feel even more sad and lonely.

Do you see how the stigmatization made Sima's depression even worse?

- People with mental illness tend to view themselves negatively.
- They may think that because they are mentally ill they are unable to do many things.
- Therefore they are less likely to seek opportunities.

Exercise 2: How to Eliminate Stigma
The good news is that stigmas can be changed. If we compare the stigma experienced by individuals today as compared to the stigma experienced by individuals in the past, we will find that stigma has changed. This is due in part to many attitude changes that have occurred as a result of research and education. An important role that you have in helping people with mental illness is that of working toward eliminating stigma. Let us take a look at the handout titled "How to Eliminate Mental Illness Stigma".

Refer to the handout titled "How to Eliminate Mental Illness Stigma" and review and discuss each item on the list. Be sure to explain the terminology used in the handout.

If time permits, conduct the following brainstorming exercise by dividing the group into smaller groups of 4-5 people. Ask them to review the list together and come up with 2 or 3 ideas for how they can begin eliminating stigma in their own communities. An example might be to educate the community by providing a public speech about mental illness stigma at a community meeting. Give the groups about 15 minutes to complete the exercise and then take time to permit each group to present its ideas to the others in the room once the group as a whole has reconvened.

We are going to conduct a short exercise by dividing into smaller groups to discuss the list of items on this handout. Form yourselves into a group of about 4 or 5 people. Once you are in your separate groups, review this list and together think of several ideas for how you can eliminate stigma in your own communities. Try to come up with at least 3 ideas. Write down your ideas so that you may present them to the rest of us when this exercise is over. You have about 15 minutes to complete this exercise. Are there any questions?

Be sure to give only positive feedback to participants. If you observe mistakes you may want to take a few moments after every group has participated to make a few general comments about "potential problems to beware of" without referring to any particular individual or group.

Key Points to Remember

1. Stigmas are negative attitudes about a group that lead to depriving the stigmatized members of that group from enjoying some opportunities that the non-members of that group enjoy.
2. Stigma exists for people with physical, financial, age and gender differences, among others, as well as for people with mental illness.
3. Stigmatization has become part of daily life for many individuals.
4. Stigmatizing words and actions are often overlooked or ignored.
5. It is important for us to learn to identify the existence and impact of stigma on individuals with mental illness, their families and their communities.

Are there any questions?

HANDOUT

Myths about Mental Illness

Myths about mental illness contribute to the development and support of stigma, which leads many people to feel ashamed and afraid to seek help for their problems. Knowing the facts about these myths is a powerful step toward eliminating the stigma.

Myth #1: People who have a mental illness are just "crazy".
Fact: Mental illnesses, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for mental illnesses, and they can be treated effectively.

Myth #2: Once crazy, always crazy. People don't recover from mental illness.
Fact: Research shows that most persons with the worst types of schizophrenia and other mental illness are able to live fulfilled, productive lives.

Myth #3: All persons with mental illness are alike.
Fact: Persons with mental illness are as diverse a group of people as any other.

Myth #4: Mental illnesses are rare, just like lepers.
Fact: Schizophrenia and other mental illnesses may account for up to eight to ten percent of the population.

Myth #5: Individuals with mental illness are unable to do anything but the lowest level jobs.
Fact: Persons with mental illness perform at all levels of work, just like the rest of the population.

Myth #6: People with a mental illness, such as schizophrenia, are usually dangerous and violent.
Fact: This is a complex misconception, but generally, statistics show that the incidence of violence in people who have a mental illness is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened and confused than violent. Research suggests that, except when people with mental illness are acutely ill, mental illness does not lead the person to any greater level of dangerousness than the general population.

Myth #7: Mental illness is the result of bad parenting.
Fact: Most experts agree that schizophrenia and other mental illnesses are biological diseases. In other words, mental illnesses have a physical cause.

Myth #8: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.
Fact: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people to recover.

Myth #9: Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or "bad".
Fact: Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a "bad" person.

Myth #10: Depression is a normal part of the aging process.
Fact: It is *not* normal for older adults to be depressed. Signs of depression in older people include loss of interest in activities and sleep disturbances. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth #11: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.
Fact: Children and adolescents can develop mental illnesses. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

Myth #12: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way "failed" or is weak.
Fact: A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

Myth #13: Schizophrenia means split personality, and there is no way to control it.
Fact: Schizophrenia is often confused with *multiple personality disorder*. Actually, schizophrenia is a brain disorder that robs people of their ability to

think clearly and logically. Medication has helped many of these individuals to lead fulfilling, productive lives.

Myth #14: People with mental illness are poor and/or less intelligent than those without mental Illness.
Fact: Many studies show that most people with mental illness have average or above-average intelligence. Mental illness, like physical illness, can affect anyone regardless of intelligence, social class or income level.

Sources: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation; National Alliance for Research on Schizophrenia and Depression (NARSAD) at http://www.mhagstl.org/myths.htm.; Mental Health Works at http://www.mentalhealthworks.ca/

HANDOUT

How to Eliminate Mental Illness Stigma

1. Education -- reduce stigma by educating others about mental illness. Dispelling the myths about mental illness is a good way to begin educating others.

2. Promote contact – reduce stigma by helping individuals with mental illness connect with others in their communities through work, social activities, spiritual activities, etc.

3. Feedback – reduce stigma by involving individuals with mental illness in the design of programs aimed at helping them. Professionals are not always in touch with the needs of individuals with mental illness. By gaining their input in the design and implementation of programs, there is a greater chance of developing useful and satisfying programs that will work toward reducing stigma.

4. Advocacy – reduce stigma by helping community leaders and government officials make decisions, policies and laws that eliminate discrimination, and recognize and protect the rights of individuals with mental illness.

5. Support groups – reduce stigma for individuals with mental illness and for the family members of individuals with mental illness by having them join together to provide mutual support and encouragement.

Source: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation;

Communication and Active Listening

Purpose of Training:
To teach community mental health workers how to use effective communication and active listening skills in helping others.

Learning objectives:
Participants will know how to identify the three basic values of a helping relationship: empathy, genuineness, and unconditional positive regard
Participants will know how to identify the goals of active listening
Participants will know how to identify the 12 barriers to effective communication
Participants will know how to identify the three clusters of active listening skills: attending, following and reflecting.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings:
Egan, G. (1998). The skilled helper: A problem-management approach to helping. Pacific Grove, CA: Brooks/Cole.
Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing, 2nd Edition*. New York, NY: The Guilford Press. Part 2 is highly recommended
Corrigan, P. W., Buican, B., & McCracken, S. (1996). Can severely mentally ill adults reliably report their needs? *The Journal of Nervous and Mental Disease, 184*, pp. 523 – 529.
Corrigan, P. W., & McCracken, S. G. (In Press). Interviewing people with serious mental illness. *Clinical and Diagnostic Interviewing, second edition*. Jason Aronson Publishers: Northvale: NJ.

References:

Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL:
University of Chicago Center for Psychiatric Rehabilitation

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

The Helping Relationship

It is NOT necessary for most people to have a lot of formal education in order to become a good helper. In fact, many of you probably already have the basic listening skills that are necessary to help other people. You probably also have important problem-solving skills that will be needed to help others too. The purpose of today's training is to:

1. identify these skills that many of you already use in your daily interactions with your family, friends and neighbors; and
2. learn how to improve these basic skills and build upon them, so that you may become better helpers.

[Translator note: The word "support" used below is NOT meant as care giving as in providing care for one's child. It is meant as encouragement and validation.]

As helpers you will want to build warm and caring relationships with the people that you help in order for them to trust you. This will permit you to be more effective in supporting and assisting them to meet their needs/goals.

Supporting them means that you will interact with them in a respectful manner by letting them know that their problem is important and legitimate.

- No matter what their problem may be, and
- Even when you may not necessarily agree with how the person views his or her situation, or

- Even if you may not agree on how the person chooses to address his or her problem.

Assisting them means that you will help them solve the problems that THEY choose to address.

- Even when you believe that another problem may be more important or
- Even if you think that another problem should be addressed first

Now let us talk more about how you can build warm and caring relationships with the people that you help. But first, let me conduct two demonstrations for you.

Exercise 1: Model Wrong, Model Right Relationship Demonstration
Use this exercise to begin a group discussion on the importance of building a warm, caring, supportive relationship with clients. Ask a participant from the audience or co-trainer to assist you. One of you will play the Community Mental Health Worker (the listener) and the other will be a client with a problem (the speaker). First you will demonstrate the WRONG way to listen, and then you will demonstrate the RIGHT way to listen. You may choose to conduct a brief group discussion after each demonstration to identify key behaviors that were either wrong or right. When demonstrating the wrong way, be sure to use obvious (even outrageous or funny) behaviors, such as looking around the room as the client speaks, thumbing through paperwork, humming a tune, or constantly interrupting the client to change the subject This exercise leads into a discussion on empathy, genuineness, and unconditional positive regard. So use the WRONG demonstration to show how the absence of these values creates problems in the relationship; and then use the RIGHT demonstration to show how the presence of these values leads to effective helping.

Three basic values in effectively helping others
Write these three values on the board.
The three basic values that you must have in order to be the most effective in helping others, according to psychologist Carl Rogers are:

- empathy,
- genuineness, and
- unconditional positive regard.

What is Empathy?

(Wait for responses and thank participants for their answers).

Empathy is often described as placing yourself in the other person's situation in order to understand his or her unique perspective, feelings, and meanings AND to be able to reflect this sensitivity back to the person.

Empathy IS:

1. Being able to say, "I understand what you mean."
2. Having a sense of how this individual or family may feel about their particular crisis, problem, or need.
3. Asking yourself, "What does it feel like to be this person right now?"
4. Being able to reflect the feelings back to the person, as if you are a mirror to the person. For example, you might say, "I can tell from how you are speaking that you are really hurt by your husband's harsh words."

Empathy is NOT:

1. Sympathy. Sympathy is having pity for someone or for their situation, while empathy is having understanding of someone's situation and being able to reflect that understanding back to them.
2. Simply agreeing with the person. In other words, to tell a woman that you agree with her that her husband is mean for yelling at her is not the same as having empathy (or understanding) for what she is truly feeling.

What are some ways to demonstrate empathy? *(Write responses on the board) Examples:*

- Pay attention to what the speaker is saying and doing
- Show a desire to understand the speaker's point of view
- Communicate an understanding of the message
- Discuss what is important to the speaker
- Refer to the speaker's feelings

What is genuineness?
(Wait for responses and thank participants for their answers).

Genuineness is responding to people in an authentic, real, credible and honest way. People will respond to us more favorably when they believe that we are genuine in the way that we are interacting with them.

What are some ways to demonstrate genuineness? *(Write responses on the board) Examples:*

- Be yourself; do not play a role or pretend to be someone other than who you are.
- Make sure that your verbal and nonverbal communication match
- Use nonverbal behaviors to communicate acceptance (smiling, appropriate body language)
- Express yourself naturally without artificial behaviors
- Use appropriate self-disclosure
- Avoid being defensive

What is unconditional positive regard?
(Wait for responses and thank participants for their answers).

Unconditional positive regard means acceptance without judgment.

Carl Rogers, who developed the concept of unconditional positive regard, describes this concept by saying that a person does not try to change a sunset. We must regard a sunset just as it is. We should therefore view people just as we might view the sunset. That is, people are just fine the way that they are. This is unconditional positive regard, accepting people exactly as they are.

What are some ways to demonstrate unconditional positive regard? *(Write responses on the board) Examples:*

- Keep an open mind
- Be consistent and follow through
- Identify and focus on what is important to the person we are helping
- Listen to the person without correcting or arguing with him/her
- Ask questions rather than giving orders
- Help the person retain a sense of control and empowerment by involving him/her in decision-making and problem-solving

Exercise 2: Role-play
This exercise gives participants the opportunity to practice empathy, genuineness and unconditional positive regard. Before the role-play, be sure to demonstrate this exercise by using a co-trainer or volunteer from the audience. After the demonstration, have participants divide into pairs, and take turns

being the client and the helper. Allow enough time for both participants in the pair to play both roles (client and helper). The client will speak about a problem that he/she is having, and the helper will demonstrate empathy, genuineness and unconditional positive regard. After the exercise, debrief by asking questions such as, "What did you find easy about this exercise?", "What did you find difficult about this exercise?", "Is there something is particular that surprised you?"

People benefit from interactions that are warm, positive and accepting. When people see that we value, accept and respect them as human beings, regardless of the fact that they may have problems, then they are more likely to permit us to help them. Some of the ways that we may help them include:

1. Assisting them in managing their problems in life;
2. Assisting them in addressing concerns or setting goals in their everyday life;
3. Assisting them in developing opportunities or accessing resources in order to solve problems or improve their life; and
4. Assisting them in learning new social, coping and self-care skills to improve their life.

Are there any questions?

Genuine and warm relations are important and very useful in helping others, especially when combined with active listening skills.

What are Active Listening Skills?
(Wait for responses and thank participants for their answers).

Active listening is a communication skill that you can use to improve your ability to understand the people that you are helping.

Active listening is:

- Important in building trust between you and others.

- RECEIVING a message from the speaker and SENDING a message back to the speaker that you have heard and understood what he or she has said.

The foundation of a good helping relationship is that of good listening skills. As a helper you will soon discover that ACTIVE LISTENING is one of the most powerful tools that you have in being effective in your job.

The Three Basic Sets of Active Listening Skills:
Refer to the handout titled, "Active Listening Skills" which lists each of the three types of skills and provides examples that can be referenced later.

One of the biggest mistakes you can make as a listener is that of jumping to conclusions or thinking that you know what is best for the other person. Active listening skills help you avoid these mistakes.

