



## Leader Manual

Developed by NAMI © 2017



*"It doesn't matter how big and how long my tunnel is . . . I can see the light at the end.  
But if I walk looking at my shoes I cannot see the light."*

—Carlos A., De Familia a Familia de NAMI teacher trainee, 2011



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Introduction

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## Acknowledgements

This seminar reflects the wisdom of more than 500 NAMI leaders who shared their insights and suggestions via surveys, polls, networking sessions, technical assistance webinars, Training of Trainer weekends and NAMI Conventions in San Francisco and Denver.

Special appreciation goes out to psychologist and family member Dr. Joyce Burland, the author of NAMI's flagship program NAMI Family-to-Family. I began teaching NAMI Family-to-Family in 1998 and was fortunate to be certified as a state trainer for the program by Dr. Burland in 2001.

This seminar is dedicated to the people of NAMI that astound and inspire me each day. Following a tragedy several years ago, I remember a NAMI State Director saying that he was simultaneously "always surprised by NAMI people and never surprised by NAMI people." He meant that no matter the situation, NAMI members act with compassion. They reach out to people who are isolated and offer support, education and empathy. NAMI members fight the discrimination that too often surrounds mental health conditions. Special thanks go to NAMI's extraordinary Education Team and the amazing staff at NAMI Ohio where I was honored to serve as Director of Programs for 14 years prior to coming to NAMI in 2013. I'm grateful to my parents for encouraging me to volunteer with NAMI Franklin County back in 1997.

Every day I am awed by my mother and brother (illustrator of the rock slide in the presenter slide deck) who face mental illness with courage, determination and humor. So, as Carlos reminded me back in 2011, it's time for each of us to look up from our shoes and walk with purpose. Our actions change lives. Share your experiences...share NAMI...make a difference.

Suzanne Robinson, MSW  
Assistant Director of National Education Programs for NAMI  
Developer of NAMI Family & Friends

*The development of this curriculum and the launch of NAMI Family & Friends would not have been possible without the generous support of Providence St. Joseph Health.*

*Material from the following NAMI programs was incorporated into this seminar: NAMI Basics, NAMI Ending the Silence, NAMI Family-to-Family, NAMI Homefront, NAMI In Our Own Voice and NAMI Peer-to-Peer. Comprehensive references for source material can be found in the manuals for each of the programs listed, please contact NAMI for details.*

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## NAMI Family & Friends Program Overview

**NAMI Family & Friends is a 4-hour seminar that informs and supports people who have loved ones with a mental health condition.** Participants learn about diagnoses, treatment, recovery, communication strategies, crisis preparation and NAMI resources. Seminar leaders have personal experience with mental health conditions in their families. **NOTE:** A 90-minute version of the seminar is also available.

**This seminar provides participants with the opportunity to learn about mental health directly from the families of people with a mental health condition.**

Audiences can ask people with lived experience questions directly. By engaging in a discussion about mental health among their peers, families and friends realize they're not alone.

NAMI Family & Friends **can be presented in any community setting.**

**The program is delivered by a team of two to four presenters, each of whom must be certified NAMI family educators in at least one of the following programs: NAMI Family-to-Family, NAMI Basics or NAMI Homefront. Each leader must be willing to share their own experience as the family member of someone with a mental health condition.**

The goal of the seminar is to offer participants practical skills and information to address their immediate concerns until they can attend a NAMI class.

During the seminar, participants learn about mental health and NAMI programs. An eBook (also available to print) is offered as a download to participants when they register. It's available in 7 languages and contains information on mental health as well as useful websites. **The eBook/manual is not used during the seminar.**

In NAMI Family & Friends, leaders are trained to **share** as opposed to **teach** the material. The style is casual. Presenters make good eye contact, chat with people upon entering the room and stay after the seminar is over (when possible) to answer questions. **Participants feel that NAMI Family & Friends presenters are caring and genuine.**

# Important Information and Resources for Program Leaders NAMI Family & Friends (F&F)

**NAMI EduHelpDesk:** [www.nami.org/eduhelpdesk](http://www.nami.org/eduhelpdesk)

The EduHelpDesk is a website that contains information for all NAMI program leaders. Within the EduHelpDesk are pages specifically for NAMI presenters, teachers, facilitators, mentors, trainers and program directors/coordinators.

## Get designated as a program leader in NAMI 360

To access the EduHelpDesk, you need to be designated as a presenter, teacher, facilitator, mentor or trainer leader for the programs you lead. Your NAMI Affiliate (NA) or NAMI State Organization (NSO) must designate you in NAMI 360, the member management software used by NAMI. If you cannot access the EduHelpDesk, confirm with your NA that you are designated as leader, for the programs for which you've been trained, in NAMI 360.

## Get access to the EduHelpDesk

- Must be designated as NAMI program leader in NAMI 360 (see above)
- Go to [www.nami.org/eduhelpdesk](http://www.nami.org/eduhelpdesk)
- Login with your NAMI username and password
- The EduHelpDesk webpage will be displayed
- To access the program information, look to the left side of the screen and click on the type of program and then the name of the program
  - You can access program extranet pages directly through the link [www.nami.org/extranet](http://www.nami.org/extranet)

## I don't have a NAMI username

- Go to [www.nami.org](http://www.nami.org) and click on Join
- Follow the instructions to Create an Account

## Manuals

The participant manual is available as a free eBook through Amazon (Kindle) and Barnes and Noble (Nook). You may also download the seminar manuals from the NAMI Store ([www.nami.org/store](http://www.nami.org/store)). They are currently not available for purchase

The NAMI Store also has downloadable electronic files of all non-trainer manuals. You will need to enter a coupon code to purchase or download any program manuals. Please contact your NSO education program director with questions about the codes.

## **Receiving NAMI Family & Friends emails for program leaders**

Your designation in NAMI 360 as a NAMI Family & Friends leader automatically adds you to the recipient list for all emails related to F&F. If you do not believe you are receiving the emails, please check with your NA or NSO to make sure you are designated correctly and have allowed NAMI to send you email.

## **Participant Evaluations**

F&F uses an online participant evaluation. Program leaders will be able to access the evaluation responses via the NAMI Portal.

The following questions will be asked:

- Rated questions: 1) I now understand more about mental health conditions, 2) I learned information that is helpful to me, 3) The program leaders communicated well, 4) The materials provided (eBooks, handouts, etc.) were helpful to me, 5) I would recommend this program to others
- Open-ended question: What information was most helpful to you? (500-character limit)

## **NAMI Family & Friends Presentation**

The F&F PowerPoint presentation is a file that can be downloaded from the NAMI Store with a coupon code.

# [INSERT] Operating Policies Tab



## NAMI Family & Friends Program – Operating Policies

**Note:** Please refer to the **NAMI National Education Programs Operating Policies** for procedures which apply to all programs including NAMI Family & Friends (F&F). F&F will be included in future versions of the Operating Policies.

### Presentation format

- The time frames and presentation format for NAMI programs must adhere to the options provided and not be altered in any way. The classes, presentations and support groups must be led by the number of trained leaders specified. The specific program presentations are described in **Table 1**.

Table 1: Presentation format

Program	Presentation format	Led/Taught by
NAMI Family & Friends	Seminar given in 4 hours or 90 minutes	2 - 4 presenters (aged 18 or older) each of whom are certified NAMI family educators in at least one of the following programs: NAMI Family-to-Family, NAMI Basics or NAMI Homefront

### Participant eligibility

- Participation in NAMI Family & Friends is open to family members and friends (ages 18 years and older), of people with mental health conditions as well as the general public. The target audience are family and friends and may include youth age 14 and older provided they are accompanied by a parent or guardian.

Table 2: Requirements to participate/attend

Program	Who is eligible to attend
NAMI Family & Friends	General public

### Program leader qualifications

Table 3: Qualifications for program leaders

Program	Program leader qualifications
NAMI Family & Friends	Prospective presenters are adult family members (parents, siblings, adult children, spouses or partners) of a person with a mental illness. Each must be a certified NAMI family educator in at least one of the following NAMI programs: NAMI Family-to-Family, NAMI Basics or NAMI Homefront.



## NAMI National Education Programs

### Operating Policies, 2017

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*These policies replace all previous versions of program policies*

*These are also located in all NAMI program manuals*

## Overview

NAMI national education programs (NAMI programs) are the intellectual property of NAMI. They are developed and owned by NAMI. They include NAMI Basics, NAMI Connection Recovery Support Group, NAMI Ending the Silence, NAMI Family-to-Family, NAMI Family Support Group, NAMI Homefront, NAMI In Our Own Voice, NAMI Parents & Teachers as Allies, NAMI Peer-to-Peer, NAMI Provider and any cultural adaptations and/or translations of these programs. NAMI considers online programs, seminars, trainings and workshops to be program adaptations, in which case all policies apply.

NAMI has invested considerable time and resources in the development, maintenance and technical support of each of these programs to ensure they address the goals and mission of NAMI. NAMI is dedicated to ensuring these programs represent NAMI accurately when they are provided in communities. The following operating policies have been developed to ensure the ongoing provision of consistent and quality programming at all levels of NAMI.

NAMI State Organizations (NSO) and NAMI Affiliates (NA), their board of directors and staff may not set policies at variance with the NAMI national education program policies stated below. These policies are also to be followed by certified NAMI program leaders (i.e., teachers, mentors, presenters, facilitators) and trainers.

Any operational issues not covered below should be addressed by the NSO in accordance with all applicable laws in their respective state.

### Access to NAMI programs and materials

- NAMI programs are the intellectual property of NAMI
- NAMI grants access to program manuals and materials to NSOs who have sought and obtained permission from NAMI to bring that program to their state
- NAs are granted access to these intellectual properties via their NSO
- NAMI programs are only available through NSOs and NAs
- In return for access to the NAMI programs, the NSO and NAs are expected to maintain the fidelity of the programs and report participation data of all trainings, classes, presentations and support groups at [www.nami.org/programdata](http://www.nami.org/programdata)

### Copyright

- All NAMI program material is copyrighted and can only be used by certified program leaders for the intended audiences
- Permission to use any material in a setting other than a NAMI program must be sought from and given by NAMI national staff in advance. In every case where permission is granted, NAMI must be referenced as the source of the material.
- No portions of a NAMI program may be used as a component for other program development or presentation

- No group or individual outside of NAMI can rewrite any of the NAMI program materials
- Permission to culturally adapt and/or translate NAMI programs and materials in either written or verbal form into another language must be sought from and given by NAMI in advance and follow NAMI procedures regarding cultural adaptation and/or translation

### **Confidentiality**

- All NAMI programs are built around the principles of mutual trust and respect among participants and leaders
- All NAMI program leaders are trained in the importance of creating and maintaining an atmosphere of respect in NAMI classes, presentations and support groups that is conducive to participants' ability to gain valuable information and support regarding mental illness
- This atmosphere of respect includes the assurance of complete confidentiality regarding participation in NAMI programs as well as any information shared by participants about themselves or others
- The only exception to this expectation of confidentiality is in a circumstance involving potential harm to a participant or someone else
- Audio or videotaping during any NAMI programs is not permitted

### **Code of Conduct**

- Program leaders are representatives of NAMI and NAMI holds these leaders to certain standards of conduct during the provision of NAMI services
- The Code of Conduct document is covered during program leader trainings and is included in all NAMI program manuals



## **NAMI National Education Programs Code of Conduct, 2017**

NAMI national education programs are built around the principles of mutual trust and respect among participants and leaders. Certified program leaders are representatives of NAMI and NAMI holds these leaders to certain standards of conduct during the provision of NAMI services. This Code of Conduct is covered during leader trainings and is included in all NAMI program manuals so that participants also know what to expect from NAMI programs.

### **What we ask of you as a NAMI national education program participant:**

- Attend programs with an open mind and open heart
- Maintain the confidentiality of all participants by not discussing personal topics outside the program
- Take from the program the information that you believe is most helpful for you
- Find an atmosphere of support in the program that enables you to feel comfortable sharing with others, knowing that what you share will be respected and held in confidence by the other participants

### **What we ask of you as a NAMI national education program leader:**

- Provide a safe and respectful environment for program participants
- Prepare for each class, presentation or support group meeting and conduct yourself, to the best of your ability, with courteous and respectful behavior
- Actively pursue maintaining your own wellness and respect your own emotional and physical resources and limitations
- Understand the difference between peer support and therapy and do not act in the capacity of a therapist or mental health professional. Offer only the services that you have been trained to provide and ask for assistance as needed.
- Respect the cultural differences of program participants
- Respect the privacy of program participants by creating an environment of confidentiality in the program setting and by holding in confidence sensitive, private and personal information. As a NAMI program leader, you must also be prepared to break confidentiality when you believe there is a danger of harm to a participant or others.
- Maintain appropriate boundaries by not engaging in romantic, physical or sexual relationships with participants in the NAMI program you are leading. Recognize that it is best practice for participants to attend a class or support group not led by someone with whom they are in a relationship, to avoid potential conflict and the discomfort of other participants.
- Refrain from promoting your own personal or spiritual beliefs
- Do not endorse/promote any individuals, groups or businesses in which you have a personal or financial interest
- Remain accountable for your own behavior and keep personal opinions and actions separate from those made as a representative of NAMI. Understand that your actions and behaviors reflect on the integrity of NAMI national education programs and impact the public perception of NAMI as an organization.

## Presentation format

- The time frames and presentation format for NAMI programs must adhere to the options provided and not be altered in any way. The classes, presentations and support groups must be led by the number of trained leaders specified. The specific program presentations are described in **Table 1**.
- In NAMI classes (NAMI Basics, NAMI Family-to-Family, NAMI Homefront, NAMI Peer-to-Peer and NAMI Provider), no greater than a one-week hiatus may be taken for holidays which may occur during the course (e.g., Thanksgiving, spring break). More than a one-week break between classes creates too great a disruption in content presentation.

Table 1: Presentation formats

<b>Program</b>	<b>Presentation format</b>	<b>Led/Taught by</b>
NAMI Basics	Over a period of 6 consecutive weeks, one class per week; OR over a period of 3 consecutive weeks, 2 classes per week; OR across consecutive weekend days with no more than 2 classes taught on any one weekend	2 co-teachers
NAMI Connection	Groups meet once a week for 90 minutes	2 co-facilitators
NAMI Ending the Silence	Presentations given in 50 minutes	2 presenters
NAMI Family-to-Family	Over a period of 12 consecutive weeks, one class per week; OR over a period of 6 consecutive weeks, 2 classes per week; OR across consecutive weekend days with no more than 2 classes taught on any one weekend	2 co-teachers
NAMI Family Support Group	Groups meet at least once per month for 60-90 minutes	2 co-facilitators
NAMI Homefront	Over a period of 6 consecutive weeks, one class per week; OR over a period of 3 consecutive weeks, 2 classes per week; OR across consecutive weekend days with no more than 2 classes taught on any one weekend	2 co-teachers
NAMI In Our Own Voice	Presentations given in 60-90 minutes	2 presenters
NAMI Parents & Teachers as Allies	Presentations given in 60-120 minutes but shorter presentations may be provided	<u>Best Practice</u> : 3 presenters (1 educator, 1 parent, 1 young adult) <u>Alternate Option</u> : 2 presenters (1 parent, 1 young adult; either the parent or young adult must

		also qualify for the educator role)
NAMI Peer-to-Peer	Over a period of 10 consecutive weeks, one class per week; OR over a period of 5 consecutive weeks, 2 classes per week; OR across consecutive weekend days with no more than 2 classes taught on any one weekend	2 co-mentors, 1 assistant
NAMI Provider	Over a period of 5 consecutive weeks, one class per week; OR over a period of 5 consecutive days, 1 class per day; OR over a period of 2 consecutive weeks, 2 classes one week and 3 classes the other; OR over a period of 2 consecutive days, 2 classes one day and 3 classes the other day	<u>Best Practice</u> : 5 presenters (2 family members, 2 individuals with a mental health condition, 1 mental health professional) <u>Alternate Option</u> : 3 presenters (1 family member, 1 individual with a mental health condition, 1 mental health professional)
NAMI Provider Seminar	Seminar is given in 4 hours	3 presenters (1 family member, 1 individual with a mental health condition, 1 mental health professional)

### Program fees

- Non-professional participants will not be charged a fee of any kind for enrolling and/or participating in any NAMI program
- NSO/NAs may charge professional organizations for offering the program to their audience, for example, NAMI Basics for professionals (social workers, case managers, etc.) or NAMI Provider (medical office staff, hospital staff)

### Cultural adaptation and translation

- Any cultural adaptation or translation conducted on NAMI programs must be approved in advance and in writing by NAMI
- The procedures for requesting and securing permission can be found on the NAMI Education Helpdesk

### Interpreting into a second language during a program

- Interpreting during a NAMI program is not recommended. The activity is distracting to the participants and program leaders. Consult with the NA or NSO about the availability of offering the program in the needed language.
- For trainings, consult with NAMI managers about the availability of certified trainers that can offer programs in the needed language

### Research on NAMI programs

- Any research studies conducted on NAMI programs or using participants in NAMI programs must be approved in advance and in writing by NAMI

- The individual/institution conducting the research must share with NAMI the data, analysis and conclusions from the research project
- The Research Approval Request form can be found on the NAMI Education Helpdesk

## Participation in NAMI Programs

### Participant eligibility

- Only people who have the lived experience for a specific education program or support group meet the attendee qualifications to attend that program. These program-specific requirements are listed in **Table 2**. The exception is the NAMI Basics program, which may be offered in its entirety to groups of professionals only.
- Participation in NAMI presentation programs (NAMI In Our Own Voice and NAMI Parents & Teachers as Allies) is open to the general public
- Participation in NAMI Ending the Silence is open to youth ages 13-18 and to the general public (the target audience is youth ages 13-18)
- Professionals (mental health, school, day care workers, etc.) are not permitted to attend NAMI education programs or support groups unless they also meet the lived experience requirements of that specific program. The exception is the NAMI Basics program, which may be offered in its entirety to groups of professionals only.
- Observers are not permitted to attend or audit any NAMI class or support group

Table 2: Requirements to participate/attend

<b>Program</b>	<b>Who is eligible to attend</b>
NAMI Basics	Parents or other primary caregivers of an individual, 22 years of age or younger, who is experiencing mental health challenges
NAMI Connection	Any adult with a mental health condition, an official diagnosis is not required
NAMI Ending the Silence	Youth ages 13-18 and the general public
NAMI Family-to-Family	Any adult with a loved one affected by mental illness
NAMI Family Support Group	Any adult with a loved one affected by mental illness
NAMI Homefront	Any adult with a loved one who is a Service Member (active duty military or Veteran) experiencing a mental health challenge
NAMI In Our Own Voice	General public
NAMI Parents & Teachers as Allies	General public, although the target audience is school personnel

NAMI Peer-to-Peer	Any adult with a mental health condition, an official diagnosis is not required
NAMI Provider	Any adult who works with people with mental health conditions and/or their family members as a part of their job: mental health professionals, lay professionals, administrative staff, etc.
NAMI Provider Seminar	Any adult who works with people with mental health conditions and/or their family members as a part of their job: mental health professionals, lay professionals, administrative staff, etc.

### **American with Disabilities accommodations**

- Under the Americans with Disabilities Act (ADA) accommodations must be made for participants who are deaf, hard of hearing or deaf-blind. Accommodations that are made, such as contracting with interpreters are the responsibility of the NSO or NA.
- Digital copies of participant manuals should be made available for those individuals that need large print versions. Copies may be downloaded from the NAMI Store. The device to read the manuals is the responsibility of the participant.

## **Program Leaders**

### **Program leader qualifications**

- All NAMI program leaders<sup>1</sup> must be NAMI members, meaning they are current in their annual dues and have a record in NAMI’s member management system
- All NAMI program leaders must be trained and certified by national or state trainers
- All NAMI program leaders must be at least 18 years of age
- Untrained individuals are not permitted to serve as teachers in a NAMI classes (NAMI Basics, NAMI Family-to-Family, NAMI Homefront, NAMI Peer-to-Peer and NAMI Provider). In cases where a teacher is unable to continue teaching the class, an untrained substitute may be appointed to help with lecturing. The substitute is not considered certified and will not be allowed to teach the class again until they participate in a regular teacher training workshop.
- Untrained individuals are not permitted to be substitutes in either the presentations or support groups
- Due to the investment of time and money to train volunteers, prospective NAMI program leaders are expected to meet outlined requirements of the NSO for the program for which they are training (e.g., teach a minimum of two course cycles for classes). It is understood that unexpected life situations may occur that will necessitate compassion and flexibility in this policy.

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<sup>1</sup> Program leaders include NAMI teachers, mentors, presenters and facilitators.

- Existence of a criminal record does not preclude individuals from leading NAMI programs. The NSO/NA will review each situation on a case-by-case basis and may deny or limit those volunteer opportunities.
- Specific additional eligibility requirements for each NAMI program are listed by program in **Table 3**

Table 3: Qualifications for program leaders

<b>Program</b>	<b>Program leader qualifications</b>
NAMI Basics	Prospective teachers must be parents or other primary caregivers of a person who exhibited mental illness symptoms prior to age 13 (the formal diagnosis may have been made years later, but symptoms appeared prior to age 13). Ideally will have taken the NAMI Basics course, but this is not required to allow NAs to expand the program into underserved areas.
NAMI Connection	Prospective facilitators are adults in recovery with mental illness. There is no prerequisite that a prospective facilitator has taken NAMI Peer-to-Peer
NAMI Ending the Silence	Prospective presenters must meet one of the following descriptions: (1) young adult age 18-35 living with a mental illness in recovery (preferably who is also a NAMI In Our Own Voice or NAMI Parents & Teachers as Allies presenter); (2) adult who is either a family member or a person with a mental illness (preferably also a trained teacher/mentor for NAMI Basics, NAMI Family-to-Family, NAMI Homefront or NAMI Peer-to-Peer, or has taken one of these courses)
NAMI Family-to-Family	Prospective teachers must be family members (parents, siblings, adult children, spouses or partners) of a person with mental illness. Ideally will have taken the NAMI Family-to-Family course, but this is not required to allow NAs to expand the program into underserved areas.
NAMI Family Support Group	Prospective facilitators must be family members (parents, siblings, adult children, spouses or partners) of a person with mental illness. There is no prerequisite that a prospective facilitator has taken NAMI Basics, NAMI Family-to-Family or NAMI Homefront.
NAMI Homefront	Prospective teachers must be family members (parents, siblings, adult children, spouses or partners) of Service Members (active duty military or Veteran) who experienced mental health challenges. There is no prerequisite that a prospective teacher has taken NAMI Homefront.
NAMI In Our Own Voice	Prospective presenters are adults in recovery with mental illness
NAMI Parents & Teachers as Allies	Prospective presenters must meet one of the following descriptions: (1) young adult age 18-35 in recovery with a mental illness who experienced symptoms during their school years; (2) parent or primary caregiver of a person who exhibited symptoms of mental illness while in school (preferably the parent will be a teacher/mentor for or have taken either NAMI Basics, NAMI Family-to-Family, NAMI Homefront or NAMI Peer-to-Peer); (3) a school professional who also is either a family member of someone with a mental illness or lives with mental illness themselves

NAMI Peer-to-Peer	Prospective mentors and assistants are adults in recovery with mental illness
NAMI Provider	Prospective teachers must meet one of the following descriptions: (1) adult in recovery with a mental illness, preferably who is also a NAMI Peer-to-Peer mentor; (2) family member or partner of a person with mental illness, preferably who is also a NAMI Basics, NAMI Family-to-Family or NAMI Homefront teacher; (3) a mental health professional who also is either a family member of someone with a mental illness or lives with mental illness themselves
NAMI Provider Seminar	Must be certified as a NAMI Provider teacher

### Mandated reporting

- For the purpose of NAMI programs, a “mandated reporter” is someone who because of other training they have received (e.g., Certified Peer Specialist) or a position they hold (e.g., mental health counselor) has been trained in their respective state’s laws around mandated reporting (e.g., suspected physical abuse, suspected harm to self or others)
- A NAMI program leader who also has the designation of being a mandated reporter in his or her state is required by NAMI to inform the participants in their class/support group of their status at the beginning of the class or at the start of each support group session, even if their specific mandated reporter regulations do not require this disclosure
- Participants in NAMI programs who are also mandated reporters should follow the requirements of their licensure and state, but are not required to inform participants of their presence
- A NAMI program leader who is not a mandated reporter in his or her state but who is concerned about something reported by a participant in their class/support group should discuss those concerns with the sponsoring NSO or NA and follow the policies and procedures of that organization, which must comply with the laws in that state

### Compensation for program leaders

- It is imperative that all NSOs and NAs understand that any form of payment to program leaders (contract fees, stipends, etc.) may be considered as an employer/employee relationship. NSOs and NAs must be familiar with federal and state law regarding regulations on employees and contractors if they opt to provide payments of any sort to program leaders. Guidance on federal law can be found at [www.irs.gov/businesses/small](http://www.irs.gov/businesses/small). On that page, click on the title ***Independent Contractor (Self-Employed) or Employee***. Additional resources are available on the NAMI Education Helpdesk. Please consult resources in your state for laws specific to your state.
- NAMI neither requires nor recommends payment of any type for NAMI program leaders.

## State Trainings

### State trainer qualifications

- All prospective state trainers for NAMI programs must be NAMI members, meaning they are current in their annual dues and have a record in NAMI’s member management system
- All prospective state trainers for NAMI programs must be screened for readiness and then be recommended to attend a NAMI Training of Trainers event by their NSO (either by the executive director or the president of the board of directors). This recommendation indicates the NSO endorses not only that the individual meets the minimum requirements, but that they are at a point in their life where they are ready to become state trainers and will be able to perform in that new role.
- Eligibility of a state trainer to train may be reviewed and eligibility withdrawn at any time by the NSO or NAMI
- Program specific eligibility requirements to become a state trainer are detailed in **Table 4**

Table 4: Qualifications to become a state trainer

<b>Program</b>	<b>State trainer qualifications</b>
NAMI Basics	Must have taught 1 complete 6-session NAMI Basics course
NAMI Connection	Must have at least 6-12 months’ experience facilitating a NAMI Connection group, utilizing the NAMI Connection Recovery Support Group model
NAMI Ending the Silence	Must have given at least 5 NAMI Ending the Silence presentations
NAMI Family-to-Family	Must have taught 1 complete 12-session NAMI Family-to-Family course
NAMI Family Support Group	Must have at least 6-12 months’ experience facilitating a NAMI Family Support Group, utilizing the NAMI Family Support Group model
NAMI Homefront	Must have taught 1 complete 6-session NAMI Homefront course
NAMI In Our Own Voice	Must have given at least 5 NAMI In Our Own Voice presentations
NAMI Parents & Teachers as Allies	Must have provided at least 2 NAMI Parents & Teachers as Allies presentations.
NAMI Peer-to-Peer	Must have taught 1 complete 10-session NAMI Peer-to-Peer course
NAMI Provider & Provider Seminar	Must have taught 1 complete 5-session NAMI Provider Education course

## State training procedures

- State training schedule, format and content may not be altered or condensed in any way. Specific formats and trainer requirements are described in **Table 5**.
- Not all trainees are guaranteed certification; certification will be decided upon by the state trainers based on the trainee's ability to demonstrate the skills required and to adhere to the program model. In cases where certification is not granted, the Non- and De-Certification Procedures should be followed to include documentation at all levels. The process for Non- and De-Certification can be found in the program trainer manual and on the NAMI Education Helpdesk.
- NSO or NAs who require an out-of-state trainer to hold a program training must contact the NAMI manager in the national office who oversees that program. The NAMI manager will identify certified trainers the NSO/NA may contact.
- All trainings must be reported to NAMI through the online data reporting system six weeks prior to the training. A link to the online data reporting system may be found on the NAMI Education Helpdesk.
- The NAMI state program director/coordinator must submit any documentation required for specific programs to NAMI after the training. This documentation is described in each of the NAMI program training manuals.

Table 5: State training formats

<b>Program</b>	<b>Training format</b>	<b>Led/Taught by</b>
NAMI Basics	Day 1 begins at 3 pm and Day 3 ends at noon, or training may be held in 2 full days	2 state trainers
NAMI Connection	2-day training workshop; states may use the 3-day model	1 state trainer for every 6 trainees plus the state coordinator or other designated staff member
NAMI Ending the Silence	One full day training workshop or one 2-hour online training. For both training formats, presenters will have an in-person practice session within 30 days of training.	2 state trainers
NAMI Family-to-Family	2.5-day training workshop	2 state trainers
NAMI Family Support Group	2-day training workshop; states may use the 3-day model	1 state trainer for every 6 trainees
NAMI Homefront	Day 1 begins at 3 pm and Day 3 ends at noon, or training may be held in 2 full days	2 state trainers
NAMI In Our Own Voice	2-day training workshop	2 state trainers plus the state coordinator or other designated staff member

NAMI Parents & Teachers as Allies	1 full day training workshop	1 state trainer
NAMI Peer-to-Peer	3-day training workshop	2 state trainers plus the state coordinator or other designated staff member
NAMI Provider & Seminar	1.5-day training workshop	1 state trainer

**Compensation for state trainers**

- It is the responsibility of NSOs and NAs to take into consideration all federal and state laws regarding employees and contractors as well as the budget amount available for this purpose
- NSOs and NAs are encouraged to contract with a state trainer for his or her services. NAMI realizes funds may not always be available, but suggests that each state trainer receive a minimum amount of \$250 per training given, with the possibility of up to \$500 when funding is available. For online trainings, it is suggested that each trainer receive a minimum of \$50.
- State trainers shall be offered accommodations the night before and nights during trainings when travel is required
- Trainers should be reimbursed for all travel expenses, including any travel and meals. Reimbursement should be for the actual expenses only
- If a state trainer from one state agrees to train in another state, the trainer should receive the going rate established by the state hosting the training

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## Successful NAMI Family & Friends Leaders

- Maintain a recovery-oriented attitude: people can get better, but recovery is individual and looks different for everyone
- Model caring behavior
- Are casual, but professional
- Demonstrate that we're all in this together—not us vs. them
- Encourage participants to seek support for themselves and teach them how to help if they recognize warning signs in others
- Emphasize that mental health conditions are medical illnesses, much like other physical illnesses including diabetes, asthma, high blood pressure, etc.
- Share stories in an unemotional and straightforward way
- Keep the message positive and help families understand they're not alone
- Demonstrate respect and appreciation
- Are friendly and approachable

## Qualifications and Training Required for NAMI Family & Friends

Presenters for NAMI Family & Friends must be experienced teachers in one of the following programs: NAMI Family-to-Family, NAMI Basics or NAMI Homefront. Presenters are certified online through NAMI's LMS (learning management system), Bridge. The online training modules explain how to lead the seminar and how to use the NAMI portal. The NAMI portal is used for registration, evaluations and data.

## Preparing for NAMI Family & Friends Seminars

Unlike NAMI classes, NAMI presentation programs like NAMI Family & Friends, NAMI In Our Own Voice and NAMI Ending the Silence are unscripted requiring several hours of independent preparation to review the slides, develop talking points, plan how to divide the slides between leaders and practice presenting. As teachers and trainers for NAMI's scripted education classes, this will require an adjustment in presentation style, but it will be a rewarding experience! Learn more about NAMI Family & Friends on the NAMI website: [nami.org/familyandfriends](http://nami.org/familyandfriends)

## Crucial Messages to Share During NAMI Family & Friends

1. Mental health conditions are medical illnesses, much like any other physical illnesses.
2. Mental health conditions aren't anyone's fault or something to be ashamed of.
3. There are specific, observable early warning signs of mental health conditions. You can help your loved one by being aware of these signs and making sure you seek support for yourself and a professional evaluation for your loved one as soon as possible.
4. If you notice these warning signs in a loved one or a friend, reach out and ask how you can be helpful—don't keep warning signs a secret.
5. If your loved one is not ready to seek help, you can educate yourself about mental health and find resources meant for family members and friends.
6. People often need professional treatment and positive coping strategies to achieve and maintain recovery.
7. The earlier treatment is sought, the better the outcomes may be.
8. Acceptance is an important part of recovery.
9. Recovery is possible for most people—there is hope.
10. Reducing stigma is key to decreasing the delay between the start of symptoms and when people get treatment.
11. You're not alone and there are many resources you can turn to for support and information.

## NAMI Family & Friends Format

**Presenters:** A minimum of two adults, age 18 or older, who are family members of a person with a mental health condition. **NOTE:** A maximum of four presenters may be used provided all meet the qualifications and have completed the online training.

**Dividing Duties:** Sample agendas are included in the manual, but leaders may divide the presentation tasks as they see fit. Activities such as the Empathy Exercise and the Communication Role Plays will be conducted by the presenters in partnership.

**Presenter Stories:** Each leader will share their personal story during the section of the seminar about mental health diagnoses. The maximum time for presenter stories is 20 minutes. With two presenters each person will have 10 minutes for their story, three presenters will have 6 minutes each and four presenters will have 5 minutes each.

**F&F Presentation Format:** Each page of the presentation in your manual includes a screenshot of the slide and a text box listing **Key Points** that you will restate in your own words. Most pages also have space for you to add **Talking Points** that will enhance and personalize the presentation. Tips to help you create your presentation are listed in this section of the Presenter Manual. All activities are bold, capitalized and in italics like this: **ACTIVITY**. The **ACTIVITY** text you should say will be **bold and italicized** and the things you should consider or look for or do during an **ACTIVITY** will only be *italicized*. A sample presentation page is below.

<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>• Stigma can include stereotyping, labeling, bullying and discrimination</li><li>• Many people mistakenly believe that people with mental health conditions are dangerous or violent—this is also an example of stigma. The truth is, people with mental health conditions are more likely to be victims of violence.</li><li>• <b>ACTIVITY: <i>Let's do a comparison. What do people do when someone they know gets a cancer diagnosis? Answers may include: mow lawn, bring dinner, shovel snow, run errands, walk the dog, carpool kids, babysit, drive person to chemo/radiation, etc. What happens or what do you imagine happens when people hear someone has been hospitalized with a mental illness? Answers may include: silence, don't want to upset or embarrass the family, don't know what to say or do, afraid they will make things worse if they reach out, etc. Share personal experiences that apply here.</i></b></li><li>• Mental health conditions tend NOT to be casserole illnesses</li></ul>
<p><b>Talking Points</b></p> <p><i>Use this space for notes about your experience as the family member of someone with a mental illness to enhance and personalize the seminar!</i></p>

## Seminar Time Frame

NAMI Family & Friends was developed as a 4-hour seminar. A 90-minute version of the seminar is also available using fewer slides and containing no breaks.

### The 4-hour seminar includes:

**F&F Presentation ..... 3 hours & 10 minutes**

The F&F seminar teaches participants about the warning signs of mental health conditions, treatment options, communication strategies, crisis preparation, coping techniques and empathy. The presentation includes a PowerPoint slide deck, activities and discussion. **Time management is crucial!** Don't go over the time limits for any part of the presentation.

**Presenter Stories .....20 minutes (see note)**

This is always the most powerful portion of the presentation. Each presenter shares the mental health journey of their loved one, the impact it's had on the whole family (the person with the condition and others), what the presenter has done to care for themselves (self-care strategies) and what things are like now (see guidelines for developing your personal story in the **Presenter Tips** section of the manual on pages PT.3 – PT.11). **NOTE: Each presenter has 10-minutes to tell their story. If using 3 presenters, each has 6-minutes and with 4 presenters each has 5-minutes for their story.**

**Breaks .....20 minutes**

The F&F seminar includes two **10-minute breaks**. Be sure to start on time after each break.

**Q&A, Evaluations and Farewell .....10 minutes**

People are usually eager to ask presenters questions and/or share their personal experiences. When the Q&A is complete, presenters will remind participants that they will receive an email with a link to the evaluation.

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***TIP FROM THE FIELD:*** *Our affiliate divided the seminar into 2-hour blocks. We've held it over two evenings so people coming from work wouldn't have to stay late. We've also done the seminar on a Saturday. We started at 10am, had a lunch donated by a local restaurant, then finished the second half by 3pm. People enjoyed the time to chat and the food was great!*

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## Empathy Exercise

Supplies: index cards, pens, scripts located in the leader manual

- Depending on the room, you may need to be flexible when conducting the voices exercise.
  - If you're presenting from a stage, have volunteers join you there and do the exercise using chairs you've set up in advance.
  - If you're presenting in an auditorium in which the chairs cannot be moved, ask for volunteers from around the room to serve as the voices. Then have them stand either behind the people in the last row of seats or beside people seated along the same aisle.

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***TIP FROM THE FIELD:*** *If you're using a microphone, don't forget to turn it off before you read the instructions to participants trying to draw the shapes. I almost made it too easy!*

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## Supplies

- Projector with cables and extension cord. **NOTE: You may need an adaptor for older projectors to work with newer laptops.**
- Laptop computer with seminar slide deck loaded. **NOTE: A flash drive containing the slide deck is good for emergencies or if equipment is provided by the host location.**
- NAMI brochures and mental health information for the resource table
- Paper or index cards, pens and scripts (located in the leader manual) for the empathy exercise using voices
- Optional supplies include:
  - Wireless clicker to advance slides
  - Paper and pens for participants to take notes
  - Water, snacks or candy if your affiliate can provide them
  - NAMI promotional material (pens, notepads, bookmarks, etc. with the NAMI logo)

## Supporting materials

- **eBook:** Offered as a download to participants when they register for the seminar. It's available in 7 languages and contains information on mental health as well as useful websites. The eBook is not used during the seminar.

- **Manual:** Contains the same content as the eBook (but the page numbers don't match). Like the eBook, the manual is not used during the seminar.

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***TIP FROM THE FIELD:*** Tell people that have brought the eBook with them that they don't need it during the seminar. If your affiliate decides to offer paper copies of the manual to participants, don't hand them out until the **END** of the seminar, it's meant to be a resource for when participants get home. The eBook/manual will distract from interaction, personal stories and seminar activities.