There are three types of active listening skills. *(Write them on the board).* They are:

1. Attending Skills
2. Following Skills
3. Reflecting Skills

We will review each of these and practice them to become better listeners. Let us begin with Attending Skills.

[Translator note: Nonverbal communication includes hand gestures, head movement, body posture and other mannerisms]

Attending Skills
The first set of active listening skills is called Attending Skills.

Attending skills:

- Let the speaker know you are listening to him or her.
- Provide the speaker with visual evidence that you are paying attention.
- Use nonverbal communication to let the speaker know that you are interested in what he or she is saying.

What is nonverbal communication? *(Wait for responses)*

You can tell a lot about what a person is feeling or thinking, based on what his or her BODY is doing. For example, if someone is talking to me, but my head is turned so that I may watch the television across the room, and I seem to be very interested in what is playing on the television, will the person think I am very interested in what he or she is saying? Probably not. Sometimes our nonverbal communication is more powerful than our verbal communication. So

we must learn how to use nonverbal communication (or attending skills) effectively in being active listeners.

Attending skills can be demonstrated by:

- Leaning toward the person who is speaking
- Nodding your head to let the person know that you understand
- Smiling at the person to encourage them to continue
- Remaining silent to let the person continue

Let me take a moment for a brief demonstration. May I have a volunteer?

For this demonstration, choose a volunteer from the audience or co-trainer and have the person talk about any subject he or she chooses, while you remain silent. Show the audience how you use attending skills to let the speaker know that you are listening.(2 minutes)

Following Skills

The second set of active listening skills is called Following Skills.

Following Skills are different from Attending Skills because with Following Skills you are SAYING something. Also, Following skills lets the speaker know that you want him or her to continue speaking. Sometimes we need to say a little bit in order to keep a conversation going. For instance we can use short phrases to encourage the speaker to keep talking.

Following Skills can be demonstrated by using phrases like:

- "What can I help you with?"
- "Would you like to talk about something?"
- "What would you like to tell me today?"
- "Is there something on your mind?
- "Continue."
- "Tell me more,"
- "What happened then?"

Asking good questions is an important skill to let the speaker know that you are following what is being said.

Let me demonstrate Following Skills. May I have a volunteer?

For this demonstration, choose a volunteer from the audience or co-trainer and have the person talk about any subject he or she chooses, while you use short phrases that encourage him or her to continue talking.

Reflecting Skills

The second set of active listening skills is called Reflecting Skills.

Reflecting Skills:

- Help you reflect feelings and meaning back to the speaker, as if you are a mirror.
- Let the speaker know that you understand what is being said.

Reflecting Skills can be demonstrated by:

1. Restating (in your own words) what the speaker has told you.

   For example, after a woman has told you about her problem of being abandoned by her husband and having no food in the house to feed her family, you could paraphrase her story by saying, “Your husband has gone and you have no food for your children.”

2. Summarizing common statements or ideas that the speaker continues to repeat in order to reflect content

   For example, you might say, “As I've been listening to you, your main concern seems to be..."

3. Interpreting the speakers feelings by connecting the speaker’s verbal and nonverbal communication

   For example, you might say, “You feel fearful because your husband is gone, you have no food, and you have no money.”

   Or, "You feel happy because things are going well in your life."

   Or, "You feel angry because you lost your job.”

Let me demonstrate Reflecting Skills. May I have a volunteer?

For this demonstration, choose a volunteer from the audience or co-trainer and have the person talk about any subject he or she chooses, and then you reflect on what was said to demonstrate that you understood the speaker.

Do you have any questions about Attending Skills, Following Skills or Reflecting Skills?

Barriers to Effective Communication

We've talked about active listening skills by learning about attending, following and reflecting. Now we are going to review common mistakes that people make when they are having a conversation with others.

Robert Bolton refers to these common mistakes as being "roadblocks" to effective communication. Use the term "barrier" if it is easier to translate.

Helpers cannot listen effectively when they create barriers to the other person's ability to speak freely. These barriers are particularly a problem when we are trying to help people understand their problems.

Refer to handout titled, "Barriers to Effective Communication" and review each item.

There are three categories of Barriers to Effective Communication:

1. Judging
2. Giving Solutions
3. Avoiding Concern

Judging

The first category is Judging. Judging is making an evaluation of what is being said based on our OWN values rather than accepting what the other person is saying. Judging comes in many forms:

1. Criticism – "Your house is dirty and you do not care for your children."
2. Name-calling – "You are crazy and a bad mother." (Using insulting labels)
3. Negative evaluation – "Anyone who does not cook and clean for her husband is a terrible wife." (Dismissing a person's concerns by making a moral statement against the person)

4. Diagnosing – "You act like you are depressed." (Reducing a person's complex thoughts and behaviors to a simple diagnosis, while ignoring all other possibilities for the problem).
5. Praising with evaluation – "You are a good cook. Too bad you don't clean the house better." (Praise can block a person from freely discussing his/her concerns when it is attached to a negative message)

As you can see, making judging statements during the conversation can create barriers for the speaker. Do you have any questions about the five judging barriers?

Giving Solutions

The next category is Giving Solutions. Unfortunately, most helpers believe the purpose of listening to others is to provide solutions. They think their job is to tell other people how to manage their lives. But effective communication is really about LISTENING to a person's problems. Listening alone may help the person feel better at first, and then together you can work on finding solutions.

Here are some examples of how giving solutions creates barriers to effective communication:

1. Ordering – "Go to your father and ask for food."
2. Threatening – "If you do not stop drinking alcohol I will tell the Imam. (Warning the person that continuing to do something will result in emotional, physical or social harm)
3. Moralizing – "Drinking alcohol is haram and brings shame to your family." (Framing a particular behavior in terms of it being sinful or wrong behavior can be a barrier to further communication).
4. Excessive questions – "What did you do? Who were you with? Who saw you do this? What did they say?" (Sometimes, our desire to gather all the information causes us to sound like interrogators).
5. Advising – "If I were you I would tell my husband to go to work." (Giving advice does not help listening. Until the person has completely told his or her story, providing advice can be distracting and can prematurely end the conversation).

As you can see, giving solutions during the conversation can create barriers for the speaker. Do you have any questions about the five barriers we've identified in this category?

Avoiding Concern

The final category is called Avoiding Concern. It refers to avoiding the concerns of the speaker. Sometimes listening to the problems and needs of others may make us feel uncomfortable, or even frightened. We may not wish to listen further so we use barriers to avoid having to listen to the speaker's story.

Here are some examples of the barriers in this category:

1. Diverting – "You think you have problems, well let me tell you about Naima!…" (Trying to change the subject from the speaker's concerns to some other subject).
2. Logical argument – "If you consider what it costs to have a wedding, it is good that your son will not marry until he finishes college." (Trying to reduce the person's message to some sort of logical fact does not help solve the complex and emotional components of the person's problem).
3. Reassuring – "Don't worry Mohamed, losing your job isn't that bad! Everyone is out of work nowadays." (Consoling someone might be a barrier to further communication, and can seem as if you are minimizing the message).

Do you have any questions about Avoiding Concerns?

Summary and Conclusion

You may be wondering what can be said when we use so many of the examples of communication barriers in our everyday interactions. We have probably all recognized that we frequently use many of these barriers when we talk with friends, family and neighbors. Do not worry about trying to eliminate the use of them immediately.

Truthfully, as helpers we will need to occasionally give advice, and we may also need to change the subject or help a person reach a logical conclusion. But when we do these things, we must recognize that we are placing a barrier between the speaker and ourselves.

When you are talking with your clients about their personal and private matters make sure to check your surroundings. Ask yourself these three questions:

- Is this a location where I would want to discuss MY personal life?
- Would I feel safe talking here about this subject?
- Can I ensure confidentiality at this location?

Sometimes conditions are not ideal for having a conversation. If you cannot make other arrangements, do whatever you can to insure the person's confidentiality, by finding the most private area possible by moving to another room.

Key Points to Remember

1. Three values of a helping relationship are empathy, genuineness and unconditional positive regard. These values are the basis of building a trusting relationship between you and the people that you help.
2. Active listening is a communication skill that you can use to improve your ability to understand the people that you are helping.
3. There are three types of active listening skills.
    - Attending Skills
    - Following Skills
    - Reflecting Skills
4. There are three categories of Barriers to Effective Communication:
    - Judging
    - Giving Solutions
    - Avoiding Concern
5. When you are talking with your clients about their personal and private matters make sure that your surroundings can insure the client's confidentiality.

HANDOUT

Active Listening Skills

ATTENDING – Use nonverbal communication to let the speaker know you are listening

- Nod your head
- Smile
- Lean toward the speaker
- Remain silent

FOLLOWING – Use short phrases to let the speaker know that you want the speaker to continue talking

- "Tell me more"
- "I see."
- "What can I help you with"
- "You look like you wish to talk"

REFLECTING – Use reflective statements to let the speaker know that you understand what is being said

- Paraphrasing (restate what the speaker has said in your own words)
- Summarizing (gather together common ideas or statements that the speaker keeps repeating
- Interpreting the speakers feelings by connecting the speaker's verbal and nonverbal communication ("You feel _____ because _____")

Source: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

HANDOUT

Barriers to Effective Communication

JUDGING

- Criticism – "Your house is dirty and you do not care for your children."
- Name-calling – "You are crazy and a bad mother."
- Negative evaluation – "Anyone who does not cook and clean for her husband is a terrible wife."
- Diagnosing – "You act like you are depressed."
- Praising with evaluation – "You are a good cook. Too bad you don't clean the house better."

GIVING SOLUTIONS

- Ordering – "Go to your father and ask for food."
- Threatening – "If you do not stop drinking alcohol I will tell the Imam."
- Moralizing – "Drinking alcohol is haman and brings shame to your family."
- Excessive questions – "What did you do? Who were you with? Who saw you do this? What did they say?"
- Advising – "If I were you I would tell my husband to go to work."

AVOIDING CONCERN

- Diverting – "You think you have problems, well let me tell you about Naima!…"
- Logical argument – "If you consider what it costs to have a wedding, it is good that your son will not marry until after he finishes college."
- Reassuring – "Don't worry Mohamed, losing your job isn't that bad! Everyone is out of work nowadays."

Source: Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Building Trust with Confidentiality

Purpose of Training:
To teach community mental health workers about the importance of confidentiality, and to secure their oath to protect the confidentiality of their clients.

Learning objectives:
Participants will know the role of confidentiality in building trust.
Participants will know the ways in which confidentiality can be violated and how to prevent such violations.
Participants will be able to discuss confidentiality with clients.
Participants will be able to review and assist their clients in completing a Consent to Release Information with their clients.
Participants will sign confidentiality oath.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings:

References:
Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

The Importance of Trust

Trust is the basis of any helping relationship. People must trust you, or they will not talk to you about things that are important. We generally develop trust in helpers who we believe are sincere and honest, who have nothing to hide from us, and who are not trying to get something from us. You can build trust by sharing things about yourself; you can build trust by following through with what you promise to do; and you build trust by not talking, with anyone other than the client **[use a word that means "one who is helped" rather than "patient"]** about things that people tell you. Of all of these ways to build trust, keeping your client's experiences private is most important. Each of these ways of building trust is important. Failing to share things about yourself or failing to follow through with what you promise, will reflect badly on you. Failing to keep a secret can get your client killed, severely punished, or banished. Let us talk about each of these in turn.

Sharing things about Yourself

Sharing things about yourself helps you to connect with your client and to develop trust. It is seen as fair, since you expect your clients to share things about themselves. However, there are some things that are appropriate to share and others that should not be shared.

Exercise 1: Sharing about Yourself.

Ask the participants to tell you what sort of things they would be comfortable sharing with a client. Write their answers on a board or pad of paper for everyone to see.

What kind of things would be okay to share with your clients? *Examples: marital status, experiences with children*

What sorts of things would not be good to share with your clients? *Examples: personal trauma experiences, sexual activities, medication that you are taking*

Discuss with the participants some of the advantages and disadvantages of sharing different kinds of items with clients. For example, advantages of sharing information about one's family include:

- *Want to make a connection with the client*
- *The client may already know much about you if you both live in the same village.*
- *Information about one's family is often shared early in meeting someone, and it would seem strange if you didn't share this sort of information.*

Disadvantages include:

- *It might be difficult to decide what sort of personal information is alright to share.*
- *Some information about you may place feelings of guilt on the client or may add to the client's burden or pain*

In general, it is good to share things that help you client know you as a person and feel connected to you. It is not good to share too much about personal problems that you may have had. Sharing this sort of information can shift the focus of the discussion from your client to you.

Following Through with What you Promise

It is important to deliver on promises that you make to your clients.

- Keeping promises builds trust
- Breaking promises breaks trust.

You should tell your client that you will do your best to obtain a resource and then keep your client informed about progress that you are making.

Maintaining Confidentiality. [use the word "confidentiality" rather than translating it into an Arabic word that is similar] Confidentiality means that what a client or patient says to a helper or doctor is kept private and not revealed to anyone else.

Confidentiality means that the client can have faith or trust in the helper not to tell anyone what the client said.

The agreement to maintain confidentiality is one of the most basic agreements in medicine.

WITHOUT confidentiality:

- We cannot expect that our clients will talk about important things of a sensitive or personal nature.
- Disastrous consequences can occur for your clients, including shame, stigma, banishment, or even in some cases, death.

This is why you must sign a Confidentiality Oath in order to work as a Community Mental Health Worker and why any helper who violates confidentiality will be terminated as a Community Mental Health Worker. Additionally, the Iraqi government has written a Confidentiality Law that says that a health care professional can be prosecuted for violating patient confidentiality. Thus, you not only can lose your job, but you can be prosecuted for violating confidentiality.