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- **Evaluation:** Remind participants that they will receive an email with a link to the evaluation. Participants who are not registered (walk-in) will be asked to provide their name and email address when they arrive. Once their information is added to the NAMI Portal, they will receive the emailed evaluation and access to the eBook.

### **Group size**

- Audiences vary in size, but most seminars have 15 – 35 participants.
- The seminar can be offered to large groups (100+), the only limit is the size of the room!
- The Program Coordinator for NAMI Family & Friends will monitor registration using the NAMI Portal

### **Location**

- Choose a location that will has **parking** and is **handicapped accessible**
- Visit the **location** in advance so you can plan how to set up the room
- Check with the host site to be sure that you may move furniture and whether you must return chairs and tables to where you found them (in a certain arrangement, stacked against the wall, etc.)
- You might be on a stage or you may be able to move around the room – **arrive early** and you will have time to get comfortable and feel calm about presenting

- Be sure that your **equipment** works and **test** the PowerPoint slides
- Get comfortable with the **sound system** including microphones whether they are on a podium, handheld or lavalier (which are attached to your clothing).

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**TIP FROM THE FIELD:** *Everyone thinks they're loud enough without a microphone...but it's not true! Some participants have hearing problems, or the room may have bad acoustics. If there's a sound system, use it!*

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- Have a plan for how to handle the **empathy exercise** – as noted above, you might have to move chairs up on a stage or you may need to adjust to an auditorium where chairs can't be moved.

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**TIP FROM THE FIELD:** *It's helpful to have extra NAMI leaders in the room to support anyone who becomes upset during the seminar, to talk with participants individually at the end and assist with clean up.*

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## **Program coordinator responsibilities**

- This role is usually handled by the NAMI State Organization or NAMI Affiliate
- Complete the online training session about the NAMI Portal in Bridge, NAMI's LMS (Learning Management System)
- Recruit presenters who are certified teachers for NAMI Family-to-Family, NAMI Basics or NAMI Homefront (see Policies for requirements)
- Coordinate presenter training. The online training session must be completed on Bridge, NAMI's LMS (Learning Management System)
- Facilitate the process of getting new people designated as F&F presenters in NAMI 360
- Outreach to venues where presentations can be hosted
- Order program materials, only if you decide to supply the participant manual in hard-copy. Remember that everyone can download the eBook when they register. The manual is referred to but not required for the presentation.
- Coordinate seminar details with presenters
- Gather and prepare seminar materials for presenters
- Ensure participation data is collected via the NAMI Portal
- Share successes, positive youth/teacher/staff response and/or difficult situations with your state program director or, as appropriate, NAMI program manager

## Presenter responsibilities

Review the **Presentation Slides** section of the manual. Practice the **Key Points** and **Activities** for each slide in your own words, add your **Talking Points** and develop your personal story using the guidelines in the **Presenter Tips** section of the manual (pages PT.3 – PT.11).

- Decide who will present each slide
- Practice the presentation with your co-leader or co-leaders once responsibilities have been divided

The diagram illustrates the components of a presentation slide. At the top is a slide titled "What is NAMI?" featuring a map of the United States composed of numerous small human figures. Below the slide is a box containing two sections: "Key Points" and "Talking Points".

**Key Points**

- **ACTIVITY:** By a show of hands, does anyone know what the acronym NAMI stands for? Take suggestions until someone gives the correct name...thank them for their answers...restate the name National Alliance on Mental Illness.
- NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental health conditions can build better lives.
- NAMI is the foundation for NAMI State Organizations, 700+ NAMI Affiliates and thousands of leaders who volunteer in local communities across the country to raise awareness and provide essential education, advocacy and support group programs at no cost to participants.
- **ACTIVITY:** By a show of hands, is anyone a leader or volunteer with NAMI? Tell the group that you'll share information about NAMI programs later in the seminar.

**Talking Points**

*Use this space for notes about your experience as the family member of someone with a mental illness to enhance and personalize the seminar!*

- Communicate with your program coordinator about seminar logistics
- Arrive at least 30 minutes early to seminar to set up equipment and materials
- Dress comfortably
  - Nice jeans or pants, a NAMI shirt, a collared shirt, sweater or blouse with comfortable shoes. You want to look approachable and polished.
- Follow the NAMI Signature Program Code of Conduct (see **Introduction** section)

# What to Prepare for the Seminar

## 1. Set up and test your equipment

In collaboration with the host site, the presenters or program coordinator should set up the equipment and get the presentation ready to begin.

## 2. Determine if you will be handing out the manual at the seminar

All registrants are offered the opportunity to download the eBook. If your affiliate chooses to provide paper copies of the manual to participants, they can be handed out at the **END** of the seminar (see **Presenter Tip** on page P.6).

## 3. Set up a resource table

Offer mental health information, NAMI materials including: brochures, newsletters, NAMI Walks, conferences, meetings, support groups, presentations and classes. If available the resource table is great place to offer candy and NAMI promotional materials (pens, paper, wristbands, pins, bookmarks, etc.).

## 4. Attendance

Use the NAMI Portal to record if a person who registered came to the seminar (see NAMI Portal training in Bridge)

If you have a walk-in, ask for their first and last name and email address. You will add this information to the NAMI Portal, allowing them to receive the online evaluation and access to the eBook.

## 5. Confidentiality

There is no expectation of confidentiality in the NAMI Family & Friends seminar. While confidentiality is crucial in NAMI classes and support groups, we cannot request a confidentiality pledge in a seminar open to the public. The participants are not required to share personal information and the seminar may be the only contact a person has with NAMI. Like conference workshops, panel discussions, interviews or speeches, each presenter will need decide what they are comfortable sharing in their community.

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**TIP FROM THE FIELD:** *Our team created an agenda so each of us knew which slides we'd present in advance. I was less nervous sharing my family's story since I knew I'd share during the slide on OCD and my co-presenter would share during the slide on bipolar.*

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# Communication and Facilitation Skills

The following information on communication and facilitation skills will help you present and lead discussions comfortably and effectively.

## Overcoming Fear of Public Speaking

One of the first challenges all public speakers face is overcoming stage fright. The truth is that you may never stop being nervous before or during a presentation. Being anxious when speaking in public is normal. Dealing effectively with these feelings can contribute greatly to the success of your presentation. The most important thing is to remind yourself how courageous you are for being willing to share your and/or your loved one's story.

The following suggestions may help transform your nervousness into a successful presentation.

### Before the presentation

- **Take care of your body.** Get enough rest the night before so you'll have plenty of energy during the presentation.
- **Eat well.** Eating a balanced, healthy meal before a presentation will give you strength and may help you feel calmer. It's a good idea to avoid sugary foods or too much caffeine. NEVER drink alcohol just before a presentation.
- **Dress appropriately and comfortably.** Wear clothes you like and feel good in. It is important to feel confident about how you look. The first impression you make will affect how your audience sees your presentation. Looking clean and neat will help your presentation be effective.
- **Be well-prepared.** Don't wait until the last minute to prepare your presentation. Rehearse out loud and in front of people, if possible, several times. Know your material so that you can give your presentation even if something unexpected happens.
- **Imagine yourself doing well.** See your presentation going smoothly, step by step, from start to finish. Picture yourself being introduced, walking to the speaker's stand and speaking to a warm, responsive audience. Imagine yourself speaking clearly. Imagine hearing the audience applauding enthusiastically when you're done and asking you good questions during the Q & A. Imagining the presentation this way will increase your confidence and help prepare you for the whole experience.
- **Think positively.** Don't think, "I know I'm going to make a mistake," or, "I'm so nervous, I'll never get through this presentation." Remember, the audience isn't looking for perfection, they are looking for real and honest stories from brave people like you!

## During the presentation

- **Concentrate on your message.** When you believe you have something important to share with your audience, it's easy to get excited about what you are going to tell them. When you focus on your message, you'll feel less self-conscious. As former First Lady, Lady Bird Johnson, observed, "The way to overcome shyness is to become so wrapped up in something, you forget to be afraid."
- **Take several deep breaths.** When people experience stage fright, they often start breathing quickly. That can cause you to run out of breath every few words and have trouble speaking clearly and easily. Breathing deeply breaks this cycle and calms you. A good approach is to breathe from the diaphragm (imagine your belly expanding as you breathe, rather than your chest moving up and down). Breathe in for a count of four, hold your breath for four counts, and breathe out slowly.
- **Move your body.** This releases nervous energy. If you're in front of the class and unable to move around before your presentation, just standing can help.
- **Gain confidence by doing.** Practice by presenting! The more presentations you do, the easier they will be and the more confident you'll feel.
- **Remember, your audience is probably curious about what you're saying.** People are interested in hearing from someone new.
- **It is okay to make a mistake.** Speakers—even professionals—make mistakes. If you learn to laugh at yourself, it can build a better relationship with your audience. It may even help them relate to you. Also, the participants don't know what you were planning to say. If you forget a part or don't say something the way you had intended, keep going with your presentation. Probably, no one will even notice.
- **Notice friendly faces and make eye contact with them.** Looking at others while you're speaking or while they are speaking to you is very important. You're letting others know that they're receiving your full attention and that you value the exchange.

## After the presentation

- **Congratulate yourself!** Sharing the most personal parts of our lives with complete strangers takes a great deal of courage. Give yourself credit, even if you think you could have done better.
- **Evaluate yourself without being critical.** Choose one or two things you'd like to improve for your next seminar, but don't make a long list of things you think you did wrong. Be sure to note the positive things you did and remember the good feelings doing a presentation gives you.

# Using I-Statements

## What are I-statements?

Most F&F presenters have a passion for reaching others. We enjoy sharing our stories to help eliminate negative stereotypes about mental health conditions.

But sometimes the language we use can create a barrier between us and the people we hope to reach. This is why using I-statements is so important to the F&F program.

I-statements begin with “I feel” or “I think” or “I experienced” rather than “people feel” or “people experience” or “everyone should.” It is impossible for one person to speak for any group. Starting a thought with “I” clarifies that you’re speaking from your personal point of view.

I-statements are non-judgmental. They don’t accuse any people or groups of certain intentions or behaviors. They’re not meant to change the person with whom you’re talking. I-statements are a great way to convey how **you** feel.

I-statements are an effective way for individuals to take responsibility for their feelings. They are especially effective when expressing needs or emotions.

## Why is this so important?

Mental illness can be controversial. Some people have strong opinions and many of us who have experienced mental health conditions are very passionate about how our feelings and experiences are perceived.

These two factors can lead to uncomfortable situations. We want to promote understanding, not make participants feel defensive or bad for having the courage to ask a question. F&F is not meant to lecture or shame people, we want to share information and our experiences with them.

Note the difference in tone between the I-statements and you-statements compared on the following chart:

<b>Comparisons</b>	
<b>I-Statements</b>	<b>You-Statements</b>
"I was hurt when my son yelled at me all the time. I just didn't know how to react at the beginning."	"You have to be more understanding towards your loved one if they have a mental illness. They can't help the way they are."
"I'm not sure what you're asking me. Can you rephrase the question?"	"Your question is confusing. Ask it a different way."
"It feels great to have friends who support me even when my son isn't doing well."	"You should be more supportive of your friend who has schizophrenia."
"Having to face mental health challenges has helped me build confidence and inner strength."	"People with mental health conditions are usually stronger than other people because we've had to endure more than you have."

### **Special note**

Beware of you-statements that sound like I-statements. For example:

*"I believe you should see a therapist to deal with your issues."*

Although the statement begins with, "I believe," it's really a you-statement. It's directing a person to do something. When presenting an F&F seminar, try not to use phrases that imply you speak on behalf of all family members. Avoid using phrases that are sound like advice such as "you must," "you shouldn't," "people need to," "society must stop," etc.

## Using Reflective Responses

### What is a reflective response?

A reflective response is a statement that validates a person's feelings or opinions by rephrasing their statement and reflecting back the feeling they have expressed. When offering a reflective response, don't repeat back directly what a person has said, but instead paraphrase what you have heard.

Use reflective responses when facilitating a discussion with the audience. Reflective responses are particularly helpful when answering an audience member who expresses strong emotions or opinions after hearing your story.

Example:

**Frustrated Father:** *"It makes me angry that the doctor doesn't listen to me when I complain about the side effects of my son's medications."*

**Reflective Response:** *"Wow, I hear your frustration. It must be hard to feel ignored by the doctor. Thank you for sharing that."*

This type of reflective response communicates several things:

- It validates the father's emotion
- It shows that the presenter was listening
- It communicates empathy and compassion

### Why use reflective responses?

Reflective responses help any group discussion run more smoothly. They encourage people to share their experiences by creating a sense of emotional safety.

Reflective responses **require** that you **DO**:

- Listen closely
- Try to capture the feelings and thoughts being expressed
- Reflect those feelings and thoughts back to the speaker
- Ask for confirmation
- Be genuine and sincere – if you don't feel it, don't say it

Reflective responses **require** that you **DON'T**:

- Interrupt the speaker before they're finished
- Project your own feelings and opinions onto what the person expresses
- Disregard what is being said by abruptly changing the subject
- Give advice or try to fix the other person or situation
- Fake sincerity or interest

### **Important things to remember**

- Be aware of comments that try to fix or change others – don't give advice
- Use I-statements and speak from your own perspective only
- It's fine to say, "I'm not able to advise you on that. I'm just here to share my story" or "I'm sorry, but I don't have any experience or expertise in that area"
- **NEVER** argue or debate with audience members! Even if someone says something you disagree with, you can still respect their point of view. Try using language such as, "Different approaches work for different people. Thank you for sharing."
- Sometimes it's best just to say, "Thank you for sharing that."

### **Reflective Response Exercise**

Practice responding to these statements:

**Discouraged Daughter:** "I can't stand it anymore. My mom will not take her medication. She is talking really fast about things that don't make any sense and she wants me to hang out with her in the middle of the night all the time. I feel so helpless. What can I do about this?"

**Annoyed Artist:** "I have a mental health condition and don't need to go to sleep early to stay well. I'm a night owl! I enjoy being up at three in the morning—it's when I'm most creative. It never hurt me!"

**Anxious Aunt:** "I'm afraid that if my nephew takes mental health medications they'll do more harm than good...all those side effects are awful! I've heard that herbal supplements are good for his condition, so I'm heading to the health food store after this seminar."

## Frequently Asked Questions and Sample Responses

*These are examples only. Please use your own words and share examples from your own lived experience whenever possible.*

**Q: Why don't people just get over depression?**

R: When depression continues over time, people may need help to deal with it effectively. It may also take some time to find good interventions like the right type of therapy or medication to create an effective treatment plan.

**Q: How do you get a mental health condition?**

R: There's a lot we still don't understand about what causes mental health conditions. In general, doctors think mental health conditions are caused by a combination of a variety of biological and environmental factors, such as:

**Inherited traits:** Mental health conditions are more common in people who have a biological family member with a mental health condition.

**Biological factors:** In addition to inherited traits, outside forces have been linked to mental health conditions—for example, traumatic brain injury or exposure to viruses or toxins.

**Life experiences:** Sometimes challenges or traumatic experiences in your life, such as the loss of a loved one, being assaulted or prolonged high stress can play a role in triggering a mental health condition. Other life experiences such as a history of sexual or physical abuse, or neglect can also be a factor. You may already have a genetic vulnerability to developing a mental health condition, and a stressful or traumatic life experience may trigger the actual condition itself.

**Brain chemistry:** These are called “biochemical causes,” and are changes that happen in the brain. Scientists believe they affect mood and other aspects of mental health. Natural brain chemicals called neurotransmitters play a role in some mental illnesses. In some cases, hormonal imbalances can affect mental health. Doctors think that inherited traits, life experiences and biological factors can all affect the brain chemistry linked to mental health conditions.

**Q: Can a mental health condition be cured?**

R: Currently, there is no cure for mental health conditions. But, there are many very effective treatments.

**Q: Does everyone have to take medications?**

R: No, but many people find that a combination of therapy and medication that works best for them or their loved one.

R: No. There are many types of treatment for mental health conditions. Sometimes people can manage their mental health through positive coping strategies and a strong support network. However, it's best to discuss options with a doctor and determine the treatment plan together.

**Q: If someone takes medicine will they have to take it for the rest of their life?**

R: It depends on the individual, their symptoms and whether other forms of treatment and coping strategies help them manage the symptoms. The decision to stop taking medication is one that should only be made in consultation with a doctor.

R: Many people try stopping their medication when they begin to feel better—but often the symptoms came back. It's frustrating—with most physical illnesses, you stop taking medication when you feel better. However, with mental health conditions, many people learn that if they feel better, it means they have found the right treatment combination and if they want to keep feeling better, they need to continue taking their medication.

**Q: Why do people stop taking medication or not want to take it in the first place?**

R: Medications typically have side effects, and some are unpleasant. The side effects that have been particularly challenging for my husband include: dizziness, upset stomach, dry mouth and decreased sex drive, to name a few. Some medications can also cause damage to other parts of your body such as your kidneys, heart or thyroid.

R: Think about a time you took medication for a physical issue such as a headache. There's a good chance once the symptoms disappeared, you quit taking the medication. Right? The same thing happens when people take medication for a mental health condition. A person may believe or hope that they are better, which sometimes leads them to stop taking their medication.

**Q: Which mental illness do you think is the worst?**

R: It's difficult to say that one mental health condition is worse than another. Each person's experience is unique and can be very challenging no matter what the symptoms or diagnosis may be.

**Q: How early or how late in life can people get a mental health condition?**

R: About half of all individuals with mental health conditions began to experience symptoms by age 14. Sometimes people can show signs as early as 4 or 5. With about 75% of all people beginning to experience symptoms by age 24, it's most common for mental health conditions to begin sometime before a person reaches their late 20s. However, even when symptoms have been experienced early in life, it often takes many years for some people to seek treatment.

**Q: What does medication do for your loved one?**

R: My son takes a mood stabilizer for his mental health condition. His medication helps keep him from having extreme feelings of happiness, sadness or anger. The medication also helps him sleep, which is a critical part of his recovery. However, there are also some unpleasant side effects like weight gain and drowsiness. But he feels that having the ability to keep his mood stable, work, have meaningful relationships and maintain his recovery is more important than the side effects.

**Q: What should my friend who is showing signs of depression do if he doesn't want to ask anyone for help?**

R: Continue to urge your friend to seek help. Facing that you might have a mental health condition can be challenging for many reasons. You could offer to go with them to talk to someone. There are also resources on the NAMI website that your friend can use to get information and support anonymously.

**Q: Do you regret not doing anything to help your child earlier?**

R: As a parent, I wish I would have known more about mental health conditions and been able to identify the signs my child was showing earlier. I could have been a stronger advocate for my child by giving more details to his psychiatrist that could have been very helpful.

**Q: Why did your wife/partner/girlfriend attempt suicide? Was she sorry it didn't work?**

R: That's a complicated question to answer—there were a lot of reasons. She was feeling miserable and didn't think she would ever feel better. At the time, she couldn't see that her situation was temporary. I'm not sure if she was sorry in that moment that it didn't work, but once she got help and began to feel better, she was incredibly grateful to be alive.