Four Exceptions to Maintaining Confidentiality

Confidentiality is so important that there are only four exceptions:

- Medical emergency. Confidentially can be broken in a medical emergency to save the life or protect the health of the client. For example, if Meram was brought to the hospital unconscious and the doctor wanted to give her a medication, it would be alright for the helper to tell the doctor that Meram is taking medication for depression. It is alright because Meram cannot speak for herself, and it is important for the doctor and others providing treatment to know that Meram is taking a medication that could affect her response to other medications. If you are faced with a situation that you believe is a medical emergency, consult with the doctor you work with, if possible and if time permits.
- Threat of suicide or homicide. Confidentiality can be broken if a client threatens to bring harm to self or to others. For example, if Ahmed said he planned on killing his wife, then it would be important to warn authorities and Ahmed's wife so that she could be protected from harm.
- Permission is granted by the client. The client can give the helper permission to tell someone else what was said. For example, Mustafa could give permission for the helper to tell Mustafa's family that he avoids family gatherings because he is depressed and not because he is angry.

- Part of Treatment Team. You are allowed to discuss what your client says with the doctor you are partnered with and with your supervisor. Both you and the doctor will provide care to your clients, and the doctor must know what is going on with the client in order to provide good care. Your supervisor will need to know what you are discussing with your client in order to provide you with useful supervision and recommendations. You will mention this fact at the first meeting when you discuss confidentiality with your client.

Do you have any questions about confidentiality or why maintaining confidentiality is so important?

Some of the questions you may be asked include:
Question: What if the client's father or husband asks what the client said to me?
Answer: You must tell him that you are not allowed to discuss anything that the client tells you. Tell him that you could lose your job or be prosecuted for telling anyone what the client says to you.

Question: What is meant by a medical emergency?
Answer: Any situation in which the client's life or health may be in danger and that information that the client has told you is needed in order to prevent physical harm or death to the client.

Question: Can you give me some examples of a medical emergency?
Examples: Suppose that your client is taking a medication that might interact in a harmful way with medication that might be prescribed in an emergency. You would need to share information about what your client was taking. Suppose that your client was severely depressed and took an overdose of his medication. You could share with the doctor what medication the client was prescribed and how many pills you thought that he had taken. Remember that if you believe a situation is a medical emergency, you should discuss the situation with the doctor you work with, if possible

Question: If my client gives me permission to talk with his family, can I tell them anything that the client has told me?
Answer: You can only tell them what the client gives you permission to tell them. If your client gives your permission to tell them anything that you have talked about, you can discuss anything. If your client only gives you permission to talk about certain things, then that is all you can talk about.

Question: What if the client is a child?
Answer: For now you will only be working with adults over the age of 18.

Question: What if the client is an unmarried girl of 18; can I talk with her mother?
Answer: No, not unless your client gives you permission.

Exercise 2: The Confidentiality Oath
Refer to the handout titled, "Confidentiality Oath". Give participants time to read the oath and then discuss its various aspects in detail. Ask if there are any questions concerning the oath. A possible question may be, "Why do I have to sign this?" Answer: "Although in the past we have always been able to operate with a verbal agreement and/or handshake, in today's world there is a need to maintain better records and documentation. Confidentiality is a serious matter and it requires this level of attention an commitment."

Have participants stand as you read the Confidentiality Oath aloud. Then have them sign the oath.

Discussing Confidentiality with Your Client
Confidentiality should be discussed during your first clinic/hospital meeting with your client. You should discuss what confidentiality means and the conditions under which it will be broken. You also should discuss the fact that the way that the manner in which you interact with your client outside of the clinic or hospital will not be changed by the fact that you are providing services to your client. Take a look at the Confidentiality Explanation.
Refer to the handout titled "Confidentiality Explanation. Give participants time to read the explanation.

Do you have any questions about this explanation? Are there any parts that you would say differently to your clients?
If participants would prefer different wording, allow them to use their own words, but make sure that the essential points are addressed.

- *What the client tells the helper will be kept confidential. That means that the helper will not tell <u>anyone</u> what the client says, except as noted in the next item.*
- *There are three exceptions to confidentiality:*
    - *The helper will share information with your supervisor and the doctor.*
    - *The helper will share information that is needed to keep the client alive and to provide care in a medical emergency.*

    - *The helper may share information if the client provides specific, written consent.*
- *The helper will interact with the client the same way that they did before they began to work together.*
- *There are penalties for violating confidentiality.*

Exercise 3: Discussing Confidentiality in Your First Professional Meeting
Now we are going to practice how you will introduce confidentiality to your client on the first day you meet.

Begin with a demonstration of how to discuss confidentiality with a client. Use a volunteer from the audience or a co-trainer to simulate how to use the Confidentiality Explanation. Then, divide the participants into pairs. One of the participants will be the client and the other will be the helper. Have them start by reading the Confidentiality Explanation to the client. Next, have them ask the client if he or she has any questions, then answer those questions. After completing the exercise, have them switch roles and repeat the exercise.

I would like for you to practice discussing confidentiality with a client during the first meeting. Please divide into pairs. One of you will be the client and the other will be the helper. (You will switch roles later, so that each of you will have the opportunity to be both a client and a helper.) You can use the Confidentiality Explanation for this discussion. If you wish, you can read the explanation word for word. After you explain confidentiality to the client, ask your partner if there any questions, and then answer them.

Do you have any questions about the exercise?

Sometimes your client will want you to speak with someone on the outside, such as a husband or wife, landlord, police, lawyer, parent or teacher. If your client gives you permission to break confidentiality, you must have your client sign a written consent before you actually speak to the other person. Although verbal consent was once good enough, things are changing and we must be prepared to always get consent in writing.

Consent to Release Information
One of the conditions in which information about a client may be shared is if the client gives you specific, written, permission to share information with another person. This person may be a family member, another healthcare provider, or anyone else that the client chooses.

Refer to the handout titled "Consent to Release Information". This is an example of a written consent to release information. Please read it over.

Note the following:

- The person releasing the information is specifically identified. Only the person (or persons) specifically listed may share information about the client. This person can be:
    - You individually
    - You and other people, such as the doctor.
- The person you are releasing information to is specifically identified. You may use the person's name or relationship to the client, such as father, mother, uncle, husband or wife. You may only release information to the specific person or persons identified.
- The information that you may release is specifically identified. You must write on the form any specific information that the client would like you to share. You may only share information that is listed on the form. Examples:
    - Problems that I am having
    - Diagnosis
    - Results of tests and assessments
    - Past experiences
    - Participation in treatment
    - Symptoms
    - Medications
    - Things we have discussed
    - Problems in functioning
    - Treatment Plan
- The consent is valid for a specific length of time. This length of time may be very short, such as one or two weeks, or it may be very long, such as a full year.
    - Clients should not sign consents for longer than one year.
    - Consents should periodically be reviewed to make sure that the client still wishes to have information released.
    - If the client does not renew the consent, permission to disclose the information ends until the client renews the consent.
- The client can revoke or terminate the consent at any time. This can be done either in writing or verbally. If the client revokes the consent, write on the consent form the date it was revoked.

- One copy of the consent form can be given to the client. The original copy of the consent form is to be retained by the clinic or hospital where the helper is employed.

Do you have any questions about the consent?

Now we will have an opportunity for you to practice explaining and completing the consent to release information.

Exercise 4: Consent to Release Information.
Begin with a demonstration of how to discuss confidentiality with a client. Use a volunteer from the audience or a co-trainer to simulate how to use the Consent to Release Information. For example, you may choose to have the co-trainer play the role of a client who wishes you (the helper) to speak with her husband on the phone. You would then explain to the client that first you must have her sign a written consent to release information before you can speak with her husband.

After the demonstration, once again, divide the participants into pairs. One will be a client; one will be a helper. The helper is to explain the consent form to the client and assist the client in completing the form. The client is going to provide consent for the helper to discuss the client's diagnosis, depression, and treatment, medication, with the client's spouse for the purpose of helping the spouse understand the nature and treatment of the client's illness. The consent will be valid for one year. After the exercise is finished, switch roles and repeat the exercise.

Once again, I would like for you to divide into pairs. One of you will be a client who would like to give the helper permission to discuss your diagnosis, depression, and your treatment, medication, with your spouse. You are authorizing release of this information for the purpose of helping your spouse understand the nature and treatment of your illness. You would like the consent to be valid for one year.
The other member of the pair will be a helper in a clinic or hospital. Your task is to explain the elements of the consent form to the client and to assist your client in completing the form. Be sure to give a copy of the consent to the client.
Do you have any questions about the exercise?

After the exercise is complete—Do you have any questions about the consent form?

Key Points to Remember

1. Trust is the basis of any helping relationship. People must trust you, or they will not talk to you about things that are important
2. Confidentiality means that the client can have faith or trust that CMHW will not to tell anyone what the client said.
3. Confidentiality should be discussed during your first clinic/hospital meeting with your client. You should discuss what confidentiality means and the conditions under which it will be broken.
4. There are only four exceptions to maintaining confidentiality:
    - Medical emergency.
    - Threat of suicide or homicide.
    - Permission is granted by the client.
    - Part of Treatment Team.
5. If your client gives you permission to break confidentiality, you must have your client sign a written consent before you actually speak to the other person.

Confidentiality Oath

I, _____, swear that I will not reveal to any person anything that my client tells me except, and only, under the specific conditions noted below. I understand that if I violate this oath I will be immediately terminated from employment and I may be prosecuted under existing or future Iraqi laws. The exceptions are:

- I may discuss with my supervisor and the doctor I work with anything that my client tells me. This is done for the purpose of providing necessary care to my client, and this will be discussed with my client at our first meeting.
- In case of a medical emergency for my client, I may reveal things that my client has said to me and details of my client's diagnosis and care. I may reveal this information only to the people treating my client, and I may only reveal information that is necessary to the care of my client. This information is revealed for the purpose of keeping my client alive and preventing harm to my client.
- My client may give me permission to reveal specific information to specific people. This permission must be provided in writing and must specify the exact information that may be revealed, to whom the information may be revealed, the purpose of revealing the information, and a specific period of time during which the information may be revealed. My client may revoke this permission at any time, either in writing or verbally.

Worker signature: _____ Date: _____

Witness signature: _____ Date: _____

HANDOUT

Confidentiality Explanation.

Good morning [afternoon], Mr. [Mrs./Miss] [client's name]. Dr. [name] has asked me to talk for a few minutes with people coming to see him before their appointment. Is that alright with you? I will be asking you a number of questions about how you feel and about problems that you may be experiencing. However before I begin, I need to explain something.

Everything that you tell me will be kept secret. That means I will not discuss anything that you tell me with anyone except the doctor and my supervisor, and they will not discuss what I tell them with anyone else. Before I was hired, I signed an oath that said that I am required to keep secret anything that a client tells me. If I break this oath, I will lose my job and I may even be prosecuted, since there is a new law that says that health care professionals are not allowed to discuss anything that a client or patient says.

Other than talking with your doctor and my supervisor, there are only two situations in which I will share anything about what you tell me. The first situation is if there is a medical emergency and I need to share information that you have told me in order to save your life or prevent you from being harmed. In that case, I will share only that information that is needed by the people treating you and only with the people who are providing care to you.

The second condition in which I will share information is if you give me specific, written permission to share that information. If you give me permission to share information that you have provided me, I will share only the information you have given permission to be shared and only with the specific people you allow me to talk with. That means that if a member of your family asks me what you and I talk about, I must say that I cannot discuss what we talked about with anyone.

If I meet you outside of the clinic/hospital, I will not treat you any differently than I did before today. [Give an example, if you knew the client before, talk about how you would treat him no differently now. If you did not know the client, state that you would act as if you did not know the client, unless the client came up to you and greeted you.] I am not doing this because I am embarrassed or don't want people to know we are seeing each other. I am doing this because our work together is private, unless <u>you</u> choose otherwise. Do you have any questions about what I have just said?

Consent to Release Information

I _____ (client's name) authorize _____ (helper's name) to disclose to _____ (individual's name or relationship to the client) the following information:

_____
_____
_____
_____

I understand that this consent is valid for _____ (list specific duration of consent, for example 30 days, 6 months, one year), unless I revoke the consent sooner. At the end of this period of time, the consent must be renewed or permission to reveal information will end. I may revoke the consent at any time. The consent may be revoked either in writing or verbally.

Client signature: _____ Date: _____

Helper signature: _____ Date: _____

One copy of the consent may be given to the client. Original copy of the consent is to be retained by the hospital or clinic where the helper is employed.

Introduction to Crisis, Stress and Trauma

Purpose of Training:
To teach community mental health workers about crisis, stress and trauma, and how to respond to someone who has experienced crisis, stress or trauma.

Learning Objectives:
Participants will know how to identify early warning signs of a crisis situation.
Participants will know how to identify situations when it is appropriate to use outside help to resolve a crisis.
Participants will understand the effects of traumatic events.
Participants will know common psychological responses to trauma.
Participants will know ways to help individuals cope with stress.
Participants will understand the different aspects of suicide.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings and References:
Bunn, M. (2005). *Training Outline: Trauma Workshop*. Bangkok, Thailand: Thammasat University.

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Eddy, S. & Harris, E. (1998). Risk management with the violent patient. In P.M. Kleespies (Ed.), *Emergencies in mental health practice: Evaluation and management* (pp. 217-231). New York: Guilford.

Lewis, S. & Roberts, A.R. (2001). Crisis assessment tools: The good, the bad, and the available. *Brief Treatment and Crisis Intervention*, 1, 17-28.

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Roberts, A. (Ed.) (1995). *Crisis intervention and time-limited cognitive treatment*. Thousand Oaks, CA: Sage.

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Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

What is a crisis?
Ask the question, "What is a crisis?" Use this question to begin the discussion. Write down the participants' answers on the board in order for all to see and discuss. The purpose of this discussion is to engage participants in thinking about what kinds of events might fit the definition of a crisis. This discussion may also build empathy for those in crisis. Thank participants for participating in the discussion.