**Q: What if our extended family doesn't believe our daughter is depressed or experiencing other symptoms of a mental health condition?**

R: There's information on the NAMI website that can help start a conversation. Think about talking to a counselor, or a doctor about resources and approaches that might help others to understand what is going on with your loved one.

**Q: My cousin is very depressed but made me promise not to tell his parents. What can I do?**

R: First, that's wonderful that you want to help your cousin. You can encourage him to talk to another adult such as a teacher, coach or counselor. There are also resources on the NAMI website you and your cousin can use to get information and ideas on how to get support anonymously.

If your cousin mentions having suicidal thoughts, talk to him about it, listen without judgment, but most importantly, TELL a trusted adult as soon as possible. It is not a betrayal to get help for your cousin during this critical time. When I asked my daughter's high school friends why they didn't tell anyone when she told them she was having suicidal thoughts, they all said they now wished they had risked her being upset so she could have been helped earlier.

**Q: What medications does your loved one take?**

R: I don't like to share the brand names of medications my loved one takes because everyone reacts differently. I can tell you that she takes a mood stabilizer/ antidepressant/ antipsychotic (focus on the type or class of medication rather than the brand).



[INSERT]  
Presenter  
Tips Tab



# Tips for Presenting the PowerPoint Slides

## 1. Create an engaging, unique and effective presentation

Ask yourself these three questions as you develop your talking points.

- How can I briefly restate the key points in my own words?
- How can I engage the family and friends in the audience?
- How can I use examples from my lived experience to illustrate the key points?

You don't have a script for this presentation. Instead, you can share a few key points for each slide that you need to cover. Use your own words, engage the audience and personalize your presentation with examples from your life. You won't have the time to include your experiences related to every slide in the seminar, but your goal should be to do so as much as possible in the allotted time.

You will need to prepare talking points for every slide, so you are comfortable presenting all topics covered in the seminar.

## 2. Be concise

Brief, specific examples have a greater impact on audiences, so keep your message concise when you're creating your talking points. This is especially important when sharing examples from your own experience.

On average, use about 1-2 minutes to present each slide. This will help you keep the attention of the participants and complete your presentation within the 4-hour timeframe.

## 3. Remember the purpose of NAMI Family & Friends (F&F)

- Raise mental health awareness
- Reduce stigma
- Offer skills and resources

F&F isn't meant to teach people all there is to know about mental illness. You are showing them that it's okay to talk about mental health conditions and the symptoms associated with them because stigma is often the most common reason people don't seek treatment.

### Use relatable examples

Engage people by emphasizing key points using examples from your life. Your presentation will be more effective if you share experiences that families can relate to. Use these questions to come up with examples from your life:

- What were the early warning signs your family member experienced?
- What role do you or your family play in your loved one's recovery?
- How do you care for yourself as a family member when things get stressful?

#### **4. Use words that everyone can understand**

When you use simple, short words, you'll help people better understand your message. Long words, technical words and slang or idioms (jargon or figures of speech) can distract people from your message. If you do use a more technical word like "psychotic," it's important to describe what psychosis looks and feels like for your loved one.

#### **5. Don't read the slides**

What you say should expand on the slide content, not repeat exactly what's written on them. Participants will read the slides on their own. If you read the slides, you'll bore your audience and they won't absorb what you're trying to communicate. Instead, use the slides just to help you pace yourself and as a reminder for what you want to say. It's helpful to have the presenter manual with the **slides, key points** and your **talking points** in view. It's also important that you can see the laptop, so you can reference the slides without having to turn your back on your audience.

#### **6. Speak clearly and loudly**

When you're speaking, try to project your voice—to speak loudly and clearly enough that even people in the back of the room can hear you. This is a different way of speaking than you do in most conversations. At the start of your presentation, ask your audience if you're speaking loudly and clearly enough and invite them to raise their hand if at any point they can't hear you. Some settings will require a podium a microphone or both. Get comfortable presenting while holding a microphone.

#### **7. Use effective non-verbal communication**

Eye contact can be challenging, but it's worth practicing. Don't look down at your notes as you speak. Instead, look at them briefly when you need to remind yourself what you want to say next. You can keep people engaged and interested in what you're saying with good eye contact, hand movements that support your words and by naturally walking around the front of the room instead of standing still in one location.

#### **8. Know your material**

Practice is essential. When you know your talking points well, you'll feel relaxed and you can focus on engaging your audience.

When you're familiar with the information in the Key Points as well as the resources listed in the participant manual, you can answer questions better and direct people to available options.

# Tips for Sharing your Personal Story

## 1. Use I-statements and avoid you-statements

Your story is your personal experience. Keep this perspective by using I-statements. Don't give opinions, advice, or make general statements about a group of people. Always avoid you-statements.

## 2. Be descriptive—use specific examples

Participants may not understand what it means to be “depressed,” “manic,” or to have a “panic attack.” Either they've never heard these terms, or they've never had them defined. You can help people understand your experiences by using descriptive, specific examples. Instead of just saying that your loved one felt anxious or sad, describe what anxious or sad felt like and looked like for your family—really paint a picture for them.

Examples of descriptive statements:

- “Just getting out of bed was like lifting a hundred-pound weight.”
- “He got himself into over \$5,000 of debt in a single day.”
- “Her heart beat so fast she could barely breathe. She thought she was having a heart attack.”

## 3. Follow the Presenter Story Guide closely as you create your story

Each section of your story can be compared to individual cars of a train. Each car of the train may be different from the other, but they are attached, all moving in the same direction toward a common destination. You can follow the **Presenter Story Guide** in this manual to help you share your story in a clear, organized way.

## 4. Present your story within the 10-minute time frame (see note)

You can't share every part of your experience in 10 minutes, but you must keep to this time limit. Remember, you're just giving participants an idea of what it's like have a loved one with a mental health condition, not telling your entire life's story. **Note: Each presenter has 10 minutes to tell their story. If using three presenters, each has 7 minutes for their story.**

## 5. Make your story relevant and relatable to the families and friends attending

Your story will be more meaningful to people if you share experiences that they can relate to. If you make your story relevant, you'll help them connect on a personal level and keep them engaged throughout your presentation. See the key questions to address in each section to create relatable talking points.

## **6. Incorporate the Crucial Messages of NAMI Family & Friends**

It's important to be genuine, but more so than with other programs, F&F has a specific purpose. We want to empower participants to talk openly about mental health, ask for help when they recognize early signs in loved one or a friend and to feel comfortable seeking professional treatment. We also want to let them know about NAMI resources like classes and support groups.

You can help us achieve these goals and reduce stigma by incorporating the Crucial Messages of F&F. You can find a list of these messages in the Presentation Prep section of this manual.

## **7. Use words that can be understood by everyone**

As noted earlier, when you use simple, short words, participants will understand your message. If you do use a medical word like manic, it's important to describe what manic looks and feels like. This will help people relate to your experiences.

## **8. Only share experiences that you're comfortable talking about**

This should be an empowering experience for you and the audience. Talking about something that deeply upsets you won't help your presentation. Please protect yourself—you are in control of what you say and how much you choose to reveal. There is no expectation of confidentiality for the seminar. Much like conference workshops, panel discussions, interviews or speeches, each presenter will need decide what they are comfortable sharing in their community.

## **9. Project your voice**

When you're speaking, try to project your voice—that is, speak loudly and clearly enough that even people in the back of the room can hear you. It's a good idea to ask your audience at the start of the presentation if you're speaking loudly and clearly enough. Again, if there is a microphone please use it!

## **10. Slow down**

Design your presentation so that you're able to speak at a relaxed pace. If you must rush to include everything, you may need to shorten your story or find simpler ways to express it. If you're unable to sound clear and in control while you share, people might not relate to your story or remember what you say. Connecting with your audience is rewarding for you and them.

## **11. Use effective non-verbal communication**

Eye contact is important when sharing your story. It can be challenging, but it's worth practicing. Don't look down at your notes. Instead, use them as a reference tool and only look at them briefly when needed.



# Language Matters

Recovery is possible for anyone with a mental health condition. Choosing words that acknowledge a person's resiliency, strength and courage in the face of challenges breaks down negative stereotypes, encourages connection and gives people hope.

You can choose words that eliminate stigma and reflect an understanding of mental health using this tip sheet to guide you. Help others see that people living with mental health conditions are just people. This simple, but caring approach may encourage someone in need to reach out for support.

It only takes one person to make a difference. Lead by example. Be that person.

A person is not their mental health condition. Just like you wouldn't say someone is cancer, use "has" or "lives with" instead. Talk about mental health in a way that empowers people. Words like "brain disorder/disease," "mentally ill" and "suffers from" can be intimidating and give the illness the power.

Language Tips	
Say	Instead of
Mental health	Mental illness
Mental health condition	Brain disorder or brain disease
Person living with a mental health condition	Consumer or patient
My daughter has Bipolar Disorder	My daughter is bipolar
Lives with or has	Suffers from, afflicted with or mentally ill

Talking About Suicide	
Say	Instead of
Suicide attempt/ attempted suicide	Failed suicide or unsuccessful attempt
Died by suicide/ suicide death	Successful or completed suicide
Took their own life	Committed suicide
Died as a result of self-inflicted injury	Chose to kill him/herself
Disclosed	Threatened

When talking about suicide, consider other meanings your words may have. For example, "committed suicide" implies that suicide is a crime. You can help eliminate the misunderstanding and stigma that prevent people from speaking up and getting support by choosing words that are more clear and neutral.



# Leader Story Guide

## Part 1: Introduction (1 minute)

Introduce yourself and tell a little bit about your life (home, family, work, hobbies, interests, friends, significant other, pets, etc.). It's important to share who you are in addition to your role as a family member of someone with a mental health condition.

**NOTE: Don't mention your loved one's diagnosis here**

## Part 2: What Happened (3 minutes OR 2 minutes if there are three presenters)

In the What Happened part of your story you'll help participants understand what it's like for your loved one to experience symptoms and the impact an undiagnosed or untreated mental health condition can have.

You only have three minutes to describe this part of your story. Use your time wisely and don't let this section become the focus of your presentation.

If you want to talk about a suicide attempt or suicidal thinking, review the Do's and Don'ts of Talking About Suicide.

### Build your "What Happened" section by addressing the following key questions:

- What was life like before your loved one started having symptoms of a mental health condition?
- What were some of the early warning signs that your loved one experienced? Did you notice them before your loved one did?
- How did friends and family react when the warning signs began?  
It's good to give some positive examples of family or friends helping you out, if that applies to your situation. We want to show that family and friends can make a positive difference. Even if you didn't have anyone that helped, you may want to say what would have been helpful to you, for example: "It would have helped if my friends had asked how my son was doing so I wouldn't have felt so isolated."
- What did the most challenging symptoms and the lowest point look and feel like in your family?
- Did the mental health condition negatively impact your loved one's success in school, relationships or anything else that's important to him/her? If so, how?
- How did stigma or a lack of understanding about what your family was going through affect you during the Crisis Phase?
- Did you or your loved one find it difficult to accept that additional support was needed? What was the impact of this on the family?
- Were there any additional barriers to treatment that you encountered with your loved one?

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### ***The Do's and Don'ts when discussing suicide attempts or suicide ideation***

#### **The Do's**

- Do emphasize prevention. Reinforce the fact that there are preventative actions that people can take if they are having thoughts of suicide or know others who are or might be. Emphasize that suicide can be prevented and to take suicide ideation seriously.
- Do list the warning signs that your family member was showing.

#### **The Don'ts**

- Don't present suicidal thoughts as an unavoidable or understandable response to mental health condition symptoms or stressful experiences. Oversimplification can lead to the belief that suicide is a normal response to relatively common life situations.
  - Don't present overly detailed descriptions of suicide attempts or methods of suicide. It can be dangerous to provide detailed descriptions of these acts for vulnerable individuals. The same is true with descriptions of self-harm like cutting—don't go into details of how you did it or what tool you used.
  - Don't normalize suicide or suicidal thinking by presenting it as a common event. Although in 2010 suicide was the 2<sup>nd</sup> leading cause of death among youth ages 12-17 years, it's important not to present this information in a way that makes it seem acceptable, common or normal. The truth is, most people don't seriously consider suicide and therefore, suicidal thinking is not normal.
- 

#### **Additional Crisis Phase tips:**

- Don't avoid the subject of suicide attempts or suicidal thoughts, but do not give graphic details either. The "Do's and Don'ts" to the left includes a few guidelines and best practices for discussing suicide with young audience.
- If you talk about self-harm or drug or alcohol use, emphasize that these were negative coping strategies and not effective ways to deal with feelings and symptoms of a mental health condition.
- Many of us have experienced traumas or challenges in our past such as addiction, homelessness, molestation, rape, physical abuse, discrimination, etc. While these may have been an important part of your loved one's life or perhaps even triggered their mental health condition, remember to keep the focus on mental health.
- If you share your experiences with doctors, law enforcement, inpatient facilities, etc., talk about them in general terms. Don't mention a person by name or the name of a facility you were at.
- Be careful not to share too much—know your boundaries. Don't go into parts of your experience that cause you pain. Keep yourself emotionally safe.
- It's impossible to share your entire story leading up to the discovery of a mental health condition and describe all the most challenging and traumatic experiences in three minutes. Remember that the objective is to just give a window into a real-life example of what it's like to experience symptoms of a mental health condition.

### **Part 3: What Helps (3 minutes OR 2 minutes if there are three presenters)**

This is an important part of the presentation, where you'll share a hopeful part of your family's journey with your audience. This is also where you will describe how your loved one maintains their recovery through treatment and/or positive coping strategies.

Start this section with the process you and your loved one went through to accept the mental health condition. Often this is a significant barrier to seeking treatment and it is also the most critical in beginning the process of recovery.

Then talk about treatment that has helped such as therapy or medication. However, don't give the name of any specific medications. Instead, you can refer to medications by type, such as a mood stabilizer, anti-depressant, etc.

Note: If you talk about self-harm or drug or alcohol use in your crisis phase, it's important to share how your loved one was able to use positive coping strategies to replace them.

Your story will be much more effective and impactful if you keep the focus on the positive parts of the journey in acceptance and recovery. It's very important that participants leave your presentation feeling hopeful.

#### **Build your "What Helps" section by addressing these key questions:**

- What kind of things helped your loved one reach acceptance? What was your own process of acceptance like?
- Did friends, family or a professional play an important role in your loved one coming to terms with their mental health condition? If so, how?
- What role has acceptance played in their recovery?
- What does recovery mean to your family?
- What roles do therapy and/or medication play in your loved one's recovery?
- What healthy coping strategies has your loved one developed to achieve and maintain their recovery?
- What roles do friends play in your own self-care as a family member?
- What role has support networks (friends, family, NAMI groups) played in both your family member and your own wellness?

### **Part 4: What's Next (2 minutes OR 1 minutes if there are three presenters)**

In this section, you will share your family's successes, hopes and dreams for the future. We want to inspire others to hope and succeed, and to feel hopeful for those affected by mental health conditions.

### **Build your “What’s Next” section by addressing these key questions:**

- How do you and your family define success?
- What successes has your loved one been able to accomplish while living in recovery? Why are these meaningful to you?
- What hopes and dreams do you have for yourself and for your loved one’s future? What are you looking forward to?

### **Part 5: Closing Statement (1 minute)**

In this section, you want to state why you are sharing your loved one’s story of recovery with the participants. Some things you could say include:

- To fight the stigma around mental health
- To encourage them to talk openly and honestly with others about mental health
- To tell you about the many services NAMI can provide and other places where you can get help
- To let them know they are not alone if they’re loved one is experiencing symptoms of a mental health condition
- To encourage those families of people experiencing symptoms to seek support for themselves...emphasizing the importance of self-care!
- To remove the shame and communicate hope

Your story will be **10 minutes** long or **7 minutes** if using three presenters. Practice as much as possible and enjoy the experience of reaching out to people!

### **Presentation tips**

- You can use index cards for notes during your presentation, but it’s important to keep them brief. Use notes only to help you remember important points or the outline of your presentation.
- When you’re giving your presentation, focus mostly on your audience and less on saying exactly what you planned. The more you practice, the easier this will be.
- Using a timer or watch will keep you on track with time.

## Presenter Checklist

As you develop your talking points, ask yourself these questions for each slide:

- How can I briefly restate the key points in my own words?
- How can I engage the participants?
- How can I use examples from my lived experience to illustrate the key points?
- How can I tell my family story in the most effective way?

Please also use this checklist as a guide.

Presenter Content and Approach	
PPT Slides	Method/Style
Key Points	<input type="checkbox"/> Talking points were concise <input type="checkbox"/> Didn't repeat content from slides word-for-word <input type="checkbox"/> Used simple, short words that can be easily understood by everyone <input type="checkbox"/> Included lived-experience examples that participants related to <input type="checkbox"/> Asked questions to engage participants <input type="checkbox"/> Used "I" statements
PPT Slides	Mental Health – Language Used
Talking Points	<input type="checkbox"/> Used the phrase <b>mental health</b> as well as <b>mental illness</b> <input type="checkbox"/> Used the phrase <b>mental health condition</b> as well as <b>brain disorder or mental illness</b> <input type="checkbox"/> Used the phrase <b>person with a mental health condition</b> or <b>person in recovery</b> instead of <b>consumer, client</b> or <b>patient</b> <input type="checkbox"/> Used the phrases/terms <b>has</b> "or <b>experiences</b> a mental health condition/mental illness instead of <b>is, suffers from, afflicted with</b> or <b>mentally ill</b>
PPT Slides	Suicide/Self-Injury – Language Used
Talking Points	<input type="checkbox"/> Used the phrases <b>suicide attempt</b> or <b>attempted suicide</b> <input type="checkbox"/> Avoided use of terms <b>failed suicide</b> or <b>unsuccessful attempt</b> <input type="checkbox"/> Used the phrases <b>died by suicide, death by suicide, took their own life</b> or <b>died because of self-inflicted injury</b> <input type="checkbox"/> Avoided use of phrases <b>successful</b> or <b>completed suicide, committed suicide</b> or <b>chose to kill him/herself</b> <input type="checkbox"/> Used the phrase <b>disclosed they are suicidal</b> instead of <b>threatened suicide</b>

<b>Personal Story</b>	<b>Actions to include</b>
Introduction	<input type="checkbox"/> Introduced yourself without mentioning mental health condition, so participants know something about you and your interests
What Happened	<input type="checkbox"/> Explained what technical words like <b>manic</b> or <b>panic attack</b> look and feel like for your loved one using examples or descriptions <input type="checkbox"/> Described early warning signs your loved one experienced <input type="checkbox"/> Mentioned suicide attempt or self-injury without providing too much detail (if applicable) <input type="checkbox"/> Mentioned self-injurious behavior or substance use/abuse, emphasizing that they were negative coping strategies (if applicable) <input type="checkbox"/> Maintained good composure without becoming overly emotional <input type="checkbox"/> Kept within 3 min on this section.
What Helps	<input type="checkbox"/> Presented acceptance as an important part of recovery both for yourself as a family and for your loved one <input type="checkbox"/> Mentioned examples of how you advocated for your loved one and worked to collaborate with them to find the best treatment options and supports <input type="checkbox"/> Mentioned positive experiences when seeking professional treatment <input type="checkbox"/> Mentioned their treatment plan without stating names of specific medications <input type="checkbox"/> Provided examples of positive coping strategies your loved one uses <input type="checkbox"/> If mentioned negative coping strategies (substance use, self-harm) in Crisis Phase, addressed how they were replaced with positive coping strategies <input type="checkbox"/> Mentioned what you do to care for yourself when things get difficult, how you maintain balance in your life <input type="checkbox"/> Mentioned what has been helpful to you (NAMI programs, peer support, etc.)
What's Next	<input type="checkbox"/> Stated accomplishments of their loved one while living in or working toward recovery <input type="checkbox"/> Mentioned improved relationships, hobbies and other personal pursuits <input type="checkbox"/> Mentioned hopes and dreams for the future
Closing	<input type="checkbox"/> Stated why you're sharing your story
<b>Personal Story</b>	<b>Things to avoid when sharing your family story</b>
	<input type="checkbox"/> Avoid focusing on unresolved anger or pain from your loved one's experiences <input type="checkbox"/> Avoid placing too much focus on the crisis phase or negative parts of the recovery journey <input type="checkbox"/> Avoid maintaining a negative outlook or lack of hope <input type="checkbox"/> Avoid mentioning doctors, facilities or specific medications by name <input type="checkbox"/> Avoid expressing the view that recovery isn't possible for everyone, rather than saying that recovery is a process and it looks different for everyone <input type="checkbox"/> Avoid using stigmatizing words or phrases such as: <b>he's schizophrenic</b> or <b>she's mentally ill</b> . Instead say: <b>he has schizophrenia</b> , or <b>she has a mental illness</b> .



[INSERT]

4-hour  
Seminar

Tab



## Seminar Time Frame (4-hour version)

### The 4-hour seminar includes:

**F&F Presentation ..... 3 hours & 10 minutes**

The F&F seminar teaches participants about the warning signs of mental health conditions, treatment options, communication strategies, crisis preparation, coping techniques and empathy. The presentation includes a PowerPoint slide deck, activities and discussion. **Time management is crucial!** Don't go over the time limits for any part of the presentation.

**Presenter Stories .....20 minutes (see note)**

This is always the most powerful portion of the presentation. Each presenter shares the mental health journey of their loved one, the impact it's had on the whole family (the person with the condition and others), what the presenter has done to care for themselves (self-care strategies) and what things are like now (see guidelines for developing your personal story in the **Presenter Tips** section of the manual on pages PT.3 – PT.11). **NOTE: Each presenter has 10-minutes to tell their story. If using 3 presenters, each has 6-minutes and with 4 presenters each has 5-minutes for their story.**

**Breaks ..... 20 minutes**

The F&F seminar includes two **10-minute breaks**. Be sure to start on time after each break.

**Q&A, Evaluations and Farewell ..... 10 minutes**

People are usually eager to ask presenters questions and/or share their personal experiences. When the Q&A is complete, presenters will remind participants that they will receive an email with a link to the evaluation.

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**TIP FROM THE FIELD:** *Our affiliate divided the seminar into 2-hour blocks. We've held it over two evenings so people coming from work wouldn't have to stay late. We've also done the seminar on a Saturday. We started at 10am, had a lunch donated by a local restaurant, then finished the second half by 3pm. People enjoyed the time to chat and the food was great!*

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**TIP FROM THE FIELD:** *It's helpful to have extra NAMI leaders in the room to support anyone who becomes upset during the seminar, to talk with participants individually at the end and assist with clean up.*

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### Key Points

- **ACTIVITY:** Set up the room in advance. Place NAMI brochures on the resource table. Be sure to have the materials for the voices exercise ready (pens, index cards and scripts). If you are providing pens and paper for taking notes have them available for participants on the resource table. **Note:** Check with your coordinator to determine if a paper manual will be provided. If so don't hand them out until the **END** of the seminar. Greet people as they arrive, take attendance (using the NAMI Portal or a sign-in form) and show them the resource table. Start on time!

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- Welcome everyone and let them know that we won't be using the eBook/manual during the seminar, it's for future reference.

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- **ACTIVITY:** Each presenter gives an enthusiastic introduction of themselves. Include first name, a fun fact about you (hobby, pets, career, etc.), how long you've been active with NAMI, your role as the family member of someone with a mental illness (**DON'T** mention your loved one's diagnosis here). **BE BRIEF** – no more than 1 minute per presenter the details come later!

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- Tell participants where the restrooms and drinking fountain are. Request that phones are turned off or silenced, ask that calls are taken outside of the room. Introduce any NAMI representatives and volunteers present, point out the materials on the resource table. Tell participants there will be breaks during the seminar (mention snacks if they'll be provided) and an opportunity to ask questions at the end.

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- The purpose of this presentation is to share general information about mental health as well as skills you can use at home that can help with communication, managing stress, self-care and crisis preparation.

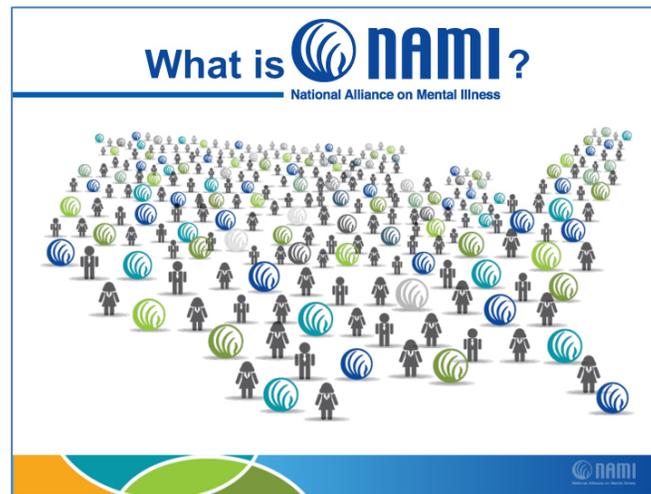
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- You'll also learn about programs and resources NAMI offers.

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- **Disclaimer:** We are not psychiatrists or social workers or therapists. But we know what it's like to have a family member with a mental health condition. We call this "lived experience."

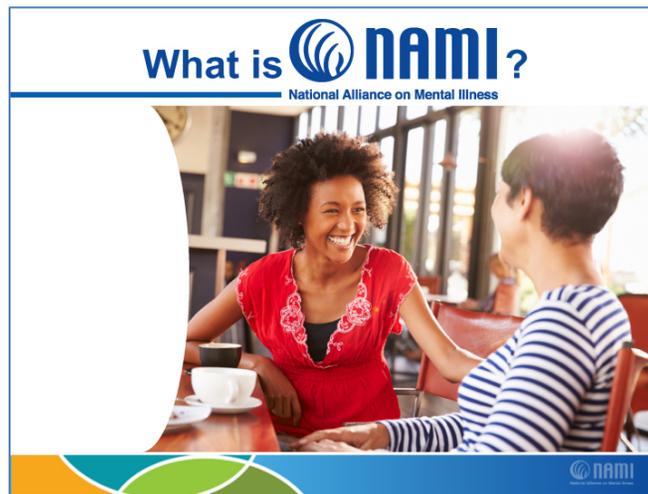
### Talking Points



### Key Points

- **ACTIVITY: By a show of hands, does anyone know what the acronym NAMI stands for?** Take suggestions until someone gives the correct name...thank them for their answers...restate the name National Alliance on Mental Illness.
- NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental health conditions can build better lives.
- NAMI is the foundation for NAMI State Organizations, 700+ NAMI Affiliates and thousands of leaders who volunteer in local communities across the country to raise awareness and provide essential education, advocacy and support group programs at no cost to participants.
- **ACTIVITY: By a show of hands, is anyone a leader or volunteer with NAMI?** Tell the group that you'll share information about NAMI programs later in the seminar.

### Talking Points



### Key Points

- **History:** NAMI began at a kitchen table because two women believed their adult children diagnosed with schizophrenia deserved a life beyond medication maintenance and institutionalization.
- Known as the original “NAMI Mommies,” these women began a battle against stigma and discrimination that continues today with tens of thousands of family members, people in mental health recovery and mental health providers who volunteer their time with NAMI.

### Talking Points



### Key Points

- **Education** – NAMI offers classes, presentations and an annual convention
- **Advocacy** – NAMI advocates for state and federal legislation and policies, NAMI State Organizations and affiliates advocate on behalf of people in recovery and their families. NAMI encourages research on the prevention, causes and effective interventions related to mental health conditions.
- **Support** – NAMI staffs a HelpLine at the national office and so do many NAMI state and local affiliates. NAMI also has support groups run by and for people with mental health conditions as well as groups run by and for family members.
- **Awareness** – NAMI fights stigma and discrimination through individual advocacy and community events like Mental Illness Awareness Week and NAMI Walks. NAMI also produces publications including our quarterly magazine the Advocate, brochures and policy reports.

### Talking Points

## WHY is this important?

- **Anyone** can be affected by a mental health condition
- **Suicide** is the 2<sup>nd</sup> leading cause of death in the U.S. in people 15-24 years old
- **Recovery** is possible

### Mental Health Facts

MULTICULTURAL

Fact: Mental health affects everyone regardless of culture, race, ethnicity, gender, or sexual orientation.



1 in every 5 adults in America experience a mental illness.

Nearly 1 in 25 (25 million) adults in America live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14, three-quarters by the age of 24.



### Key Points

- You may have heard these statistics, two of which can be upsetting
- One of the major goals of this seminar is to emphasize, through our stories, that recovery is possible. Mental health conditions can be unpredictable but there is hope!
- You'll learn **FACTS** about diagnoses and treatment options from reliable sources including NIMH which is the National Institute of Mental Health, SAMHSA which is the Substance Abuse and Mental Health Services Administration, the Veteran's Administration (VA) for military or Veteran families and many more.
- You'll learn **SKILLS** in the areas of communication, recognizing signs and symptoms of relapse and we'll share tips for managing crises
- You'll receive **RESOURCES** that may help you, your family and your loved with a mental health condition

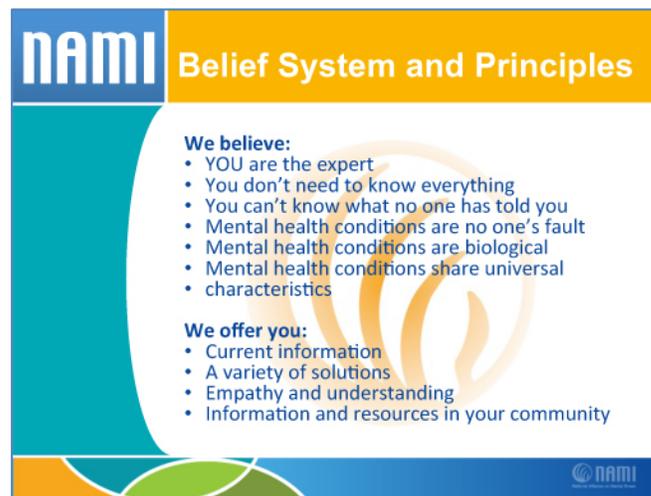
### Talking Points



### Key Points

- NAMI uses a **PEER** approach which means the lived experience of the volunteer leaders is the **HEART** of NAMI programs. Family members like the two of us (*point to your co-leader*) teach other families, and people with a mental health condition teach their peers while sharing their own journey toward recovery.
- NAMI program leaders attend intensive training to lead NAMI programs using comprehensive curriculum
- Support groups are also facilitated using this peer-leader approach (families lead families and people with a mental health condition lead groups for each other).
- We'll go into more detail about the programs and resources NAMI has to offer a bit later in the seminar.
- **Transition:** Now we'd like to discuss some basics about mental health

### Talking Points



## Key Points

### WE BELIEVE:

- **You are the expert.** We honor the fact that you and your loved one are the best judges of what will and won't work in your situation. We want you to learn to trust your own instincts and take from this program whatever you find helpful.
- **You don't need to know everything.** NAMI programs are not designed for you to remember everything you learn today. At the end of this seminar, we want you to know where and how to find the information you need.
- **You can't know what no one has told you.** As you learn new facts in this program, you may feel that you should have already known some of this information, or that you should have found it on your own.
- **Mental health conditions are no one's fault.** Because of stigma, many families are wrongly blamed for their loved one's difficulties which can be devastating. We'll discuss the impact of trauma and the environment as well.
- **Mental health conditions are biological.** We recognize that stigma leads some to believe that people with mental illness can choose to behave differently—others don't know that mental health conditions require medical intervention such as therapy and medication like any other physical illness.
- **Mental health conditions share universal characteristics.** Rather than talking about specific diagnoses, we focus on the symptoms and challenges presented by the conditions—regardless of the diagnosis. Symptoms can overlap and a diagnosis can change over time.

### WE OFFER YOU:

- **Current information.** We review the curriculum on a regular basis to reflect scientific advances in the field.
- **A variety of solutions.** There is no magic formula that will fix everything, and no treatment approach guaranteed to work for everyone, but we know it's possible to live well with mental health conditions.
- **Empathy and understanding.** When we understand how our loved one experiences their life, communicating and solving problems with them gets easier.
- **Information about resources in your community.**

## What are mental health conditions?



- Mental health conditions **ARE**:
  - Medical illnesses that change how people think, feel and act
  - Something common and treatable
- Mental health conditions **ARE NOT**:
  - Anyone's fault or something to be ashamed of
  - The end – you can achieve goals



### Key Points

- NAMI advises anyone experiencing new symptoms to seek a full physical evaluation
- Mental health conditions are medical illnesses, like any other physical illness
- They are treated with medication and therapy much like heart disease, cancer, diabetes and injuries
- They aren't the fault of the person experiencing symptoms or their family (we'll talk about the impact that the environment and trauma can have a bit later)
- Mental health conditions aren't something to be ashamed of, anyone can have a mental health condition
- A mental health condition doesn't mean a person can't have a good life or achieve goals

### Talking Points

**Facts**

1 in 5 **ADULTS** in the U.S. experience a mental health condition in any given year and 1 in 5 **YOUTH** (aged 13-18) have experienced a mental health condition at some point in their life.

Nearly 60% of **ADULTS** and 50% of **YOUTH** (aged 8-15) with a mental health condition don't receive treatment

**STIGMA** is a major reason people don't seek help

NAMI

**DATA SOURCES:**

1. Ahrensbrak et al., "Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017.
2. Merikangas et al., "Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child and Adolescent Psychiatry*, 2010 Oct;49(10):980-9.

**Key Points**

- 1 in 5 adults experience a mental health condition in any given year and 1 in 5 youth (aged 13 – 15) have experienced a mental health condition at some point in their life.

**Many people don't get help or treatment for reasons that can include:**

- Lack of insurance or the cost of assessment or treatment
- Limited access to mental health providers (shortage of psychiatrists)
- Shame, fear and stigma associated with mental health conditions

**Ethnic and cultural groups can experience other forms of stigma:**

- **LGBT** (lesbian, gay, bisexual and transgender) people may confront bullying, stigma and prejudice based on their sexual orientation or gender identity while also dealing with the societal bias against mental health conditions.
- In the United States, only about 25% of **African Americans** seek mental health care, compared to 40% of **white adults**. As a community, **Latinos** tend not to talk about mental health issues and are less likely to seek mental health treatment. **Asian Americans** also seek mental health care at lower rates than **whites**.
- Possible reasons for these differences include distrust attributed to prejudice and discrimination in the health care system, language barriers, cultural differences and lack of mental health professionals with similar cultural or ethnic backgrounds.
- The experiences of **Military personnel, Veterans** and their families must also be handled with sensitivity. Stigma often discourages active duty Service Members from seeking treatment for PTSD or other conditions, for fear of jeopardizing their military careers. Even Veterans may not seek treatment for fear of appearing weak.
- **Transition:** Let's talk a bit more about stigma

**Talking Points**



### Key Points

- Stigma can include stereotyping, labeling, bullying and discrimination
- Many people mistakenly believe that people with mental health conditions are dangerous or violent—this is also an example of stigma. The truth is, people with mental health conditions are more likely to be victims of violence.
- **ACTIVITY: Let's do a comparison. What do people do when someone they know gets a cancer diagnosis?** Answers may include: mow lawn, bring dinner, shovel snow, run errands, walk the dog, carpool kids, babysit, drive person to chemo/radiation, etc. **What happens or what do you imagine happens when people hear someone has been hospitalized with a mental illness?** Answers may include: silence, don't want to upset or embarrass the family, don't know what to say or do, afraid they will make things worse if they reach out, etc. Share personal experiences that apply here.
- In the U.S. we say mental health conditions tend NOT to be “casserole illnesses,” meaning people don't bring meals when your loved one is in a hospital or jail because of a mental illness.

### Talking Points





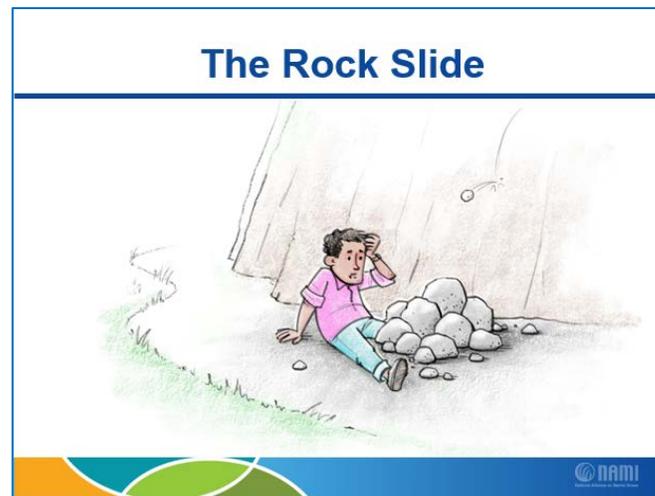
#### Key Points

- Each condition has its own symptoms, and there is a list of common warning signs in your manual.

#### Some common signs of mental health conditions in adults and youth can include:

- Crying regularly, feeling tired or unmotivated, not answering phone calls or texts and/or not wanting to leave the house or their room.
- Severe mood swings meaning a person is extremely upbeat and excited one minute and crying or isolating themselves the next.
- Drastic changes in sleeping habits such as little or no sleep for several nights in a row or not being able to get out of bed.
- Extreme paranoia or difficulty perceiving reality
- Signs of self-harm (cutting or burning) or abuse of alcohol or drugs
- **ACTIVITY: Are there any warning signs you've seen that we haven't mentioned?** Start the conversation by sharing a BRIEF example that illustrates some of the warning signs you've experienced with your relative.

#### Talking Points



### Key Points

- Mental health conditions bring unwanted symptoms and take away or diminish characteristics at the same time.
- Think of the impact of mental illness as a rock slide.
- Let's use a physical injury as an example. This person was walking when some rocks rolled down a hill onto his leg. Now he has the unwanted "symptoms" of pain, being trapped and having a broken foot! He'll probably need help moving the rocks and getting to a hospital. He may require surgery to repair the bone and a cast to protect his leg. He'll probably need crutches to move around until he's healed. Because of his injury there may also be things he can't do like drive his car, walk his dog or work because he must carry things at his job. The injury is painful, requires expensive treatment and has an impact on his daily life.
- Whether a condition is mental or physical, we may have no control over the severity of symptoms that appear. Recovery will require treatment, such as therapy and medication, and social support from family and friends.
- Just like a rock slide, we can't control the severity of mental health conditions. They are disorders of the brain and the symptoms are expressed as complex, often unwanted behaviors.
- **Transition:** Let's talk about some of the changes that occur when a person has symptoms of a mental illness.