Possible responses include: a situation where a person is in need of urgent attention, having overwhelming problems, being in war, being attacked, not having food, water, or housing.

Everyone will probably experience a crisis at some point in life. Crisis situations are NOW, offering little time for thinking or review. Helpers need to be calm and confident in handling these situations. It is important to know what you should DO and what you should NOT DO. In this training we will discuss what a crisis is and how it develops, review some common crises, and discuss some ways to effectively intervene and respond to someone in a crisis.

Definition of crisis:

- Any event or situation that is so far outside a person's normal experience that he or she is unable to resolve it with usual methods of coping.
- A crucial turning point that demands a decision.

Common components of a crisis
There are common components of a crisis that can help us identify when a situation is a crisis. Let's discuss these now. *(Ask for examples of each of these from the audience)*

- <u>(Usually) Sudden stressful event</u>. *Examples: death of loved one, loss of job, rape, torture, natural disasters, birth, new marriage, (not all crises are due to "bad" experiences)*

- <u>Ongoing high-risk situations</u>. *Examples: long-term illness, homelessness, war*

- <u>Inability to resolve stressful or ordinary situation with normal coping skills</u>. *Examples: conflicts with neighbors or authorities, transition to adulthood, change in resources*

Crisis Perception
If the person perceives the event as a crisis, it is. The event (i.e., the stressful event or high-risk situation) is not necessarily what defines a crisis, but rather the individual's level of distress about the situation that determines whether or not an event is a crisis.

Crisis Reaction
Crises vary between persons. The same event may evoke different reactions from different people. Some people will organize new adaptive behaviors and others will adopt maladaptive behavior. For example, losing a job is a very unpleasant experience for almost anyone. However, some people respond by developing new techniques and resources to cope with the loss and seek a new job, while others become very depressed and see the situation as hopeless.

Some common maladaptive ways of coping with crisis events include grief, anger, excessive sleep, retreat to fantasy, use of alcohol and/or drugs, developing avoidance behaviors or compulsive rituals, and somatic symptoms such as ulcers and migraines.

In order to understand how crises occur, we must first understand the nature of stress.

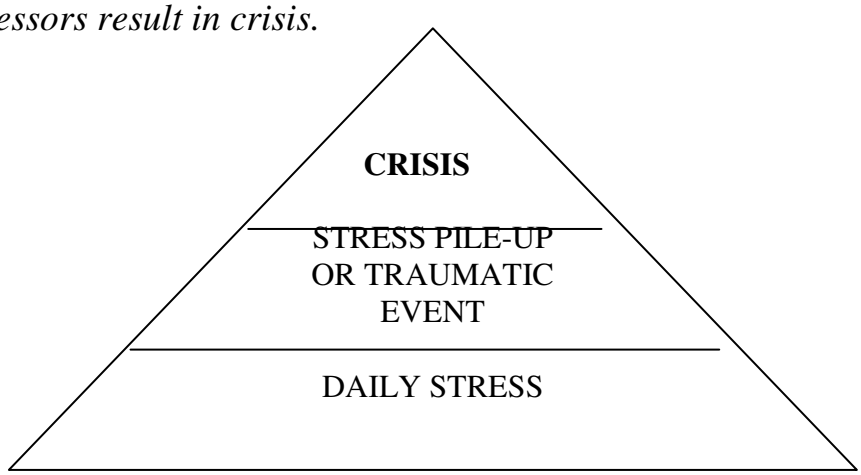
What is stress?
(Wait for responses and thank participants for their answers)

Stress:
- Is the emotional and physical tension or strain that we experience as we attempt to adjust to our constantly changing environment
- Can either help us or hinder us depending upon our reaction to it
- Can create both positive and negative feelings
- As a positive influence it can motivate us to action
- As a negative influence it can result in emotional and/or physical distress or illness *(Examples: Feelings of depression, anger, fear, distrust, headaches, stomach problems, difficulty sleeping, high blood pressure)*

Stress and Crisis
Stressful events are common to nearly everyone's life. Most people are able to handle the ordinary stressors (daily hassles) life brings, e.g. meeting work

requirements and schedules, handling family matters, working out differences in relationships. However, the stress experienced as a result of a single significant event, such as death of a loved one or loss of a job, may precipitate a crisis. Let me demonstrate this for you.

Draw the following diagram on the board. Its purpose is to help people see the relationship between stress, trauma and crisis. It is important to emphasize that not all stressors result in crisis.



Daily Stress

At the base of this pyramid we have the daily stress that occurs in everyone's life. Most of the stress that we experience is not significant enough to lead to crisis. And most people handle these stresses without much difficulty.

Can you give me examples of daily stress that many people experience without going into crisis? *(Wait for responses and thank participants for their answers. Examples: going to work, driving in traffic, caring for children)*

Stress Pile-up

Several small stressful events can simultaneously occur, pile up or accumulate, in a short period of time, which can precipitate a crisis. Some individuals may be able to cope with each event as it comes along, but at some point, they reach their emotional limit (or breaking point) and a crisis ensues. The situation that eventually provokes the crisis may be relatively minor, but when added to the other stressors, it is enough to push the person past a point of feeling in control of the stress.

Can you give me examples of accumulated stress (or stress pile-up) that may lead to crisis? *(Wait for responses and thank participants for their answers. Example: baby is born and mother becomes ill and cannot care for baby)*

Traumatic Events

Crises occur in any setting and can happen to anyone. Extremely serious stressful events are referred to as traumatic. Traumatic events include the types of things one sees in a war, a death of someone close to them, or rape. These extraordinary stressful events can often lead to crisis regardless of the existence of other stressors in an individual's life.

Can you give me an example of a traumatic event that alone can lead to crisis? *(Wait for responses and thank participants for their answers. Examples: rape, torture, death of a loved one, natural disaster)*

Let us discuss trauma in further detail.

What is trauma?

(Wait for responses and thank participants for their answers).

Trauma is a physical and psychological response to traumatic events. Trauma affects the way that people think, feel, and behave.

Can you give me an example of how trauma affects the way that an individual thinks? *Examples: forgetfulness, loss of concentration and memory*

Can you give me an example of how trauma affects the way that an individual feels? *Examples: fearful, depressed, distrustful*

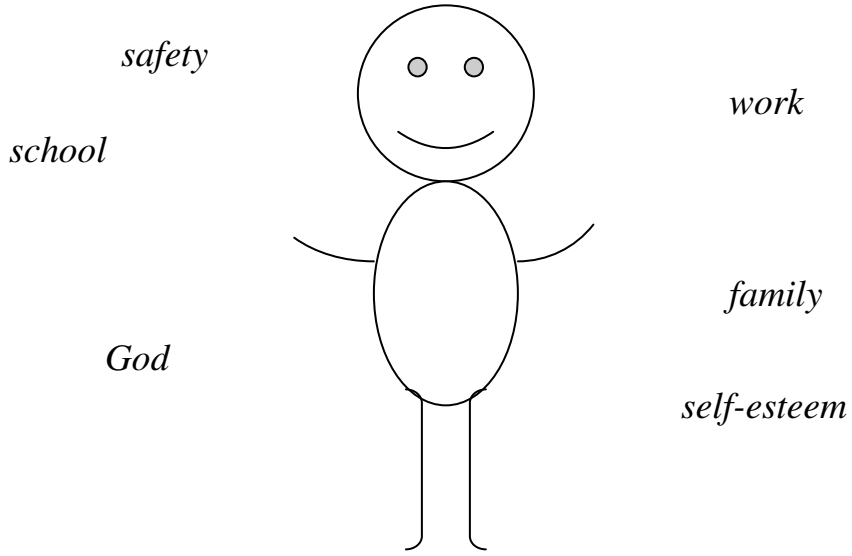
Can you give me an example of how trauma affects the way that an individual behaves? *Examples: withdraws, isolates, lacks energy*.

What is fundamental to perceived trauma is that the individual's worldview is shattered—there is no meaning, control, connection, safe place, or dependable individual. The individual reacts with helplessness, disconnection, powerlessness, loss of control, difficulty in communicating, and chronic or disrupted feelings of fear and vulnerability. You will note that this very reaction is a barrier to obtaining help. No one is safe, and there is no way to communicate.

Draw a stick figure of a human body on the board. Use this drawing to begin a discussion on the effects of trauma in a person's environment. Ask participants to give you an example of a relationship or function in a person's life that would be affected by the person's trauma. For example: School-the trauma may lead the person to stop attending school; Job- the person may not be able to work; Family- the person may not be able to care for his/her family.

The purpose of this group discussion is to help participants realize that trauma affects every relationship and interaction that the individual has. Another purpose of this exercise is to build empathy and understanding for those who suffer from trauma.

When we think of an individual who has trauma, what areas of his or her life do we think are affected by the trauma? *(Write answers on the board, surrounding the figure of the person. Example:)*



Real and Perceived Trauma

Trauma may be a response to:

- Actual experiences that are violent or life-threatening for the person.

  Can you give me examples of REAL threats? *(war, rape, torture, assault with a weapon or animal)*

- Incidents that are PERCEIVED as being violent or life-threatening.

Can you give me examples of PERCEIVED threats? *(believing that rape or torture will occur again, fearing another war will take place, living in a neighborhood where people are often assaulted or killed)*

It is important to remember that traumatic events do not necessarily have to take place in order for a person to be traumatized by them. In other words, even if someone was not harmed by an event, or could not possibly have been harmed by the event, it does not really matter because if the person BELIEVES that the danger truly existed, then the individual was traumatized.

Do you have any questions?

Primary and Secondary Trauma

There are two types of trauma that you will encounter in your job:

Primary trauma occurs when people experience or witness traumatic events firsthand.

Secondary trauma is experienced when people read newspapers, watch television, or listen to others talk about traumatic events. Secondary trauma can have a tremendous emotional impact on community mental health workers, in particular, who provide comfort and empathy to victims of trauma. This means it is important for you to learn and practice ways of coping with trauma yourself.

Crisis Prevention

One way to help people is to prevent stressful events from escalating into crises. Whenever possible, it is best to intervene early to prevent escalation and defuse the situation. This can be accomplished when you:

- Learn the early warning signs of crisis and
- Encourage persons to develop coping skills for dealing with potential crises.

Learning Early Warning Signs

People who have repeated crises may be able to identify early warning signs that indicate early stages of a crisis or increased vulnerability and high-risk situations for crisis responding. You can use simple questions to help them identify their early warning signs. It is important to use these questions when they are not currently in the middle of a crisis. Here are some examples of questions you can ask?

- Think about the last time you were in crisis, what happened early in the crisis?
- How were you feeling at the time?
- What thoughts came to your mind?
- What are some things that might tip you off (provide a clue) that a crisis is coming again?

Have the individual list their answers to these questions and keep track of them so that they can identify when crisis is occurring again.

Common Early Warning Signs of Crisis
Specific signs of crisis are unique to the individual, but some kinds of signs appear frequently. Some common early warning signs of crisis include:

- Sleeping difficulties (either increased or decreased)
- Inability to concentrate, feeling jittery, irritable, and tense
- Upset stomach, eating problems
- Social withdrawal
- Crying, very fragile emotional state
- Confusion: feeling overwhelmed, chaotic
- Fatigue
- Pains, headache

Can anyone add any signs of crisis to this list? (Wait for responses and thank participants for their answers)

Remember that appearances may be deceiving. While it is important to note the individual's appearance, the outward appearance of someone should not be used to determine the extent of crisis. The person may exhibit a normal appearance, but be in shock and require appropriate interventions. In addition, many people ignore or deny an emotional problem because of mental illness stigma. Expression of emotional distress is culturally variable and may be expressed as physical symptoms. Individuals may put up a good front, try to continue their usual activities, and not seek help until a situation is completely out of control and they are in the height of a crisis.

Suicide and Parasuicidal behavior
Suicide and parasuicidal behavior are specific types of crises that require special immediate attention.

Suicide is intentional self-inflicted death.

Parasuicide refers to:

1) non-fatal, intentional self-injurious behavior resulting in actual tissue damage, illness, or risk of death; or
2) taking a drug or other substance with the intent to cause bodily harm or death.

Parasuicide includes:

1) suicide attempts
2) self-injury with no intention to cause death
3) suicidal gestures and manipulative suicide attempts

The term parasuicide is preferred because it describes a behavior without an inference of motivation or intent and because it is less pejorative. People may engage in parasuicidal behavior for a variety of reasons, including as a way to regulate mood. It may be helpful to assist them in identifying alternative ways to cope with the pain they experience. Never assume that parasuicidal behavior is only a gesture or an attempt to manipulate and ignore it. All attempts may potentially lead to death.

Refer to handout titled "Suicide Risk Factors" and discuss each item in detail.

Aggression and Violence

Aggression and violence are crises that also require immediate attention. They can take place in any location that serves the public and may be increased in hospitals who serve people in distress. It is very difficult to accurately predict whether or when a particular individual will be aggressive. Aggression can take many forms: verbal aggression; aggression against oneself; aggression toward objects; aggression toward others, including violence and other aggressive acts toward other people; and intimidation. As with suicide, inform your supervisor and follow your team's protocol if a person becomes aggressive.

Coping with Crisis

Adaptive resources help people cope with crisis. Adaptive resources are resiliency factors that include:

- personal resources (such as an individual's strengths and skills, psychological and physical health, finances and education)

For example, Fatimah has been diagnosed with cancer. Physically, she has been feeling very weak lately. And on many days she is unable to get out

of bed. Although her physical health is poor and she is no longer as active as she once was, Fatimah can still rely on her intelligence and strong spiritual beliefs in order to help her through her crisis. Fatimah prays every day and continues to read books and write letters to friends as a way to help her cope with the cancer.

What are some other personal resources that could be resiliency factors to help Fatimah cope? *(Examples: ability to choose between treatment options, good sense of humor, money to pay for medication)*

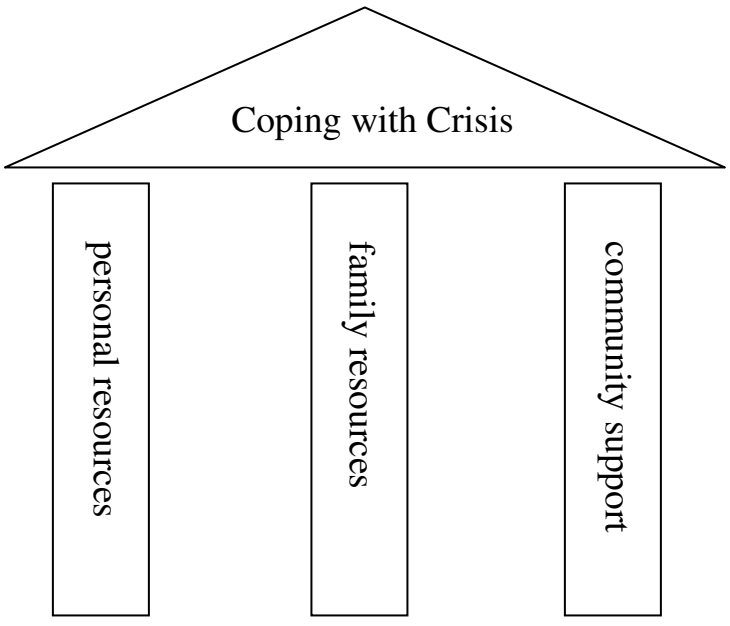
- <u>family resources</u> (such as family cohesion/closeness, adaptability and communication)

For example, when Fatimah is unable to leave bed, her daughter Jamila, age 12, will bring her food and tea, and will sit with her to talk for a while so that Fatimah does not feel lonely.

- <u>community support</u> (such as friendship and emotional support from neighbors and coworkers).

For example, when Fatimah's husband, Hakim, is unable to leave his work in order to take Fatimah to the hospital to see the doctor, their neighbor Naima will drive Fatimah to the hospital. Naima makes an effort to visit Fatimah frequently to talk about things that are happening in the neighborhood.

Draw this diagram on the board to show how the three types of adaptive resources help the person cope with crisis.



We can use this diagram to demonstrate how the three types of adaptive resources can help an individual cope with his or her crisis. The three adaptive resources are represented by three pillars that hold the roof on this building. As you can see from this diagram, even if one pillar becomes cracked or is missing, there are still enough adaptive resources to keep the roof from falling. However, if two of the pillars are missing, the roof will collapse.

Another important point to keep in mind is that, as community mental health workers, you will have the task of helping people strengthen their adaptive resources (e.g., learning new skills, finding jobs, developing new social relationships).

There are a number of simple things that you can do to help people cope with crisis. *(Refer to handout titled "Coping with Crisis").* This handout lists simple things that people can do to feel better every day, even when they are in the middle of crisis. Become familiar with these suggestions and think of new suggestions that you can use when you are helping people learn to cope.

Key Points to Remember

1. A crisis is any event or situation that is so far outside a person's normal experience that he or she is unable to resolve it with usual methods of coping.
2. A crisis is also a crucial turning point that demands a decision.
3. Trauma is a physical and psychological response to traumatic events.
4. Trauma affects the way that people think, feel, and behave
5. We can help people cope with crises and trauma by helping them build their adaptive resources (or resiliency factors).

HANDOUT

Suicide Risk Factors

Factors that increase the risk of suicide:

- Second mental or substance abuse disorder
- Hostile and/or rigid temperament
- History of sexual abuse
- History of previous suicide attempt
- Hopelessness
- Inability to carry out activities of daily living
- Stressful life events, e.g. loss of a close relationship

Coping with Crisis

There are many things that can happen in life that can cause you to feel ill, uncomfortable, upset, anxious, or irritated. Here are some things you can do to help yourself feel better quickly. Read through the following list. Check off the ideas that appeal to you and give each of them a try. Use these techniques whenever you are having a hard time or as a special treat to yourself.

- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading or gardening.
- **Get some exercise.** Exercise is a great way to help you feel better while improving your overall stamina and health. The right exercise can even be fun.
- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings. All ways are correct. Don't worry about how well you write. It's not important. It is only for you.
- **Use your spiritual resources.** Spiritual resources vary from person to person. For some people it means praying, talking with your Imam, or talking with a spiritual leader.
- **Do something routine.** When you don't feel well, it helps to do something "normal" the kind of thing you do every day or often, things that are part of your routine like taking a shower, washing your hair, making yourself a cup of tea, or calling a friend or family member.
- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.
- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information about it at a library or on the Internet. Go to a class.
- **Listen to music.** Delight yourself with music you really enjoy. If you enjoy music, make it an essential part of every day.
- **Make music.** Drums and other kinds of musical instruments are popular ways of relieving tension and increasing well-being. Perhaps you have an instrument that you enjoy playing, like a harmonica, oud, piano, or guitar.
- **Sing. And Dance.** It fills your lungs with fresh air and makes you feel better. Sing and dance by yourself. Sing and dance for the fun of it. Sing and dance along with your favorite music. Sing and dance to your favorite songs you remember from your childhood.

Perhaps you can think of some other things you could do that would help you feel better.

Hope, Empowerment and Recovery

Purpose of Training:
To teach community mental health workers about hope, empowerment, resiliency and recovery for people with mental illness.

Learning Objectives:
Participants will learn a paradigm for recovery
Participants will know how to define wellness and describe it using multiple dimensions of well-being
Participants will know how hope and empowerment promote recovery
Participants will learn factors that contribute to resiliency
Participants will know how to identify and discuss the case manager's role in supporting recovery

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings:
Anthony, B. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159-168.
Mead, S., & Copeland, M.E. (2000). *What recovery means to us*. New York: Plenum Publishers. Available at www.mentalhealthrecovery.com
Ralph, R.O. (2000). Recovery. *Psychiatric Rehabilitation Skills*, 4(3), pp. 480-517.

References:
Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

What is recovery? Have you ever heard of it before?

Ask the question, "What is recovery?" Wait for participants to respond and thank them for their answers. This question may give you an idea of the current level of understanding among the participants concerning recovery. Be sure to write the answers on the board. Some possible answers include: free from disease, getting better, recuperation, return to normalcy.

We will begin this training session by discussing recovery, what it means to recover, and what is required to recover. And then we will discuss how hope and empowerment can aid in recovery.

Defining Recovery

As you can see there are many different views of recovery. When we talk about recovery from mental illness we are talking about restoring a person to an optimal level of functioning. For example, restoring a man to the ability to function with his family or in his community so that he may be able to have a job, friends and a family of his own.

It may be helpful to refer the audience to the continuum used earlier in the training session on the Introduction to Mental Illness. Remind them that a person can move back and forth along this continuum.

GREAT	NORMAL	DISTRESSED	SEVERE
Elated	*Okay*	*Sad*	*Suicidal*
Very Happy	*Content*	*Depressed*	*Hallucinating*
Excited	*Happy*	*Worried*	*Psychotic*

There are two things to remember about a person's optimal level of functioning:

1. An "optimal level of functioning" will vary from one person to the next.

In other words, an optimal level of functioning for one person may not necessarily be an optimal level of functioning for another person.

For example, Amir's optimal level of functioning may permit him to be fully employed and living independently, while Yusif's optimal level of functioning may permit him to bathe and dress himself with assistance. As you can imagine, Amir and Yusif have extremely different lives with vastly different daily activities, yet both men have reached their optimal level functioning.

2. The individual's "optimal level of functioning" is actually determined by that individual's particular strengths, interests, impairments, goals, etc.

So when we compare Amir and Yusif, perhaps we discover that Amir's illness is not as debilitating as Yusif's illness. Or perhaps we discover that Amir is in his twenties and Yusif is in his sixties! Do you have any questions?

Recovery and Wellness
This is probably a good time to discuss *wellness* as it relates to recovery. We are going to learn how to look at wellness in a different way, by discovering that a person can be without wellness in one area of life and yet can be very well in another area of life.

What is Wellness?
(Write answers on the board. Example: healthy)

Wellness is the presence of physical, emotional, social and/or environmental well-being.

Remember, when helping an individual with mental illness, well-being should always be considered within the context of the individual's current or potential

abilities and goals. This means that what wellness might mean to Amir who is 23, may vary greatly from what wellness might mean for Yusif who is 63. For Amir, wellness might mean the ability to complete several intensive workouts every day while simultaneously maintaining a relationship with his wife. For Yusif, wellness might mean regular contact with his children and a walk around the building three times a week.

Using this example you have probably already figured out that not only does the meaning of wellness vary from one person to the next, but it also means that probably no one in the world is perfectly able to achieve his or her greatest ability in all domains of life. For example, maybe Amir can claim to have a high degree of wellness in the area of exercise habits and physical strength. But perhaps he has a very low degree of wellness in the area of emotional stability. It is not uncommon for an individual to have positive well-being in one part of life while being in a great deal of need in another part of life.

Exercise 1: Dimensions of Well-being

Instructions for Exercise 1: The goal in this exercise is to help participants begin to recognize the strengths that people have in their various domains of functioning. Provide participants with the handout titled, "Dimensions of Well-being" so that they may have this for future use. Draw four horizontal lines on the board and label each according to the diagram below. Write "very poor" on the left end of the lines and "very high" on the right end of the lines as indicated. Then read the instructions to the group and ask the group if they have any questions before beginning the exercise.

Then readthe vignette below and permit the group to engage in an open discussion about where on the continua the individual's four dimensions of well-being may exist. After the exercise, debrief by asking the group what they thought about the exercise, what they discovered about dimensions of well-being, and how they might use this perspective in helping others.

DIMENSIONS OF WELL-BEING

Very poor _____ *Very high*
Physical

Very poor _____ *Very high*
Emotional

Very poor _____ *Very high*
Social

Very poor _____ *Very high*
Environmental

Now we are going to participate in a group exercise. I will read a story about a person, describing the emotional, physical, social and environmental well-being of this person. Think about where this person's well-being in each area may appear on various points along the continua, from very poor to very high. Are there any questions before we begin?.

Mohamed, is 45 years old, and has a store where he works each day. His wife Sarah, who is 40 years old, stays at home and helps with the housework and cooking. They live with Mohamed's extended family — his parents, his three brothers and their wives, and Mohamed's two sisters. There are 19 children in the home, including Mohamed and Sarah's four sons and two daughters. Lately Sarah has been unable to sleep. She has nightmares and during the day she is afraid to go outside. She is easily startled. And on occasion she feels attacks of panic come over her, during which she is unable to catch her breath. Mohamed is very worried about her because he thinks she may be traumatized because of the war and all that she has seen. So Mohamed takes Sarah to the doctor, who says that Sarah is really traumatized. The doctor says that Sarah needs medication, however, there are no medications available where they live. Although Sarah does not have access to appropriate medications, she has learned some effective coping skills for dealing with her problem. For example, she has learned to stay busy taking care of her children, cooking and cleaning for her husband. She has been in fairly good health but recently she has not been eating well.

So, based on what we have read, how is Sarah's physical well-being?

How is Sarah's emotional well-being?

How is Sarah's social well-being?

How is Sarah's environmental well-being?

Do you have any questions?

Recovery is a Process
Recovery is a process, not an outcome. Recovery takes time.

When we talk about recovery we are actually talking about a long and complex process during which the individual with mental illness experiences changes in his or her attitudes, feelings, goals, behaviors, and/or skills.

For example, when a person with mental illness gets better, his or her attitude improves. He or she begins to feel better. He or she is happier. He or she may be able to sleep better. He or she may become more motivated to work, or might want to go back to school to learn something. Or perhaps the person will become more engaging in life, with family and friends.

Recovery Can Bring Relief from Symptoms and Disabilities
Recovery includes relief from the symptoms and disabilities of the illness, and it also involves improvements in certain areas of life that may have been negatively affected by the illness such as work, school, relationships and hygiene.

It may be necessary to explain or review common terminology such as diagnosis, disability, symptom, sign, treatment and/or rehabilitation.

Diagnosis is the act of identifying a medical disease or disorder based on the existence of certain symptoms or signs.

Disability is a condition or impairment that limits an individual's activities or level of functioning in life.

Signs are behaviors or indications of disease that can be observed by others.

Symptoms are changes in functioning or sensations that are experienced and/or reported by the individual experiencing the symptoms.

Treatment refers to the procedures or applications that are meant to relieve the symptoms or signs of the illness.

Rehabilitation is the process or program aimed at helping individuals with disabilities regain and maintain their optimal level of functioning.

It may also be necessary to conduct a brief discussion about how mental illness impacts the individual's life. Examples include: relationships, self-care, vocational.

Recovery is Different for Each Individual
Even the process of recovery itself will look different between Amir and Yusif. You see, even if Amir and Yusif were both the same age, 23 years old, Amir will probably recover from mental illness in a different way than will Yusif. The reason why recovery is different for each individual is because we each have different life histories, attitudes, feelings, values, skills, etc. These factors may affect the way we experience mental illness, and these factors may also affect the way we recover from the mental illness.

Three Things to Remember about Recovery

1. A doctor is not necessarily the only person who helps an individual with mental illness get better. The person also needs social support, in the form of close family and friends who consistently make themselves available to listen, understand and to provide encouragement for the individual.
2. Even though we might not know the causes of mental illness, we DO know that people CAN recover from the effects of trauma, depression, etc.
3. Some symptoms never fully disappear, but their frequency and duration usually decrease with recovery. For example, someone recovering from PTSD may still experience nightmares during the night, but may still be able to wake up in the morning and go to work without any problems.