### Talking Points



### Key Points

- In the eBook/manual, there are lists of behaviors and characteristics that can change when a person develops symptoms of a mental health condition. Mental health conditions may deeply alter the personality and behavior of the people we care about.

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- It may seem like our loved one should be able to control or stop these behaviors, but they can't. Knowing this will help us to separate the person we love from the symptoms of the condition.

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- **Positive symptoms** are behaviors you never saw before, which may be **Added** to your loved one including:
  - Unpredictable over-reaction to things
  - Uncontrollable sadness, crying, anger or paranoia
  - Inappropriate and bizarre behaviors
  - A need to withdraw and isolate

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- **Negative Symptoms** are behaviors you've always counted on which may be **Taken Away** from your loved one including:
  - Ability to focus and concentrate
  - Ability to cope with minor problems
  - Enjoyment of family, friends, work
  - Optimism, faith, belief in the future

### Talking Points



### Key Points

- We each have many reactions to mental health conditions when they hit someone we love.
- We may feel traumatized. There can be overwhelming stress and anxiety and we need to learn about the impact this takes on our emotions.
- We rarely get a chance to talk about these feelings with people in the mental health system. However, with other family members, like the participants in this seminar, we can talk openly about our feelings and reactions.
- **ACTIVITY:** Review the list and confirm that what participants are feeling is common. Ask to your co-presenter: **What was your experience with these feelings?** Both presenters share their experience with one of two of the feelings. You'll help the participants feel more comfortable about their reactions.

### Talking Points



### Key Points

- People tend to go through stages when a traumatic event occurs.
- In **Stage 1**, we recognize that a catastrophic event can be a staggering blow and imposes sudden, overwhelming stress
- In **Stage 2**, we are full of emotion and have a different set of needs. We need to express our concerns, learn to cope and understand the symptoms of the condition.
- And in **Stage 3**, we are getting it together. We need to restore the balance in our lives; we find purpose in advocacy and action; we need to help others.
- The presence of the mental health disorder is a constant, but our reactions are usually dependent on how our loved one is doing at any given time often changing drastically if a crisis occurs.
- Severity of symptoms and how a person functions will vary and people with the similar diagnoses may not respond the same treatments.
- We want you to have a solid grasp of your own reactions to the strain of mental illness.

### Talking Points

### Important Points about the **STAGES**



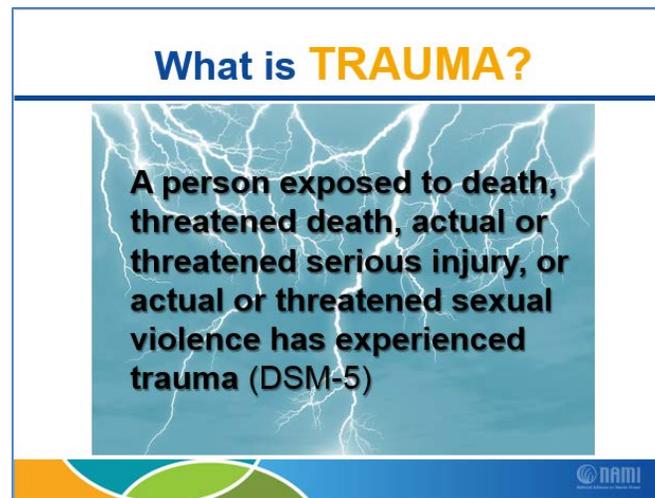
- None of these stages are “wrong” or “bad”
- This process is ongoing - for most of us it takes years to navigate
- Different family members are often at different places in the cycle
- This cyclical process is not about expectations
- With time, you will begin to recognize these stages and emotional reactions



#### Key Points

- **None of these stages are “wrong” or “bad.”** They are normal reactions to abnormal events that everyone experiences when struggling to cope with serious conditions and trying to deal with critical disruptions in their lives.
- **This process is ongoing—for most of us it takes years to navigate.** It is not something that you go through once, then you are done. The process is also cyclical; we will start it all over again every time our relative has a relapse or experiences a serious setback.
- **Different family members are often at different places in the cycle,** which is why we sometimes have difficulty communicating with each other and agreeing on what to do.
- **This cyclical process is not about expectations.** This is a human process that we each do our way. If you know where you are in the process, you can be kind to yourself. We believe it offers hope to see that we do get through pain and grief to acceptance.
- Family members experience predictable reactions to the emotional shock of realizing that someone we love is not just experiencing behavioral problems, adjustment difficulties or having a bad couple of weeks, but in fact has a condition that we can't “fix,” and that may be with them the rest of their life

#### Talking Points



### Key Points

- The word “trauma” has a variety of meanings and implications. The DSM-5 (Diagnostic Statistical Manual used by clinicians to diagnose mental health conditions) classifies trauma this way: “A person “exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” has experienced trauma.

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- The DSM-5 states the person must experience this trauma in at least one of the following ways: **1)** direct exposure, **2)** witnessing, in person **3)** indirectly, by learning that a close relative or friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental **4)** repeated or extreme indirect exposure to aversive details of the event(s), usually during professional duties (for example, first responders, those collecting body parts or professionals repeatedly exposed to details of child abuse). This doesn’t include indirect non-professional exposure through electronic media, TV, movies or pictures.”

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- According to SAMHSA, adverse childhood experiences (ACEs) are stressful or traumatic events that can result in toxic stress and excessive amounts of the stress hormone, cortisol. When cortisol levels are chronically elevated it can cause permanent changes in the brain and gene expression, related to the development and prevalence of a wide range of health problems throughout a person’s lifespan. ACEs can include: all forms of abuse and neglect; witnessing abuse or neglect; substance misuse within household; incarcerated household member; homelessness; natural disasters or war.

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- Exposure to trauma is stressful and can affect the brain and body at any age. Psychologists who specialize in emotional responses to trauma emphasize that each person must find a “new normal.”

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- **ACTIVITY: By a show of hands, how many of you can relate to the term new normal? Give a BRIEF example of something you had to adjust to in your “new normal.”**

### Talking Points

# TRAUMA



## Catastrophic Stressor

- Is generally an unanticipated event
- There is little time to prepare for it
- One has little previous experience and few sources of guidance
- It has a huge emotional impact
- Involves threat or danger to self or others

nami

### Key Points

- Another way to view this type of trauma is as a “catastrophic stressor.”
- Families agree that this definition accurately describes the experience of having a mental health episode happen in their family. It is a catastrophe, and the first time it happens it creates acute panic, fear and disbelief. It’s an extreme, destructive source of stress.
- The attacks that took place on September 11, 2001 are among the most well-known mass traumatic experiences in our country. You probably felt shock, fear and denial. Maybe you lost your appetite, had insomnia or cried a lot. At some point, days, weeks or months later, you realized that your feelings were not as “raw” as they had been. After experiencing an event of this magnitude things never go back to the way they were, but they can be good again. It’s not the same “normal” as before the event, but it can be normal (or typical) again—just different. This is another example of a “new normal.”

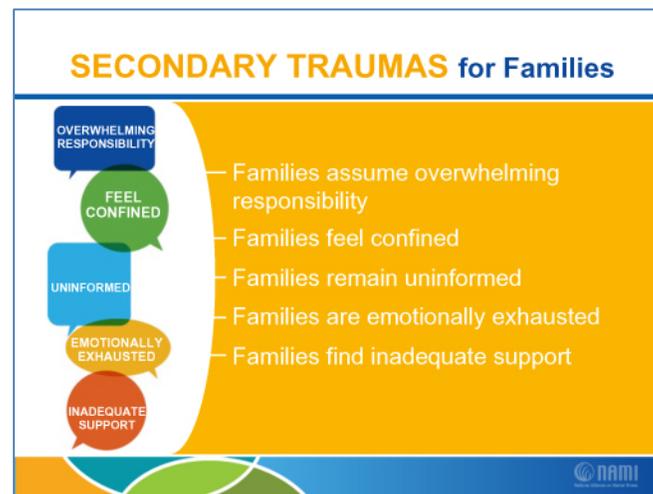
### Talking Points

MISINTERPRETATIONS of Natural Reactions to Trauma		
Natural trauma response people have	In family, response may be viewed as	In individual, response may be viewed as
Shut down	Withholding, cold	Uncommunicative
Angry	Demanding, unreasonable	Out of control
Dazed	Disinterested, aloof	Fragile
Worried	Enmeshed	Bothersome
Blaming others	Dysfunctional	Irresponsible
Withdraws	Something to hide	Lacks motivation
Cuts off contact	They're the real problem	Uncooperative

### Key Points

- Let's talk about how these stages can look to outsiders, and how our reactions can be misinterpreted.
- Think about it: no one assumes that people with heart disease, cancer or stroke are faking it, or come from dysfunctional families, simply because they require inpatient care and ongoing treatment. No one mistakes typical trauma reactions among these patients and their families as pathological or wrong.
- A family member's reaction to the trauma of mental illness is sometimes misinterpreted as problematic or as the cause of the condition.
- Most of us facing a psychiatric emergency have never been to a mental health facility, police station or courthouse before, which is itself traumatic. We are frightened, don't know what to expect or where to get help.
- **ACTIVITY: For those of you with loved ones who showed signs of distress as children, raise your hand if you've been given unhelpful advice from strangers when your child had a meltdown at the grocery store? Anyone told they needed parenting classes? Were you told you were too enmeshed with your child or had a dysfunctional family? Give a BRIEF example if you have one that relates.**

### Talking Points



### Key Points

- Without support and information, families can experience secondary trauma. Typically:
- **Families assume overwhelming responsibility:** It's not an uncommon experience for families to become the primary caregivers of their loved one, even though they have not training.
- **Families feel confined:** Everyone in the home experiences challenging and sometimes frightening aspects of how mental illness affects the person they love which can be stressful, exhausting and isolating for everyone, including the person with the condition.
- **Families remain uninformed:** Many families have no previous knowledge of mental illness and can't recognize or understand its symptoms. To them, it may look like their relative is doing things on purpose, by being immature, lazy, stubborn or weak, especially in the beginning.
- **Families are emotionally exhausted:** Having any health crisis can be isolating. Families may feel resentment toward their loved one for the stress the condition has put on others, and then feel ashamed of that resentment, or start to disconnect as a way of coping. Because symptoms can affect personality traits and communication, family members may have trouble connecting to their loved one and feel a terrible loss of closeness.
- **Families find inadequate support:** Families are routinely told that providers can't discuss anything about their loved one because of confidentiality laws like HIPAA, which we'll discuss later. When providers are unclear on what they can legally share, they may decline to listen to the family, even though that is permitted.
- **ACTIVITY: Raise your hand if these secondary traumas feel familiar!**

### Talking Points

## Secondary Traumas for the Person in **RECOVERY**

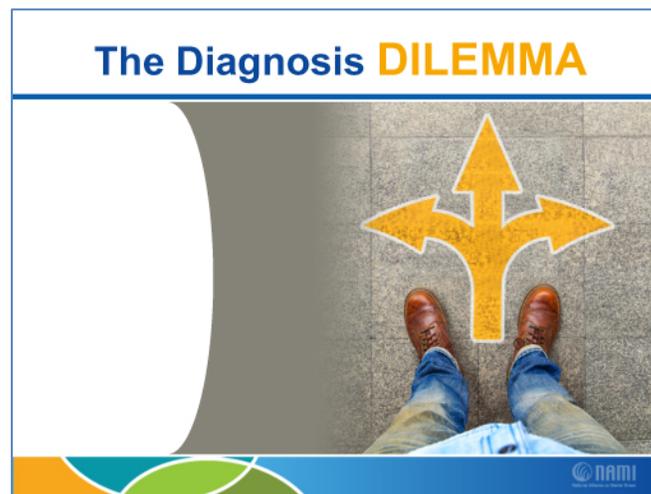
-  Making treatment decisions
-  Medication side effects
-  Self-harm
-  Co-occurring mental health condition and substance abuse
-  Criminalization



### Key Points

- The issues listed here and the strain around them greatly complicate the treatment process and can be barriers in progress to mental health recovery.
- Let's face it...mental health conditions create trauma and stress for everyone!
  - The person experiencing the symptoms
  - The family and friends who love that person
  - And the clinicians who want to provide effective treatment

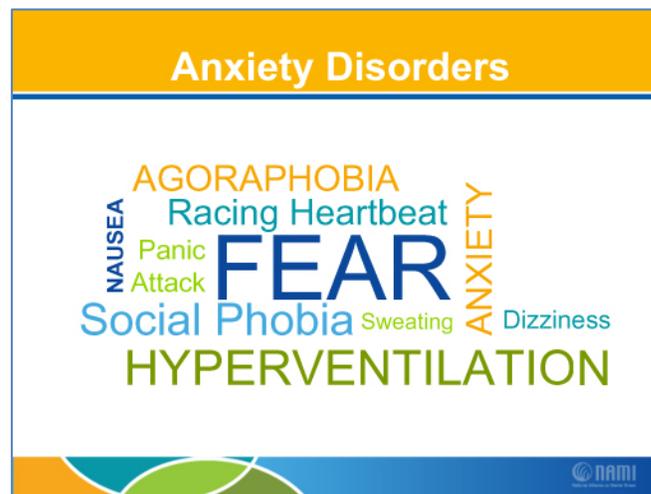
### Talking Points



### Key Points

- With children and adults, it's essential for people experiencing symptoms to ask for, and get, a complete physical as part of their diagnostic work-up. The “body” signs of depressive conditions can mimic illnesses of the thyroid and adrenal glands while anxiety can feel like a heart attack, so various physical disorders may need to be ruled out. Screening for traumatic brain injury, Lyme disease, dementia, cancer or other issues may also be needed to determine what your loved one is experiencing. Sharing your observations with the provider can help determine a diagnosis.
- Information about family history and other health conditions that your relative can provide to a mental health provider (psychiatrist, nurse practitioner, therapist, counselor, etc.) will help them diagnose the condition and recommend effective treatment.
- It will take time to get an accurate diagnosis because symptoms overlap
- Educate yourself so that you can help your relative as they navigate the “new normal” we mentioned earlier when we talked about trauma.
- We're going to talk about the most common diagnoses today. There is information about other mental health conditions on [nami.org](http://nami.org) and in the eBook/manual.

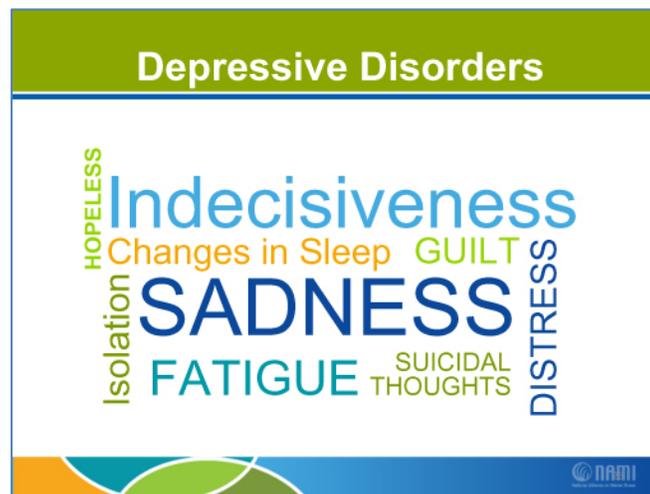
### Talking Points



### Key Points

- Nearly everyone experiences anxiety. Speaking in front of a group makes most of us anxious, but that motivates us to prepare. Driving in heavy traffic is a common source of anxiety, but it keeps us alert and cautious to avoid accidents. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday things, an anxiety disorder may be the cause.
- **ACTIVITY: Most specific phobias that raise our anxiety levels don't require medical attention. What are some common phobias or fears you can think of?** Answers may include heights, spiders/bugs, flying, water/swimming, birds, bears, cats, snakes, etc. Add something silly to help get the suggestions started.
- Anxiety disorders are the most common mental health concern in the United States.
- An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder and approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home.
- Most people develop symptoms of anxiety disorders before age 21 and women are 60% more likely to be diagnosed with an anxiety disorder than men.
- **ACTIVITY: Leader insert your 10-minute family story here if your loved one has anxiety (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).**

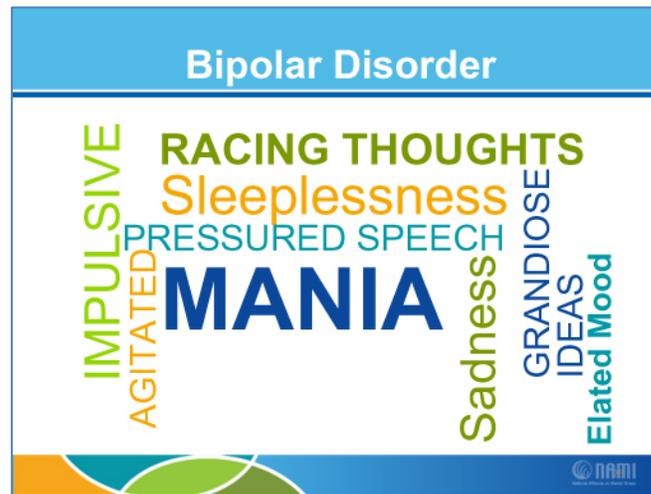
### Talking Points



### Key Points

- Depression is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding, treatment and a good recovery plan. With early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people get better. Left untreated, depression can be devastating, both for the people who have it and for their families. Some people have only one episode in a lifetime, but for most people depression recurs. Without treatment, episodes may last a few months to several years. People with severe depression can feel so hopeless that they become a risk for suicide.
- An estimated 16 million American adults—almost 7% of the population—had at least 1 major depressive episode last year. People of all ages and all racial, ethnic and socioeconomic backgrounds can experience depression, but it does affect some groups of people more than others.
- Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.
- **ACTIVITY:** *Leader insert your 10-minute family story here if your loved one has depressive disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).*

### Talking Points



### Key Points

- A person with bipolar disorder may have distinct manic or depressed states. A person with mixed episodes experiences both extremes simultaneously or in rapid sequence. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. Someone who is manic might believe she has special powers and may display risky behavior. Someone who is depressed might feel hopeless, helpless and be unable to perform normal tasks. People with bipolar disorder who have psychotic symptoms may be wrongly diagnosed with schizophrenia.
- People's symptoms and the severity of their mania or depression vary widely. Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally. (from NAMI website)
- **ACTIVITY:** Leader insert your 10-minute family story here if your loved one has bipolar disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