Are there any questions?

Recovery requires change
Recovery involves action on the part of the individual with the mental illness and it requires the individual to make certain changes in the way that he or she thinks and behaves.

Change is difficult for everyone. For each of us, there tends to be a natural tendency to resist change because change is painful. For the individual in recovery for mental illness, change may be particularly painful for two reasons:

1. In order for change to take place the individual has to first admit that something is wrong or needs to be fixed. For example, a person may have previously spent years trying to cover up the signs of domestic violence. But things will not get better until the person admits there is a problem that needs to be changed.

2. It is always easier to continue with the way things are. In other words, a person struggling with the thought of dealing with domestic violence may think it is easier to continue doing what he or she has always done than to take the risks involved in attempting to change.

Have you ever known someone who appears to be miserable in his or her current situation but seems to be more afraid of the unknown consequences that may occur if he or she made a change to that miserable situation?

Keep in mind that change does not necessarily have to be bad to be painful. Even good change can be painful or frightening. And sometimes when people initially believe that change is bad, they may later come to view the change as being a good thing when they look back at what resulted from the change.

Recovery is a Choice

Recovery is a choice and cannot be forced on another individual.

- Rehabilitation techniques can assist you in helping to motivate people in recovery
- But the ultimate decision to recover must be made freely and without coercion
- We cannot force people to recover.

We can show a man a path, but we cannot force him to walk on it.

Recovery Requires a Safe Environment

- Individuals need a safe environment in which they may choose recovery.
- They also need a safe environment in which they may do the work required for recovery.
- It may be helpful for you to view recovery as a way that individuals with mental illness can approach the challenges that they face each day.

- By approaching their challenges as being *opportunities* rather than as being barriers, they are able to bring about their own growth and healing.

Are there any questions?

Hope is a motivator for recovery
One of the ways that you can nurture individuals in order to motivate them for recovery is by instilling *hope*.

- In times of despair when people do not feel as if their situation can improve, they need to be given the idea that things *can* get better for them.
- Part of some mental illnesses is a profound loss of faith and hope. This loss of faith is the **result** of the illness, not the **cause** of the illness.
- People have to believe that there exists a real possibility for their life to improve.
- One of the most important and most fulfilling roles you have in helping other people is that of instilling *hope*.
- People have to believe that their situation *can* and *will* get better in order for them to make improvements. Without hope they will not take action; without hope they will not take the risks involved in making change.

Use an appropriate example of how a person had hope that things would get better and in time things did indeed get better. An example: People in Kurdistan believed that there would be a political change and in time they got the attention of Americans who helped bring about change for their community.

How do we build hope?
Wait for participants to respond and thank them for their answers.

Instilling hope is an effective way to help people change their life. Here are some ways that you can build their hope:

1. View the situation more positively. Help them see that recovery IS possible. Individuals have to possess the belief that their action toward change will ultimately bring about their desired outcome.

2. Focus on recovery rather than on illness. Focus on the destination rather than on the rocks and ruts in the road. For example, rather than emphasize the individual's symptoms or complications due to his or her illness, you can discuss the positive improvements that have been made in his or her life as a result of the changes that have been made.

3. Normalize their experiences. A powerful way to demonstrate your respect for the dignity of the people you help is to convey to them that you understand what they are going through. This can be difficult. You understand them by listening even though you cannot know what they have gone through since you are not them.

4. Focus on their strengths rather than their weaknesses. For example, instead of concentrating attention on areas in their life that are in need of improvement, identify and concentrate on skills that individuals have to offer. And then look for ways to enhance these skills.

5. Create a supportive and safe environment. This not only refers to the safe and supportive environment that you create when you work directly with the individual, but it also refers to helping the individual develop a supportive network of friends and family who can also create a safe environment in which the individual can take new risks in making change.

Finally, remember that hope is limitless. With a caring environment, and with the belief that the individual can bring about change, you will find that people have tremendous capability to contribute to their own recovery.

What is Empowerment?
Wait for participants to respond and thank them for their answers

Empowerment refers to giving individuals or families the ability to take more control of their own decisions in recovery.

Part of your job is to help people become empowered.

- Individuals may want to speak with their families about any decisions to make.
- Individuals/families who are empowered have a sense of control over their lives and over the choices that they make.

- People who are empowered express feelings of self-worth.

Although you cannot empower another person, there are things you CAN do to increase opportunities for empowerment so that they may empower themselves:

1. You can present your clients with choices about their treatment options, housing, medication and jobs. When they make these decisions for themselves, they are empowered.
2. You can provide personal respect and encouragement. Confidence, self-esteem, and self-respect contribute to empowerment.
3. You can have them focus on things they can *do* for themselves as opposed to focusing on things that they cannot do.

Can you think of other things you can do to help people empower themselves?

Many people look at a family's resiliency as being a reason to NOT help the family. For instance, some people may incorrectly think that because a family has survived a tragedy then that family has automatically overcome all of its hardship, pain and barriers that are related to the tragedy. They may wrongly assume that because the family is resilient, then the family does not need help. This next section attempts to view resiliency from the perspective of utilizing resiliency to identify and build on the family's strengths.

What is Resiliency?
Wait for participants to respond and thank them for their answers

Resiliency means to "bounce back" from a crisis or problem. It is being able to rebound or return to conditions the way they were before the crisis. For many people, resiliency can help them survive traumatic experiences.

Iraqis are very resilient people, but this does not mean that Iraqis do not need help to rebuild and rebound from all that has been experienced. As helpers, it is your job to promote resiliency in families, in order to help them recover from whatever challenges and crises they may be facing. You will accomplish this by helping families recognize that they have survived and therefore have skills and strengths that they can use to become more empowered. You will also help them identify how they have coped before, during and after the crises. This too may help them feel more empowered. In essence, you will help families realize that they are resilient and help them build on their resiliency.

(Refer to the handout titled, "Five Characteristics of Resilient Families" which lists examples of family strengths. It is important to note that this list of characteristics is not all-inclusive and may vary from one family to the next).

As you can see from the handout titled, "Five Characteristics of Resilient Families," there are several factors that can help us assess how resilient a family might be. These factors also give us clues to how we might help a family become more resilient and empowered. Resilient families tend to be:

1. Adaptable. They are capable of coping with everyday problems because they learn to adjust to new situations. For example when a family member becomes ill cannot do housework, another family member will do the housework instead.
2. Roles. They have clearly defined roles and responsibilities within the family. For example, the father knows that his family depends on him to go to work each day so that they will have money to survive. He also knows he can depend on his wife to care for the house and children while he is away.
3. Relationships. Resilient families know how to build and develop new relationships with others. For example, they have strong relationships with extended family members, neighbors and friends in their community. These relationships can be very useful in times of need or crisis.
4. Commitment. Resilient families are committed and loyal to one another. For example, even when times are difficult, the family remains intact and functioning as a cohesive group.
5. Courage. Resilient families keep going and do not give up in spite of the trauma they experience. They have the courage to work hard to become more resilient. For example, a resilient family will have the courage to let go of things like anger, in order to bring about healing and forgiveness.

This list represents only a few of the characteristics that you will notice in strong Iraqi families. There are probably many more that we could add to this list. As a helper you will want to assist families in identifying their own strengths and find out areas that they wish to improve, in order to build on their strengths and resiliency. To demonstrate this, let's do an exercise.

Exercise 2: Group Discussion

Remember the story of Mohamed and Sarah that we discussed earlier? Remember, Mohamed is 45 years old and goes to work at his shop each day. Sarah, his wife, is 40 years old. They have four sons and two daughters, and

live with Mohamed's extended family members. Mohamed and Sarah have suffered many years of war and Sarah is traumatized. She experiences panic attacks and does not want to leave the house. Sometimes her depression is so bad that she stays in bed all day. Their oldest daughter, Fatemah, age 14, helps with the cooking and cleaning. On the days when Sarah is not doing well and cannot leave her bed, Fatemah works extra hard to keep the younger children quiet so that Sarah may rest. And when Mohamed is away at work and no other adult relatives are at home, Fatemah goes to the neighbor for help when she doesn't know what to do.

Conduct a group discussion by asking questions like these:

Based on what we know about this family, would you say that they are resilient?

Using the handout titled, "Five Characteristics of Resilient Families" which areas would you say are STRENGTHS for this family? And why?

If you were helping this family and wanted to assess their resiliency in other areas in order to find out if they have other strengths, what would you look for?

(Possible answer = Find out if they have clear roles by asking what activities they do. Is someone responsible for cooking? For shopping? For gardening?)

Are there any other areas that you are interested in finding out about Sarah and Mohamed's situation?

Do you have any questions?

Key Points to Remember

1. Recovery from mental illness is about restoring a person to his or her optimal level of functioning.
2. An "optimal level of functioning" will vary from one person to the next.
3. The individual's "optimal level of functioning" is actually determined by that individual's particular strengths, interests, impairments, goals, etc.
4. One of the ways that you can nurture individuals in order to motivate them for recovery is by instilling *hope.*
5. Empowerment refers to giving individuals or families the ability to take more control of their own decisions in recovery.

HANDOUT

DIMENSIONS OF WELL-BEING

Very Poor _____Very High

Physical

Very Poor _____Very High

Emotional

Very Poor _____Very High

Social

Very Poor _____Very High

Environmental

HANDOUT

FIVE CHARACTERISTICS OF RESILIENT FAMILIES

1. **Adaptable.** They are capable of coping with everyday problems because they learn to adjust to new situations. For example when a family member becomes ill cannot do housework, another family member will do the housework instead.

2. **Roles.** They have clearly defined roles and responsibilities within the family. For example, the father knows that his family depends on him to go to work each day so that they will have money to survive. He also knows he can depend on his wife to care for the house and children while he is away.

3. **Relationships.** Resilient families know how to build and develop new relationships with others. For example, they have strong relationships with extended family members, neighbors and friends in their community. These relationships can be very useful in times of need or crisis.

4. **Commitment.** Resilient families are committed and loyal to one another. For example, even when times are difficult, the family remains intact and functioning as a cohesive group.

5. **Courage.** Resilient families keep going and do not give up in spite of the trauma they experience. They have the courage to work hard to become more resilient. For example, a resilient family will have the courage to let go of things like anger, in order to bring about healing and forgiveness.

Intake and Assessment

Purpose of Training:
To teach community mental health workers how to conduct a client intake and assessment interview in helping individuals with emotional distress or mental illness.

Learning objectives:
Participants will understand the importance of conducting a thorough intake and assessment.
Participants will know how to use the Patient Intake Sheet to document present and historical information about the client.
Participants will know how to identify some principles for the follow-up sessions in helping clients.
Participants will know how to help clients discuss chief complaints and symptoms.
Participants will be able to provide four reasons why it is important to keep clear and accurate records.

Training Format:
Didactic lecture, group exercises and group discussions

Equipment:
Chalkboard, flipchart or dry erase board with markers. Overhead projector or LCD projector (optional)

Presentation Materials:
PowerPoint slides or transparencies and handouts

Recommended Readings:
Egan, G. (1998). The skilled helper: A problem-management approach to helping. Pacific Grove, CA: Brooks/Cole.

Recommended Readings and References:
Psychiatric Rehabilitation Certificate Program (2000). Tinley Park, IL: University of Chicago Center for Psychiatric Rehabilitation
American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorder, 4th Edition-Text Revision. Washington, D.C.: APA.

Training Script:

Welcome, Introductions and Daily Agenda

Begin each training day with a friendly greeting. Introductions should be made (when appropriate). Discuss logistics regarding restroom location, lunchtime and breaks, the need (or not) for taking notes, any assessments (e.g., pretest/posttest) that will take place, format of the training, and expectations regarding individual and group participation. Complete any unfinished business, answer any questions or review homework from the previous training.

Discuss the Purpose of today's training.

Review the Learning Objectives for today's training.

What is an intake?

Ask participants "What is an intake?" Wait for responses and thank participants for their answers.

Intake:

- Initial interview with a new client or patient
- Usually the first step taken by a CMHW when a client seeks help
- A process whereby a client requests service and a determination is made regarding the kind of service (if any) to be provided
- The CMHW attempts to gather initial information from the client in order to determine what help is needed
- The CMHW provides the client with information about the:
  - treatment and services that may be provided
  - service providers (i.e., facility, CMHWs, doctors, etc.)
  - client's rights (e.g., confidentiality)
  - referrals and resources

What is an assessment?

Ask participants "What is an assessment?" Wait for responses and thank participants for their answers. Also, use participant answers when covering the following points. For example, "as Mohammad pointed out, one of the purposes of assessment is…"

Assessment:

- A judgment concerning the client's current condition based on information gathered from the client and possibly other sources, including a medical, psychological and family history
- Information about the problem for which the client is seeking help, used to determine whether the client should receive services, referral, and/or additional assessment
- The ongoing gathering of information to aid in planning and providing treatment

Assessment can be viewed as having three purposes:

1. Description – To communicate the details of something, such as describing a person's appearance, behavior, interactions, etc.

   For example, Mamir arrives at the clinic today and his hair is not combed. His face has not been washed and his clothing is filthy and tattered. He walks slowly across the room, with his eyes looking toward the ground as he approaches you.

   Is there anything about Mamir's appearance that may be important in assessment? *Lead a brief discussion about the value of observation (as a tool for gathering information) in conducting an assessment*

2. Prediction – To foretell what might occur at some later date based on information that has been gathered, such as with repeated hospitalization following substance abuse. Treatment planning is a form of prediction, since you are predicting that a particular intervention will help the client achieve a goal or resolve a problem.