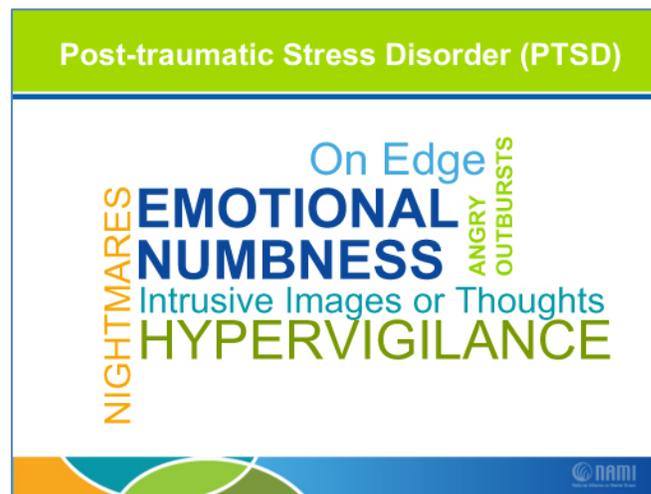
### Talking Points



### Key Points

- Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them.
- The compulsive physical (hand washing, repetitive touching, etc.) or mental (silently repeating special words, images or numbers, etc.) acts are aimed at preventing or reducing the anxiety generated by the obsessive thoughts.
- Symptoms typically begin during childhood, the teenage years or young adulthood, although males often develop them at a younger age than females. More than 2% of the U.S. population (nearly 1 out of 40 people) will be diagnosed with OCD during their lives.
- **ACTIVITY:** *By a show of hands, how many of you are neat and like things in order and put away in the proper place? How many of you are pile people who may have stacks of papers and stuff? Guess what...neatness doesn't mean you have a bit of OCD and piles don't mean you are a hoarder. We should tell you that hoarding was once considered a symptom of OCD but is now classified as a distinct condition.*
- **ACTIVITY:** *Leader insert your 10-minute family story here if your loved one has OCD (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).*

### Talking Points



### Key Points

- Traumatic events, such as military combat, assault, an accident or a natural disaster, can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms long after the traumatic event is over.
- Because the body is busy increasing the heart rate, pumping blood to muscles for movement and preparing the body to fight off infection and bleeding in case of a wound, all bodily resources and energy get focused on physically getting out of harm's way. This resulting damage to the brain's response system is called posttraumatic stress response or disorder, also known as PTSD.
- PTSD affects 3.5% of the U.S. adult population—about 7.7 million Americans—but women are more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is in a person's early 20s.
- **ACTIVITY:** Leader insert your 10-minute family story here if your loved one has PTSD (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

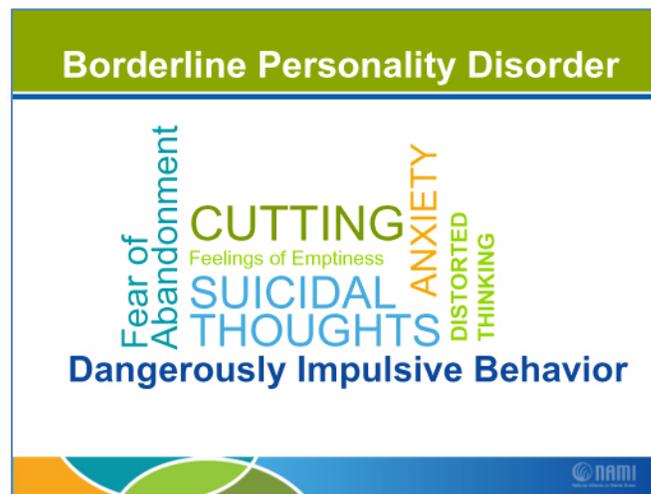
### Talking Points



### Key Points

- Schizophrenia is a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others.
- It is a complex, long-term medical illness, affecting about 1% of Americans.
- Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early 20s for men, and the late 20s to early 30s for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
- Some symptoms can be categorized as **thinking** which can include delusions, paranoia, suspiciousness, disorganized speech or **sensory** meaning the senses are more acute, the person is easily overwhelmed by stimuli and hallucinations featuring one or more of the senses may occur. Some helpful definitions from MedicineNet.com are:
  - **Hallucination:** A profound distortion in a person's perception of reality, typically accompanied by a powerful sense of reality. Hallucinations may be sensory experiences in which a person can see, hear, smell, taste, or feel something that is not there. (Retrieved from MedicineNet.com, owned and operated by WebMD, 2018)
  - **Delusion:** A false personal belief that is not subject to reason or contradictory evidence and is not explained by a person's usual cultural and religious concepts (so that, for example, it is not an article of faith). A delusion may be firmly maintained in the face of incontrovertible evidence that it is false. (Retrieved from MedicineNet.com, owned and operated by WebMD, 2018)
- **ACTIVITY:** Leader insert your 10-minute family story here if your loved one has Schizophrenia (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

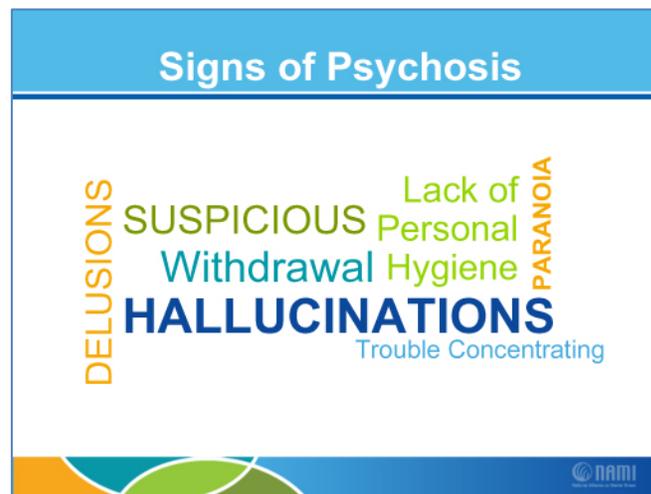
### Talking Points



### Key Points

- Borderline personality disorder (BPD) is a condition characterized by difficulties in regulating emotion. This difficulty leads to severe, unstable mood swings, impulsivity and instability, poor self-image and stormy personal relationships. People may make repeated attempts to avoid real or imagined situations of abandonment. People with BPD may experience a level of distress that leads to destructive behavior, such as self-harm (cutting) or suicide attempts.
- It's estimated that 1.6% of the adult U.S. population has BPD but it may be as high as 5.9%. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. In the past, men with BPD were often misdiagnosed with PTSD or depression.
- **ACTIVITY:** Leader insert your 10-minute family story here if your loved one has a personality disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

### Talking Points



### Key Points

- Most people think of psychosis as a break with reality. Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing and believing things that aren't real or having strange, persistent thoughts, behaviors and emotions. While everyone's experience is different, most people say psychosis is frightening and confusing.
- Psychosis is a symptom, not an illness, and it's more common than you may think. In the U.S., approximately 100,000 young people experience psychosis each year. As many as 3 in 100 people will have an episode at some point in their lives.
- Early or first-episode psychosis (FEP), refers to when a person first shows signs of beginning to lose contact with reality. We are still learning about how and why psychosis develops. It's thought to be triggered by a mix of genetics (family history), and life stressors during critical stages of brain development.
- Sometimes psychosis can be the start of a more serious condition like schizophrenia or bipolar disorder. Risk factors that may contribute to the development of psychosis include stressors such as physical illness, substance use (marijuana, hallucinogens and stimulants) and psychological or physical trauma.
- **Emphasize:** Psychosis can occur in different mental health conditions. If a person has untreated schizophrenia, bipolar disorder, depressive disorder, PTSD, OCD, etc. or if a treatment stops working or is suddenly discontinued.

### Talking Points



### Key Points

- Dual diagnosis, also called co-occurring diagnoses, is a term for when someone experiences a mental health condition and a substance abuse problem simultaneously. You may have heard this referred to as co-occurring disorders.
- This is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when that person uses heroin during periods of mania.
- It doesn't matter which condition developed first.
- People experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to get relief from the troubling symptoms they experience. Research shows though that drugs and alcohol make the symptoms of illness worse.
- Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.
- **ACTIVITY: By a show of hands, how many have had a loved one self-medicate? Has anyone's loved one experienced substance use or abuse? How many have a loved one that is diagnosed with a co-occurring mental health and substance use disorder?**

### Talking Points



### Key Points

There are many painful aspects of having a mental health condition such as:

- Watching peers and siblings pass them by developmentally
- Having hopes, dreams and plans altered
- Fear of never reclaiming life as it was before symptoms
- Isolation – losing touch with friends and family
- Hating what the illness has done
- Shame about actions when experiencing symptoms – arrest, expulsion from school
- Unemployment – living on fixed income or in supervised housing
- Fear of relapse
- Altered social life
- Loss of pride
- Pain of hurting loved ones
- But there is hope! With treatment and support recovery is possible!
- **Transition:** Let's talk about some famous people who have dealt with mental health conditions

### Talking Points



### Key Points

- **ACTIVITY:** Pause a few seconds to allow the audience time to read the names on the slide.
- Many people affected by mental health conditions, not just the famous names you may recognize on this slide, are able to live well and succeed.
- Having a mental health condition doesn't mean a person can't achieve goals and live a wonderful life. Goals and timelines may be changed by mental illness. Everyone won't become rich and famous but each of us has something valuable to contribute, whether it's as an employee, a dedicated volunteer or a caring friend.
- Never give up hope!
- **ACTIVITY:** Mention some of the famous people on the slide using the details listed on the opposite page. Talk about what made the person famous, their connection to mental illness (individual with symptoms/diagnosis or family member) and the condition that has had an impact on them.

### Talking Points

## Famous people with mental health conditions

<b>Alicia Keys (has depression)</b> – Grammy-winning singer, songwriter
<b>Buzz Aldrin (has depression and alcoholism)</b> – USAF fighter pilot in the Korean War, engineer, astronaut and 2 <sup>nd</sup> man on the moon
<b>Michael Phelps (has ADHD and depression)</b> – Swimmer and Olympic champion
<b>Carrie Fisher (had bipolar disorder and addiction)</b> – Actress and author, best known as Princess Leia in the <i>Star Wars</i> films
<b>Will Smith (has ADHD)</b> – Oscar-nominated Actor and Grammy-winning rapper
<b>Cheryl Stayed (has depression)</b> – Author best known for the book <u>Wild</u>
<b>Adele (has generalized anxiety disorder)</b> – Grammy-winning singer, songwriter
<b>Emma Stone (had childhood panic disorder)</b> – Actress best known for Oscar-winning performance in <i>La Land</i> and films <i>Easy A</i> and <i>Crazy, Stupid, Love</i>
<b>Dwayne “The Rock” Johnson (had depression)</b> – Actor, singer and retired wrestler
<b>Margaret Cho (has Depression)</b> – Comedian, actress and author
<b>Bruce Springsteen (has depression)</b> - Grammy-winning singer, songwriter
<b>JK Rowling (has depression)</b> – Author best known for the Harry Potter series
<b>Lady GaGa (has depression)</b> – Singer, actress, founder Born this Way Foundation
<b>John Nash (had schizophrenia)</b> – Nobel Prize winning mathematician, portrayed by Russell Crowe in the movie <i>A Beautiful Mind</i>
<b>Terry Bradshaw (has depression)</b> – NFL Hall of Fame quarterback, won 4 super bowls with the Pittsburgh Steelers, current football analyst and occasional actor
<b>Abraham Lincoln (believed to have had depression)</b> – 16 <sup>th</sup> President of the U.S.
<b>Brian Wilson (has schizoaffective disorder)</b> – Singer, co-founder of the Beach Boys
<b>Demi Lovato (has bipolar disorder and addiction)</b> – Singer, songwriter and actress
<b>Brandon Marshall (has borderline personality disorder)</b> – NFL All-Pro wide receiver, mental health activist #StrongerThanStigma
<b>Patrick Kennedy (has bipolar disorder and addiction disorder)</b> – Former U.S. Representative and founder of the Kennedy Forum
<b>David O. Russell (family member whose son has bipolar disorder)</b> – Director, screenwriter known for <i>The Fighter</i> , <i>Silver Linings Playbook</i> , <i>American Hustle</i> and <i>Joy</i>
<b>Glenn Close (family member whose sister has bipolar disorder and whose nephew has schizoaffective disorder)</b> – Actress, co-founder of BringChange2Mind
<b>Rick Warren (family member whose son had depressive disorder and died by suicide)</b> – Pastor and author of <u>The Purpose Driven Life</u>
<b>Utkarsh Ambudkar (Oot-karsh Am-bood-car) (has anxiety and depression)</b> – Actor, singer, rapper best known for the film <i>Pitch Perfect</i>
<b>Clark Gregg (has anxiety and addiction)</b> – Actor, writer best known as Agent Phil Coulson in the Marvel Comics world and for the TV show <i>The New Adventures of Old Christine</i>
<b>Mayim Bialik (family member)</b> – Actress, PhD neuroscientist best known for <i>Big Bang Theory</i> , <i>Blossom</i> and the film <i>Beaches</i>
<b>AJ Mendez Brooks (has bipolar disorder)</b> – Retired WWE (World Wrestling Entertainment) star, NYT bestselling author of <u>Crazy is My Superpower</u>

**The BIOLOGY of Mental Health Conditions**



“What we have to get across, is how it is that people get mental illness. Nobody is to blame. This is not a mental weakness. These are diseases just like any other neurobiological disorders. They just happen to affect complex behaviors.”

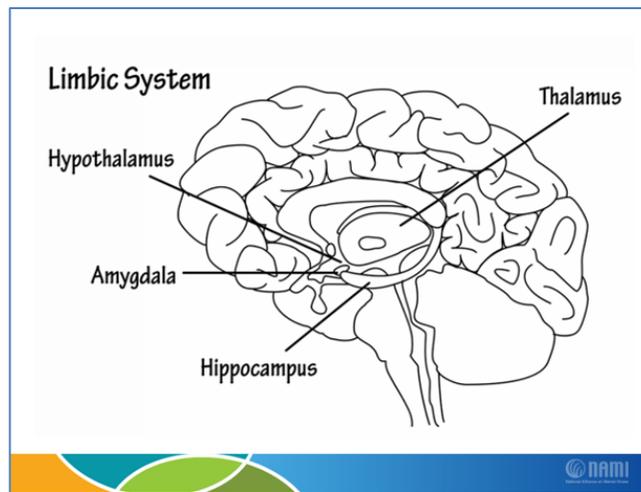
Dr. Steven Hyman, former Director of the National Institute of Mental Health (NIMH)



### Key Points

- The breakthrough we're all waiting for still eludes the scientific community, but in 2014, NIMH launched the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative which aims to revolutionize our understanding of the human brain.
- This commitment to more research dollars using better technology will lead to a much more complete picture of the brain. This type of understanding is necessary to find new ways to treat, cure and even prevent mental health conditions. It will also fill major gaps in our current knowledge about how the brain records, processes, utilizes, stores and retrieves large quantities of information.
- **Transition:** We'd like to share some of what is known about how the brain works and what happens when someone has a mental illness.

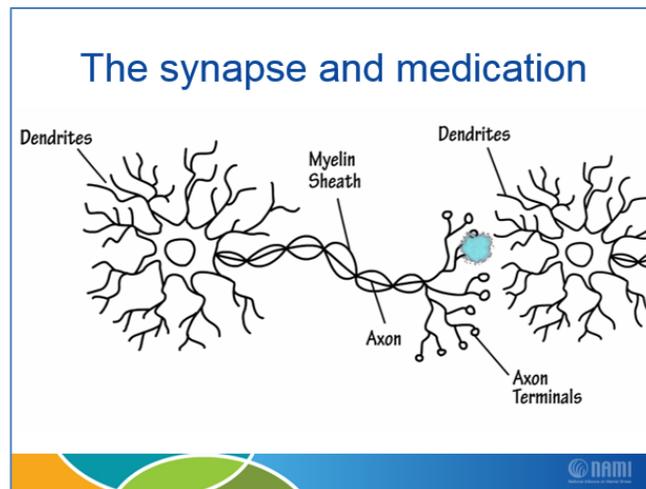
### Talking Points



### Key Points

- Below the brain surface, or cortex, you will find several structures with long names like hypothalamus, thalamus, amygdala and hippocampus. Together they create the Limbic system. Emotions like anger and happiness, drives like hunger and dominance, and instincts along with the regulation of other body processes take place in the limbic system. As you may guess, research has shown that the limbic system plays a part in all mental health conditions.

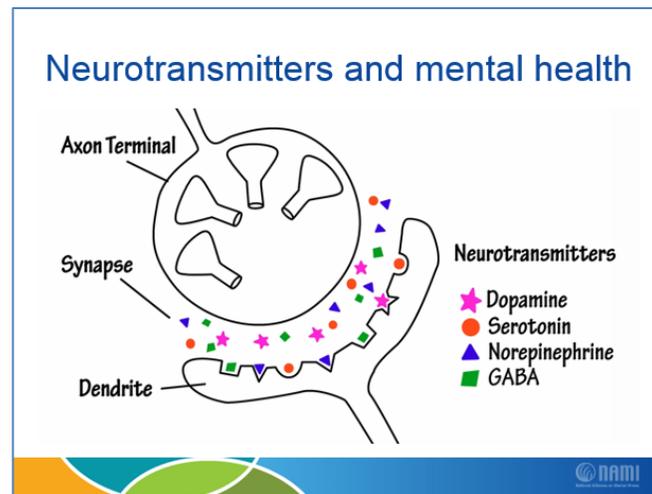
### Talking Points



### Key Points

- Inside every brain, at microscopic levels, is an impressive system of over 100 billion nerve cells communicating with each other using electrical and chemical signals.
- We know this system is made up primarily of neurons - cells that can communicate with each other. And Glial cells that support and protect the neurons.
- For a message to cross from an axon to a dendrite across the synapse—everything must work in exactly the right way and at the right time. Stored inside each axon terminal are chemicals called neurotransmitters, such as dopamine and serotonin. These chemicals are needed help to deliver the electrical message across the synapse.
- Why do we need to know this? Because most medications used today to relieve mental health symptoms do so by adjusting one or more neurotransmitters.
- Medications can impact how the different neurotransmitters are released, absorbed or metabolized. This affects both the number of messages transmitted and the quality of each message. Unfortunately, not every medication works the same way in every person, it is highly individualized. This is part of the challenge of finding the best medication for each person's symptoms.

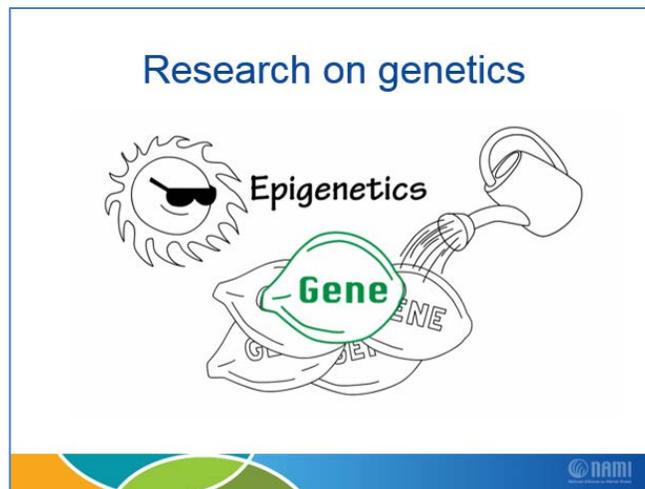
### Talking Points



#### Key Points

- The type and number of neurotransmitters present in the synapse between the neurons directly impacts the way messages are sent and received. The way the messages are sent and received influences how a person thinks, feels and behaves.
- There are four major neurotransmitters believed to be involved in most mental health conditions: dopamine, serotonin, norepinephrine and gamma-aminobutyric acid, or GABA. Symptoms result when there is either too many or too few of these neurotransmitters in the synapses, or when they are not absorbed properly.
- For example, when someone is experiencing symptoms of depression, serotonin neurotransmitters are likely involved.
- And when someone is experiencing symptoms of psychosis, dopamine neurotransmitters likely aren't doing their job properly.