   For example, Sera states that she would like to stay out of the hospital and live with her family in their home. She has been in the hospital four times in two years since she first started having problems with hearing voices. Sera usually does very well for several months after being released from the hospital. She responds very well to medication. But in time she becomes bored, stops taking her medication, and her symptoms come back again.

   Is there anything about Sera's past history that may be important in assessment? *Lead a brief discussion about the value of noting patterns of behavior and events in conducting an assessment.*

3. Evaluation – To examine and analyze the effectiveness of the individual's treatment plan and the treatment program itself. In an ongoing assessment process, information is gathered to find out what effect the treatment plan (and the services you provide) are having on the client. For example, are goals being met? Should the services be changed or continued?

   During the past three months, Dadwar reports that his depressive symptoms have decreased. This was Goal #1 on his treatment plan when he first arrived at the clinic. He has been taking his medication each day and he reports that he has had no adverse side effects. He also reports that he has not had a panic attack in the past two months. Although Goal #2 on his treatment plan was for Dadwar to return to work, he has not been able to return to work yet because he is still afraid that his anxiety symptoms may return and embarrass him while at his job. However, he says that has been thinking more positively about eventually returning to work if he continues to progress in treatment.

   Is there anything about Dadwar's progress (or lack of progress) that may be important in assessment? *Lead a brief discussion about the value of assessing each individual goal separately, in addition to assessing the overall progress of a client in treatment*

Are there any questions?

Why are the intake and assessment interviews important?
Wait for responses and thank participants for their answers

The intake and assessment processes provide key information to be applied in planning and providing services to your clients and their families.

The information that you gather during intake and assessment determines what types of services and resources are appropriate in meeting the needs of the individuals and families who seek your help.

When you conduct an accurate and thorough intake and assessment interview, you are helping streamline the provision of services, so that the busy physician can work more efficiently in helping many clients.

The information you gather during intake and assessment can help you identify types of resources and referrals that you can use in helping clients. For example, you may discover that in addition to seeing the doctor for medication, the client may also need help from you in order to find a job or find a place to live.

By conducting a timely intake and assessment, you become instrumental in the early identification, assessment, and treatment of problems that could possibly get worse for the client if the problems are ignored or treatment is delayed. When significant problems or needs are identified through intake/assessment, then appropriate services or referrals can be made to assist people in overcoming their problems or meeting their needs.

What are some specific steps you must take in conducting the initial intake and assessment interviews?
Wait for responses and thank participants for their answers. Write their answers on the board and conduct a short group discussion. Answers may include:

- Establish rapport with the client. For example, the use of warmth, empathy, genuineness and sensitivity can help the client feel more comfortable about discussing his or her problems.
- Structure the interview. For example, have a clear idea of how much time you plan to spend with the client and find a safe place where the client can discuss his or her problems in confidence.
- Introduce yourself. Use a culturally and socially appropriate greeting, introduction, and explanation of what will occur during the interview.
- Gather information. The interview should be information seeking, not judgmental. Probe for detail and explore inconsistencies, but do not cross-examine the client.
- Convey interest and concern. Listen attentively and ask questions or make comments that demonstrate your interest in what the client is discussing.

What are the minimum standards regarding information you must give the client when conducting the initial intake and assessment interviews?
Wait for responses and thank participants for their answers. Write their answers on the board and conduct a short group discussion

There are certain procedures or rules that apply to the intake and assessment processes. Over time you may become familiar with more procedures and rules

at the facility where you work. For now, however, the minimum standards you must meet when conducting an intake or assessment interview with a client include explaining the following to the client:

- the client's rights (specifically confidentiality)
- the facility's services and treatment process
- the types of professionals or paraprofessionals who may be providing the client with services
- the type of assessment that will be conducted by the CMHW (e.g., "I am going to ask you some questions about your present illness and symptoms, and about your medical and family history")

Can you think of anything else that should be explained to the client in the initial intake and assessment?
Write the answers on the board and thank participants for their answers

Conducting the Initial Intake and Assessment Interview
The initial intake and assessment interview is essential and is a key component of providing appropriate and effective services. There are four tasks that you will want to accomplish in conducting the initial intake and assessment interview.

Identify the Problem: One of the first tasks that you will want to accomplish in conducting the initial intake and assessment is to identify a problem that the client wishes to solve or eliminate. This could be a problem with emotions, finances, housing, relationships, etc. It is important to remember that the CLIENT is in charge of his or her recovery. And the CLIENT must identify the problem as being a problem. In other words, you cannot coerce or manipulate the client to recognize a problem that he or she does not believe is a problem. *(Motivational interviewing techniques will be discussed in another training).*

Identify a Goal: Once the client identifies a problem, the next task is to identify a goal that both you and your client can agree to work on together. If the client is unable or unwilling to identify a goal, then gather information about the client's problems that may be interfering with his or her ability/willingness to set a goal. For example, a person may be involved in a violent domestic relationship (the problem), but could be too afraid to leave the relationship (a possible goal). So help the person identify a goal that he or she is willing and able to work toward. For

example, instead of leaving the violent relationship, perhaps the person may be willing to set a goal of simply devising a safety plan while remaining in the abusive relationship.

Identify Steps Needed to Achieve the Goal: Next, help the client identify the steps that he or she will need to take in order to meet his or her goal. What skills, resources, strengths or qualities does the individual need in order to help him or her meet the goal? What problems need to be overcome in order for the person to achieve the goal? For example, if a client desires to achieve the goal of having a job, will the client first need to receive some vocational skills training?

Treatment Plan: Once the problem, goal and steps are identified, you can use this information in developing a treatment plan. We will discuss treatment planning in further detail in another training. For now, remember that a treatment plan is:

- a written document that describes the treatment services and interventions that the client will receive
- an outline of the clinical steps that will be followed in restoring the client to his/her optimal level of functioning
- includes information about the client's strengths, problems, history, needs and goals
- identifies how and when progress will be assessed

Are there any questions?

There are many different types of assessment tools and screening instruments that can be used in gathering information. Assessment instruments can be used to evaluate a wide variety of risk factors and domains of functioning, such as:

- goals,
- symptoms,
- substance use/abuse,
- aggressive behavior,
- physical health status,
- mental health status,
- spirituality,
- resources,
- empowerment,
- family and peer relationships,
- educational and vocational status,
- social and recreation skills,

- quality of life, and
- inclusion in community life

Over time you will become more familiar with different assessment tools as they become available to you. In performing your job as a CMHW you will be using the Patient Intake Sheet to conduct the initial intake and assessment interview.

Exercise 1: Completing the Patient Intake Sheet Group Discussion
The goal of this exercise is to familiarize the training participants with the Patient Intake Sheet, and to identify and overcome any perceived barriers to using the Patient Intake Sheet.

Refer to the handout titled, "Patient Intake Sheet". Begin the group discussion by reviewing every item on the sheet and providing examples of the type of information that the CMHW may document in each section. A model of a completed Patient Intake Sheet is provided for reference.

During the group discussion as questions like:

How easy or difficult would it be for you to discuss this subject (e.g. past medical history) with a client?

Give me an example of how you might ask the client about what means he or she has used in the past for dealing with his/her condition?

What is the importance of asking about a person's family history?

Once the group discussion is over, debrief the participants and elicit any final thoughts about using the Patient Intake Sheet. This can be accomplished by asking questions like:

Is there something (an item or question) that you would add to the Patient Intake Sheet?

Do you think that the Patient Intake Sheet will be useful in helping you and your client identify problems, goals, and steps toward recovery?

The Importance of Accurate Record Keeping
When completing the Patient Intake Sheet, you should describe the client in a clear, concise and respectful way. You will also want to make sure that you describe things in detail so that you will not have to rely on your own memory

later on. There are four important reasons why you will want to keep accurate and thorough records, beginning with a well-documented intake and assessment interview.

1. Accurate records provide information about the client's symptoms and problems. This information can show how the illness or problems have changed over time or have changed as a result of treatment. Accurate records provide information about what types of interventions and services have been attempted in the past, and with what rate of success.

2. Accurate records provide information about the client's goals and strengths. Accurate records show what steps have been taken toward attaining the goals, what barriers exist in reaching the goals, and what results have occurred with past efforts to either reach these goals or overcome these barriers.

3. Accurate records provide a way for treatment providers and staff members to communicate with one another regarding a client's treatment and care. Accurate records allow for continuity of care, efficiency and effectiveness in treatment.

4. Accurate records provide legal documentation that can be useful in protecting or advocating for a client's rights. Accurate records provide legal documentation of the treatment that the client received and the results of that treatment.

Do you have any questions about the importance of accurate record keeping?

Exercise 2. Completing the Patient Intake Sheet Role-Play
Distribute blank copies of the Patient Intake Sheet for this role-play exercise. Before having the participants conduct this role-play exercise, be sure to demonstrate the role-play by using a co-trainer or audience volunteer to help you. One of you will play the role of the CMHW and the other will play the role of the client. Simulate the intake and assessment interview for the audience. Afterward, ask them if they have any questions

Then, divide the participants into groups of two. One of the participants will play the role of a client coming in to see the doctor; the other will be the CMHW who is conducting the initial intake and assessment interview. After completing the exercise, have the participants switch roles and repeat the exercise.

Now we will do a role-play exercise so that you have the chance to practice completing the Patient Intake Sheet that we have been discussing. I would like you to divide into pairs.

- One of you will play the role of someone coming to see the doctor because you are having headaches, neck aches, problems sleeping, shortness of breath during the day at work, and are feeling very tense and nervous. You may add a few other symptoms, if you choose. Or you may choose an entirely different problem to discuss with the doctor.
- The other person will play the role of a CMHW who is conducting an initial intake and assessment interview. You are screening people before they see the doctor. I would like you to use the Patient Intake Sheet as you complete this exercise. You will ask each question in order to complete the form. Remember that before you begin asking the questions on this form, you will review confidentiality with your client. (Use the confidentiality explanation from the previous lecture.)

Do you have any questions about what you are to do?

After the exercise is complete and everyone has had a chance to play both the client and the CMHW, debrief by asking questions about the experience, such as, "What did you find surprising about this exercise? What did you find easy to do? What did you find difficult to do?…"

Exercise 3: Making a thorough description – Group Discussion
The purpose of this exercise is to help participants recognize the importance of using language and descriptions that are clear and concise. Read the vignette and then begin a group discussion by asking questions about the strengths and weaknesses of the description.

I am going to read a short vignette to you, and then we will discuss how well I have described this individual.

Roza is a 26-year-old female who has never married. She lives with her mother and father. She was referred to the clinic when she was discharged from the hospital. She states that her long-term goals are to get married and have children. Roza reports that problems associated with Schizophrenia (specifically, hearing voices, feeling like people are telling her to hurt herself and others, and difficulty with concentration) have interfered with her ability to be around other people. She tends to be isolated and rarely leaves her house.

Roza states that her strengths are her religious beliefs and that she loves to sing and dance.

What are the strengths of this description?
(Examples: The description includes her goals and strengths. It discusses symptoms in addition to mentioning a diagnosis. It explains how her symptoms affect her functioning.)

What information is missing that you think could improve this description?
(Examples: Does she have siblings or extended family members living with her? Does she or did she attend school? When did the symptoms occur? Why was she in the hospital? Does she take medication for the symptoms?)

Probing for More Detail
In time you will feel more comfortable using the Patient Intake Sheet. You will also feel more comfortable with asking questions that probe for more detail about problems that the client is having or has had in the past.

Refer to the handout titled, "Symptom Questionnaire". This is provided as an added resource and/or additional assessment tool that CMHWs can use in screening patients for the doctor. This is also a good optional exercise to add to the training if you have time to conduct another role-play. Some people are uncomfortable with asking probing questions, so it may be necessary to conduct a short group discussion about why probing questions can help the client feel better. For example, probing questions let the client know that the CMHW cares about the client's problems and is interested in finding out more details.

The Symptom Questionnaire provides examples of probing questions that you could use to elicit more detail about a particular problem. This form does not replace the Patient Intake Sheet. The Symptom Questionnaire is being provided to you as a reference sheet to help you learn how to ask probing questions. For example, if a client tells you that he or she is experiencing pain, you could follow-up by asking probing questions such as:

Where are the pains located?
Are there things that make the pain better or worse?
Have you done anything to help relieve the pain?
Have you done anything to prevent the pain from occurring?
What have you tried to prevent the pain? How has it worked?
Does anything work to relieve the pain for even a short time?
Did anything work in the past, but no longer works now?

Has this problem interfered with your ability to function in any way?

Other questions that you may want to regularly ask your clients during the initial intake and assessment interviews are:

What do you think is causing the problems that we have discussed today? What do you think is going on?

Is there anything else that is going on with you that you would like your doctor to know about?

By asking probing questions you can help clients identify their problems, goals, and strengths in better detail. With practice you can become more skilled at asking probing questions that can assist in treatment planning.

Do you have any questions?

Key Points to Remember about Intake and Assessment

1. Discuss confidentiality with the client before doing the interview
2. The purpose of ongoing assessment is to describe, predict, and evaluate.
3. The four tasks to be accomplished during the initial assessment are:
    - identify problem,
    - identify goal,
    - identify steps to achieve goal, and
    - treatment plan.
4. It is important to keep thorough and accurate records for each client.
5. Asking probing questions can give you more detail about problems that the client is having or has had in the past.

Patient Intake Sheet

Hospital / Health Center:
Name of the CHMW: Signature:_____

Form number:
First session: Duration:

Date:

Patient name:

Age: Sex:

Full Address:

Education background:

Occupation:

Social status: Telephone number:

Number of children: Male Female

Economic status:

Provisional diagnosis:

Chief complaint:

Duration:

History of present illness, special emphasis on the history of prison or torture

Life events:

Present symptoms:

Relation with his/her surroundings

- Family:
- Relatives:
- Friends:
- Closest person the patient can talk to concerning his/her problems:

Means used by the patient for his /her condition:

- Seeking physician:
- Receiving medications:
- Traditional healer:
- Others:

Family history:

- History of same condition in his family
- History of suicidal attempt or suicide in the family
- History of prison or torture in the family

Medications:

- **Prescribed (by whom, for what):**

  Non-prescribed (over the counter) including herbal preparations:

Habits:

• Smoking	Yes	No	Numbers / day
• Drinking	Yes	No	Amount
• Drug abuse	Yes	No	Kind

Past medical and surgical history for example, have you ever had any concussions, loss of consciousness, broken bones, operations including outpatient surgery, seizures, hospitalizations, or serious illnesses?:

Hobbies:

What are those topics that the patient wants to work on:

Treatment plan in cooperation with the trained physician:

Homework based the treatment plan:

Some Principles for the Follow up Sessions:

Session No.: _____ session period: _____ date: _____

1. Reviewing the tasks given to the patient to accomplish, from the last session:

2. Current patient's condition:

3. Points which are improved from the patient's condition, from last session until now:

4. Re-planning treatment, in coordination with the trained physician:

5. What are the main points and areas that the patient prefers to be worked on and improved?

6. Patient's homework based on agreed treatment plan:

Some Principles for the Follow up Sessions:

Session No.: _____ session period: _____ date: _____

1. Reviewing the tasks given to the patient to accomplish, from the last session:

2. Current patient's condition:

3. Points which are improved from the patient's condition, from last session until now:

4. Re-planning treatment, in coordination with the physician:

5. What are the main points and areas that the patient prefers to be worked on and improved?

6. Patient's homework based on agreed treatment plan:

Note:
This page should be used for every session.

Patient Intake Sheet (Explained)

Hospital / Health Center:
Name of the CHMW: Signature:_____

Form number: ***Each client has a form and a form number which will be used for successive sessions, however new treatment plan will be recorded in the last page. With every session a copy from the last page will be used for recording the session.***
First session: Duration:

Date:

Patient name:

Age: Sex:

Full Address:

Education background:

Occupation:

Social status: ***Single, Married, Divorce,*** Telephone number:

Number of children: Male Female

Economic status:

Provisional diagnosis:

Chief complaint:

Duration:

History of present illness:

- ***Detail information on his complaint. For example, sleep disorders, sadness, obsession, etc***
- ***Aggravating and relieving factors***
- ***Any other symptoms associated with his / her condition. For example, loss of appetite due to sleep disorder***

Life events:
With special emphasis on the history of prison or torture

Present symptoms:
The symptoms associated with his / her condition, through questions, like sleep disorders, sadness, suicide ideas, suicide attempts, loneliness, loss of appetite, etc

Relation with his/her surroundings

- Family:
- Relatives:
- Friends:
- Closest person the patient can talk to concerning his/her problems:

It's important for patient to assign some one in order to express his / her own feeling

Means used by the patient for his /her condition:

- Seeking physician: ***Different specialties especially Psychiatrist***
- Receiving medications: ***Type of medications? For which condition?***
- Traditional healer: ***Religious man (Mulla, Shekh, priest , prayer)***
- Others:

Family history:

- History of same condition in his family
- History of suicidal attempt or suicide in the family
- History of prison or torture in the family

Medications:

- **Prescribed (by whom, for what):**

  Non-prescribed (over the counter) including herbal preparations:

Habits:

• Smoking	Yes	No	Numbers / day
• Drinking	Yes	No	Amount
• Drug abuse	Yes	No	Kind

Past medical and surgical history:
Example chronic diseases like Hypertension, Heart diseases, Diabetes, Epilepsy, etc and history of any surgery.

Hobbies:
Take advantages from the client's hobbies that could be use in treatment plan

What are those topics that the patient wants to work on:
Through discussion with the client you have to take the points (raised by him / her to be solved) into consideration. For example the client has problem of communication with his / her family so you have to give priority to solving that problem.

Treatment plan in cooperation with the trained physician:

- ***Giving feedback to the trained physician***
- ***Registration of medicine been prescribed for him /her the physician***
- ***Fixing appointment, if needed***
- ***Referring client to available regional social services which might assist him / her***
- ***Referring client to specialists in different fields of medicines according to needs***

Homework based the treatment plan:

- ***After each session you should give the homework to the client based on treatment plan***
- ***Put a timetable for each homework***
- ***Give homework to client's family; example monitoring patient's medications,***
- ***Homework should not be given as advices and should be given as ways and technique***

Some Principles for the Follow up Sessions:

Session No.: _____ session period: _____ date: _____

7. Reviewing the tasks given to the patient to accomplish, from the last session:

8. Current patient's condition:

9. Points which are improved from the patient's condition, from last session until now:

10. Re-planning treatment, in coordination with the trained physician:

11. What are the main points and areas that the patient prefers to be worked on and improved?

12. Patient's homework based on agreed treatment plan:

Some Principles for the Follow up Sessions:

Session No.: _____ session period: _____ date: _____

7. Reviewing the tasks given to the patient to accomplish, from the last session:

8. Current patient's condition:

9. Points which are improved from the patient's condition, from last session until now:

10. Re-planning treatment, in coordination with the physician:

11. What are the main points and areas that the patient prefers to be worked on and improved?

12. Patient's homework based on agreed treatment plan:

Note: *This page should be used for every session.*

Symptom Questionnaire

Client ID: _____ Date: _____

Interviewer: _____

(Remember that you should discuss confidentiality with the client before doing this interview.)
Introduction for client: As I mentioned earlier, I will be assisting the doctor by doing a brief screening interview with his patients before see him. Hopefully, this will allow the doctor to spend more time focused on your specific problems as well as identifying additional concerns that may be important to discuss with him. I will be asking questions about a number of different areas. Do you have any questions? May I begin?

1. Pain. Have you been having problems with pains of any sort?
If yes, where are the pains located? _____
_____
Are there things that make the pain either better or worse? (Probe: time of day; temperature; noise or light; things that you do, such as lying down, moving in a certain way; eating or drinking certain foods or beverages) _____
_____
_____
Have you done anything to help relieve the pain? Have you done anything to prevent the pain from occurring? What? How has it worked? Does anything work for even a short time? Did anything work in the past, but not now? _____
_____
_____
Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

2. Sleep. How have you been sleeping lately? (Probe: difficulty falling asleep, difficulty staying asleep, problems waking up too early and not falling back to sleep, oversleeping, sleepiness during the day, awake at night and sleepy during the day, nightmares or terrifying dreams, anything else?) _____
_____
_____
If client reports a problem with sleep: In the past seven days, on how many nights have you had this problem? _____
How long have you had this problem? _____
Have you done anything to relieve or prevent your problems with sleep? What? How has it worked? (Probe: eating or drinking certain things, not eating or drinking certain things, taking herbs or medicines, exercises, prayer or meditation.) _____
_____

Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

3. Eating. How has your appetite and eating been lately? (Probe: loss of interest in food, eating more or less than usual, increased or decreased weight, difficulty maintaining a desirable weight.) _____
_____

4. Chest problems. Have you had problems with your chest, such as pounding heart, racing heart, or pains in your chest? How about problems with your breathing, such as difficulty catching your breath, rapid breathing or hyperventilating, choking sensations, feeling like you are smothering, difficulty catching your breath? Please tell me about this. What is it like for you? _____
_____
How often does this happen? _____
Is this problem more or less likely to occur at any particular time or in any particular situation? (Probe: time of day, during or before doing any activity) _____
_____
Does the problem come on gradually or suddenly? Do you have any warnings that the problem is likely to occur? _____
_____
Have stopped or avoided doing any activities because of this problem? What?
_____
Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

5. Stomach and bowel problems. Have you had any problems with your stomach or your bowels? (Probe: upset stomach, gas, cramps, fluttering feelings in the stomach, diarrhea or constipation, nausea, vomiting) Please tell me about this. What is it like for you? _____
_____
How often does this happen? _____
Is the problem associated with eating any particular kind of food? What? _____
_____
Is this problem more or less likely to occur at any particular time or in any particular situation? (Probe: time of day, during or before doing any activity) _____
_____

Does the problem come on gradually or suddenly? Do you have any warnings that the problem is likely to occur? _____
_____
Have stopped or avoided doing any activities because of this problem? What?
_____
Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

6. Concentration and memory problems. Have you had any problems with your memory or your ability to concentrate or focus your attention on things? Please tell me about it. What is that like for you? _____
_____
How often does this happen? _____
Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

7. Mood. How has your mood been lately? Have you had any problems with feeling depressed or worried about things? What has that been like for you? (Probe: sad for no reason, uninterested in things that you used to be interested in, feeling hopeless, worried and anxious, jittery and easily startled, fearful for no real reason) _____
_____
_____
_____
How long have you been feeling this way? _____
What was going on in your life when you started feeling this way? _____
_____
_____
Have you done anything to relieve or prevent this problem from occurring? What have you done? How has it worked? _____
_____
Has this problem interfered with your ability to function in any way? If so, how? (Probe: problems with work, taking care of the house, taking care of family, relations with spouse)
_____
_____

8. Housing. Are you having problems with your housing? If yes, what sort of problems are you having? _____
_____

9. Work. Are you having problems with work or with finding work? If yes, what sort of problems are you having? _____
_____
_____

What do you think is causing the problems that we have discussed today? What do you think is going on? _____
_____

Is there anything else that is going on with you that you would like your doctor to know about? If yes, what? _____
_____
_____

Help Sheet #1: Depression

When someone you know has
depression

Everyone experiences times of sadness in life, such as when they have problems with work, family, illness, or a death of a loved one. However, depression is much more serious than simply being sad for a short time. Depression can lead to symptoms such as loss of appetite, loss of energy, or difficulty sleeping. People with depression often isolate themselves from family and friends. They may not have the desire or energy to complete daily activities like going to work or having tea with friends. Common symptoms of depression include extended periods of unexplained crying or sadness. People with depression can also experience intense feelings of irritability, pessimism, hopelessness, worry, anxiety, anger, or rage. They may feel worthless, helpless, or extremely guilty. They may have difficulty with memory or concentration. Depression can also cause people to experience unexplained aches and pains throughout their body. In addition, they may also have thoughts of death or suicide

When someone you know has depression, there are things that you can do to help:

- Recognize that willpower alone will not make the depression go away.
- Permit the person to talk about his or her feelings, if the person wishes to.
- Let the person know that you are available to offer support and assistance.
- Encourage the person to get additional support from friends and family members.
- Encourage the person to use his or her religion or spirituality to help with coping.
- Encourage the person to get treatment from a doctor for the depression.
- Assist the person in recognizing the onset of symptoms of depression.
- Encourage the person to remain as physically and socially active as possible.
- Suggest that the person avoid making major decisions while he or she is depressed.
- Help the person adhere to normal activities and daily routines.
- Remind the person to complete activities of daily living that may be overlooked.

Help Sheet #2: Stigma

When someone you know has a
mental illness

When people have a mental illness they often have to deal with the added problem of *stigma*. Stigma refers to the fear, shame, mistrust and discrimination that result from negative stereotypes associated with mental illness. Stigma can have a terrible impact on a person's emotional and financial health. For instance, stigma can cause a family member to ignore or reject another family member who has a mental illness. Or stigma can lead a business owner to fire an employee simply because the employee has a mental illness. Unfortunately, stigma can also lead to violent acts against people with mental illness. Since stigma is often based on myths about mental illness, people can learn to overcome stigma by learning the truth about mental illness.

When someone you know has mental illness, there are things that you can do to help:

- Remember that sheer willpower alone will not make mental illness go away.
- Remember that people with mental illness can recover with treatment.
- Encourage the person with mental illness to seek treatment from a physician.
- Remember that a person with mental illness is probably no more violent than anyone else.
- Educate yourself and others about mental illness, signs, symptoms, and treatment.
- Let the person with mental illness know that you are available for support and assistance.
- Encourage the person to get additional support from friends and family members.
- Assist them in maintaining daily routines and setting reasonable goals.
- Encourage them to stay physically and socially active.
- Become aware of your own stigmatizing behavior.
- Treat people with mental illness with the same respect and dignity you give others.

Help Sheet #3: Trauma

When someone you know has experienced trauma

Many people experience (or witness) traumatic events such as war, torture, disasters, or physical abuse. These events can lead to emotional or psychological problems for the victims, as well as for their families, friends, and neighbors. Trauma affects different people in different ways. Trauma can result in high levels of anxiety, depression, panic, irritability, anger, aggression, and/or substance abuse. Many people who have been traumatized will also experience difficulty with concentration or trouble sleeping. Many trauma victims have nightmares or flashbacks about their traumatic experience. They may try to avoid people, places or things that remind them of the traumatic event. Some victims of trauma appear to be overly sensitive to their surroundings, and others seem to lose their ability to express emotions altogether.

When someone you know has experienced trauma, there are things that you can do to help:

- Do not force or pressure the person to talk about his or her traumatic experience.
- If the person chooses to talk about it, calmly listen to him/her tell you about the trauma.
- Permit the person to talk at his or her own pace, without interruption or judgments.
- Let the person know that you believe what he or she has told you about the trauma.
- Assist the person in returning to normal activities and daily routines as soon as possible.
- Tell the person that it was not his or her fault that the traumatic event occurred.
- Let the person know that you are available to offer support and assistance.
- Encourage the person to get additional support from friends and family members.
- Encourage the person to use his or her religion or spirituality to help with coping.
- Encourage the person to get treatment from a doctor for symptoms that occur.
- Respect the persons' choices by permitting him or her to make decisions about treatment.
- Be patient with the person when he or she behaves abnormally.