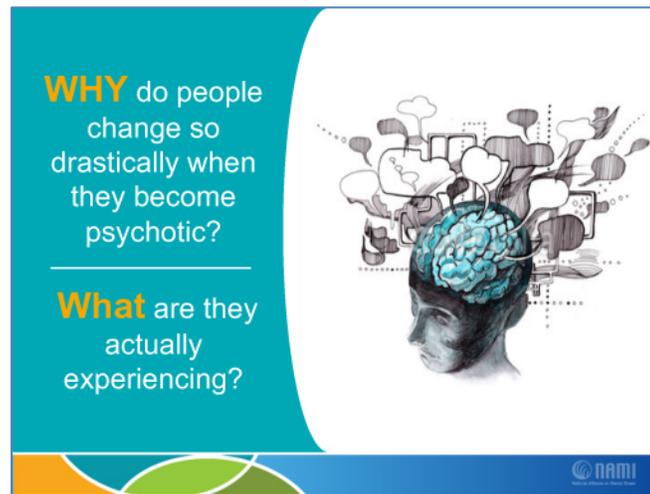
#### Talking Points



### Key Points

- Science is also exploring how a gene's composition and function may change over time. This type of research is called epigenetics.
- For mental health conditions, this research is showing that something is transmitted genetically, but it's not enough to guarantee that a mental health condition will develop. Something else needs to occur for mental health distress to begin. There are two major thoughts on what that something else might be.
- Biological scientists call it a "second hit" and believe it may come from a virus, an injury in the womb or during birth, exposure to toxic substances or problems with the immune system. Even though this "second hit" may occur before birth or in infancy, the distress and behaviors that result don't begin to show until the child enters the developmental stage of adulthood.
- Social scientists look for how social and cultural environments impact the development of mental health conditions. They look at the neighborhood a person lives in, their health habits, other medical conditions they may have, any traumatic events they have experienced, and every other social aspect of the person's life.
- It's important for you to know that someone who has both a genetic predisposition to a mental health condition and a stressful environment, is NOT guaranteed to develop symptoms. The opposite is also true. Someone without a known family history and without a traumatic life experience MAY develop a mental health condition.

### Talking Points



**WHY** do people change so drastically when they become psychotic?

**What** are they actually experiencing?

### Key Points

- Regardless of the diagnosis, intrusive or compulsive thoughts, fears or even hallucinations can all interfere with the individual's ability to think and relate to others. Before we review communication skills, we want to provide a picture for you of what it can be like for someone with symptoms of a mental health condition.
- Now we want to take you through an activity, so you can experience what it feels like for a person with a thought disorder.
- **Transition:** This is what we call an **empathy exercise**.
- **Note:** Review tips for how do conduct empathy exercise in auditorium settings (see page P.4 in Presentation Prep section). Have pens, index cards and scripts ready for voices exercise.

### Talking Points

### **Setting up the exercise**

- *Have index cards and pens/pencils available.*
- **Leader #1** *will ask for 4-8 volunteers (depending on the size of the seminar attendees) to be the patient.*
  - **Leader # 1** *stays in the room with the seated patients and has them sit next to one another in a line. Explain that they will be asked to do a simple drawing exercise. Hand out index cards and pens.*
- **Leader #2** *will ask for the same number of volunteers and will take them out of the room for instructions*
  - **Leader #2** *will explain that they will stand behind the patient's chairs and be a "chorus" of:*
    - *the "voices" in the head of each patient*
    - *random noises in the environment*
  - *Give each person a "Voices" Role Play Card. Confirm the statement on the card is okay for them to read and let them know they don't need to act out the voice. Ask them to speak in a normal voice repeating the message on their card.*
  - *Tell them to wait for **Leader #2's** cue before they start to read and to continue reading until **Leader #2** says "STOP."*
  - **Leader # 2** *brings the voices back into the room and asks them to line up*

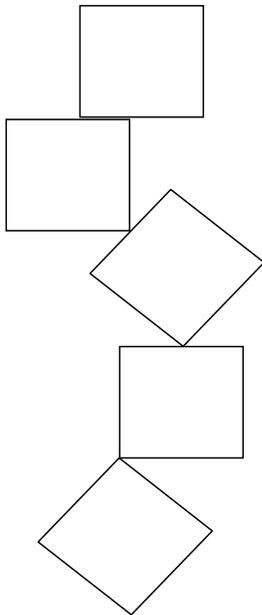
### **Doing the exercise**

- *Once the patients are seated and the voices are lined up behind them:*
  - **Leader #1** *will give the seated patients the drawing instructions.*
  - **Leader #2** *will cue the voices once the first instructions are given.*

**Leader #1** reads the instructions below in a strong voice, without expression

This is not a test. No one will be checking your performance, but there are a few rules:

1. Please don't ask questions.
2. Please don't look at your neighbor's paper.
3. Please don't interrupt me, or make any comments until after I call "Stop"



1. All right, let's begin
2. Draw a square.
3. Draw a second square, lining up its right side with the midpoint of the bottom of the first square.
4. Draw a third square turned at an angle, so that the midpoint of one side meets the right bottom point of the second square.
5. Draw a fourth square, lining up the midpoint of its top with the lowest point of the third square.
6. Draw a fifth square, placing its top point on the bottom left hand point of the fourth square.
7. **Call STOP!**

### ***Debriefing the exercise***

- *Ask for people's reactions to the exercise, starting with the group sitting down who played the patients.*
- *Ask seated people what they felt:*
  - *Uncertainty? Confusion? Anxiety? Did they tune out, give up, not try at all? Did they feel disoriented? Frustrated?*
  - *Point out that their reactions are like those of people with symptoms of a mental health condition*
- *Ask the voices about their experience.*
- *Did everyone get a sense of how difficult it is to focus with this distraction?*
- *Have the volunteers move back to their seats.*



## **Empathy Exercise (Voice 1)**

Don't trust the people leading this exercise. They're trying to trick you so they can lock you up. They're all trying to make it look like you're crazy.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 2)**

You've got to get away. If you stay here in this room they'll hurt you! Hurry! You should run while they're not looking!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 3)**

Everyone in this room is staring at you. You can't trust any of them; they just pretend to care. You've got to get away!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 4)**

This is what they warned us about—people giving you directions that don't make any sense, they're trying to confuse you. You can't trust these people. It's all a trick!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 5)**

This is the weather report for the city. The barometer is rising and today will be milder with a high of 55, with clouds tomorrow.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 6)**

I looked in on the patient today and he still seems psychotic. He's not responding fully to the medication...let's take the dose up to the next level.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 7)**

This person is evil. The devil has sent this person to get you to do bad things. Don't do what they are asking you. You will go to eternal damnation.

(Repeat until the exercise stops)

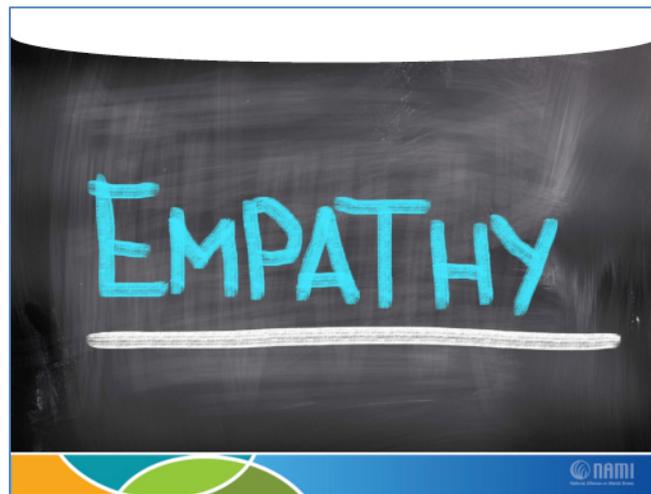


## **Empathy Exercise (Voice 8)**

Hello dear! I wanted to call to see how you're doing. Is the medication working? We sure hope it will help. Do you need clean clothes? We're coming to take you to lunch on Sunday.

(Repeat until the exercise stops)





### Key Points

- **ACTIVITY:** *By a show of hands how many of you trying to draw found that frustrating?*
- That last exercise was exaggerated but we did that to make a point. Having a mental health condition is tough! Unwanted symptoms and feelings can take over which frustrates us and our loved one. Fears, anxiety and other frightening thoughts can be just as disabling and disruptive to a person's ability to pay attention and interact with others as hallucinations are. The voices exercise can give us empathy for what our relative may be experiencing.
- If your loved one is anxious around crowds, looking for the exit in every room, or experiencing other intrusive (meaning disturbing and unwanted) thoughts, it limits their ability to interact with the outside world—including you and the other people they love. As difficult as it may be for you, don't take it personally; they're not choosing to behave this way. At NAMI we like to say love the person, hate the illness.
- Empathy is the capacity to recognize emotions that are being experienced by someone else. We are trying to learn about our relatives by understanding their world. If we have empathy, we'll be aware of the difficulties they're experiencing and we'll no longer expect them to respond as if nothing was happening.

### Talking Points



### Key Points

**Empathic Guidelines can be found in your eBook and they remind us to:**

- Support instead of criticizing
- Encourage instead of punishing
- Reward positive behavior and ignore negative behavior
- Recognize and accept all the person's symptoms (you don't have to like the symptoms, just understand that the person may not be able to control them)
- Patiently encourage independent behavior
- Maintain basic expectations
- Validate the emotional content of what our loved one expresses
- Have empathy for ourselves
- **Transition:** The voices exercise reminds us of how difficult communication can be for someone experiencing symptoms of a mental illness. We want to share some tips that may make talking to your loved one easier.

### Talking Points



### Key Points

- Use short, clear, direct sentences. Long, complicated explanations can be difficult for people experiencing mental health symptoms to follow. They may stop listening.
- Keep the content of what you say simple. Discuss only one topic at a time and give only one direction at a time. Be as concrete as possible.
- Keep the level of stimulation as low as possible so your loved one will be able to listen and understand you. Keep your voice low and calm, keep your body language calm and still, and speak respectfully and carefully rather than accusing or criticizing.
- If your loved one seems withdrawn and reluctant to talk, pause the conversation and give them space for a while. Don't try to force a conversation. You'll have a better chance of getting the response you want when your loved one is ready to interact with you.
- Assume that your loved one may not be able to absorb or understand some of what you say to them. You may need to repeat instructions and directions. Be patient.
- Be pleasant and firm.
- Saying things that contradict each other, or saying one thing and doing the opposite, makes it hard for your loved one to understand and trust you. When you communicate clearly and well, you show your loved one respect and create clear boundaries around what you can and will tolerate (yelling, cussing, etc.).
- Emphasize that these skills are even more important in times of stress or crisis
- **Transition:** Now let's look at two different techniques you can use when communicating with a person who is experiencing symptoms of a mental health condition

### Talking Points

**I-Statements**

- I am speaking in a very specific, direct manner
- I am at the center of the communication
- I take complete responsibility for my feelings and opinions
- I don't waiver
- I say what I mean

**Example:** "I don't like it when there's smoking in the house."





### Key Points

- I-statements focus on the facts, without blaming anyone. They allow you to express your personal feelings about what your loved one has chosen to do and say.
- Using I-statements regularly can change the atmosphere in your home. If one person changes their communication style, it will absolutely influence how the rest of the family communicates, too.
- When you get used to using I-statements, don't make the mistake of undoing their impact by expressing doubt or by adding something that reverses the point you just made. Say what you mean, and mean what you say, period.
- Remember, our relative's thinking is often distracted, disorganized and disturbing. It helps them when we are clear, calm and concise. I-statements can also help you request something of your relative and give them positive feedback, like praise.

### Talking Points

**ACTIVITY:** *Sample I-statement conversation between the co-leaders*

**Family Member:** *I get worried when you sit and stare out the window all day, just smoking and drinking coffee.*

**Loved One:** *But I'm not bothering anyone.*

**Family Member:** *I know you aren't bothering anyone, but I worry about you and I'd feel better if there were something else you could do.*

**Loved One:** *Well, maybe I'm happy just sitting here; did you ever think about that?*

**Family Member:** *Actually, I hadn't thought that you might be happy just sitting there, but I still feel worried.*

**Loved One:** *You're just being ridiculous. You don't want me to be happy.*

**Family Member:** *I disagree—I do want you to be happy, but I still worry. If you'd like to take a walk or something, I'd be glad to go with you.*

**YOU – Statements**

When we move away from I-Statements with our loved one, we tend to:

- Feel defensive
- Blame and become judgmental
- Make assumptions about the other person's motives
- Generalize a specific problem to other situations and accusations begin to snowball
- Vent our negative feelings





### Key Points

- That I-statement conversation might not sound familiar to you because we usually have “you” conversations with our loved ones. So, let’s hear the exact same conversation using the pronoun “you” instead of “I” and see what we notice (*use script on facing page.*)
- Do you hear the difference? The conversation using you-statements sounds full of attacking and blaming. Anyone in this type of conversation will probably get defensive. When people communicate this way, the interaction becomes extremely tense very quickly.
- In short, without I-Statements, discussions can become arguments. We get more frustrated and our loved one feels defeated. We voice our anger and frustration in a way that makes the conversation deteriorate quickly.
- Before leaving I-Statements, we need to mention they’re also great for making requests and giving positive feedback. I-Statements are a direct form of communication that may feel awkward but can be effective. Mental health conditions require us to do things differently to support our loved ones.
- **ACTIVITY: How many of you thought these examples would have been more realistic with cussing? We kept them simple to show you how to use the skill. I-statements may not work all the time, but they will help you stay calm and on topic when conversations get heated.**

### Talking Points

**ACTIVITY:** *You-statement conversation between the co-leaders*

**Family Member:** *You never do anything but sit and stare out the window all day, just smoking and drinking coffee!*

**Loved One:** *But I'm not bothering anyone.*

**Family Member:** *You're bothering me! Can't you find something else to do?*

**Loved One:** *Well, maybe I'm happy just sitting here; did you ever think about that?*

**Family Member:** *You, you, you! It's always about what makes you happy!*

**Loved One:** *You're just being ridiculous. You don't want me to be happy.*

**Family Member:** *So, you're saying it's my fault?*

**Loved One:** *I can't win! You're always on my case!*



### Key Points

- A central part of reflective responses is staying with the emotional content of what your relative says, instead of arguing with them about how they see the situation.
- Don't try to convince your relative of what you think is true. Instead acknowledge what is real to them.
- With mental health conditions, we're dealing with a unique set of behaviors in our relative. How do we cope with someone who blames us for everything we try to do to help and protect them, who may be experiencing paranoia, whose descriptions of reality might appear delusional?
- We tend to avoid talking to our relatives about their behavior and troubled feelings because we're afraid that mentioning them will only make things worse.
- The opposite is true. When we can reflect what our relatives are feeling back to them, it often reduces those feelings and makes it easier to communicate with them.
- Reflective Responses are useful whenever our family member is communicating something unusual to us, when they're being oppositional, or when we're being challenged for some action we had to take that makes them angry.
- **Transition:** Let's hear what reflective responses sound like

### Talking Points

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## Reflective Response **EXERCISE**



- Listen for the feelings behind the words
- No invalidating or arguing the moment you hear the statement
- There is no one "right" response to any situation



### Key Points

- In conversation we often want to explain our side or convince the other person to agree with us. Reflective statements simply acknowledge what our loved one has said. I'm going to ask my co-leader to give me a statement

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- **ACTIVITY: Co-leader says, "Why did you have me committed? I don't even need to be in the hospital!"**

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- ***At this point, I can answer in two different ways. I can respond from "my side," explaining my position saying, "We didn't want to put you in the hospital. We didn't know what else to do. We love you," etc.***

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- ***OR...I can stay with my loved one's statement, and simply reflect it back. A Reflective-Response might be, "I can see you're really angry. I guess I would be too if I felt that somebody I trusted had locked me up against my will. I must seem heartless to you right now."***

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- When we validate their experience, our loved one feels heard; they feel respected and they feel less lost. After all, there is still a person in there, dealing with the symptoms of a mental health condition.

### Talking Points

**ACTIVITY:** *Sample reflective response conversation between co-leaders and the participants if they are willing. One leader calls out an outburst and waits for volunteers, if no none responds the co-leader offers reflective responses.*

- ***You're always on my case!***
- ***A young person might say: "I'm not going to the therapist! She just asks lots of weird stuff and I don't want to talk to her."***
- ***A military family might hear: "This family would be better off if I was deployed again."***
- ***"Nobody in this house cares what I want to do, or what I have to say about anything!"***
- ***"Everything I touch falls apart. You'd all be better off without me"***



### Key Points

- As we begin our discussion of the various mental healthcare service systems, the first thing we need to point out is that these systems can be bureaucracy at its finest; each is complex and can be difficult to navigate. Some of the greatest gaps in our nation's healthcare systems, can be found in mental health care. Waiting lists, staff shortages and a lack of funding create frustration for the patient, the family and the clinicians.
- This makes the complicated life you're already living even more difficult to navigate. You'll probably face resistance and obstacles from these healthcare systems, especially at the beginning. You may need to be an advocate for your loved one; you'll need to be smart, tough, and persistent for their sake and yours. You'll also want to be nice or at least diplomatic! We wish it were different, but it's not. Your best allies are NAMI and other advocacy organizations as well as other family members like you.
- ***ACTIVITY: Most of you probably deal with multiple systems when it comes to mental health. By a show of hands how many have dealt with schools or universities? The Department of Defense or the VA if you loved one served in the military? Mental health agencies? Crisis services – maybe a mobile unit or a 24-hour facility? Psychiatric hospitals? Law enforcement? Jails? How about Social Security? Public Housing or a group home?***
- Each of these systems has rules, regulations and acronyms! Some are huge bureaucracies that are complex and confusing.
- You'll find additional resources in the eBook/manual and on the NAMI website.

### Talking Points



**Key Points**

- Asking for help is difficult and intimidating. When the person seeking services encounters resistance from the treatment providers—a rude receptionist, canceled or rescheduled appointments, lots of eligibility paperwork—a common response is to get frustrated and give up.

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- This is a normal response, but extremely unfortunate because it only delays the recovery process.

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- Across systems, a lack of understanding about ethnicity, culture, traditions, customs (including those associated with the military and Veterans), can further complicate treatment.

**Talking Points**



### Key Points

- According to the American Psychiatric Association, mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). They can be severe or mild and are associated with distress and/or problems functioning in social, work or family activities (source APA website)

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- Before we talk about treatment and recovery, we want to remind you about the key concepts. NAMI believes that:

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- Mental health conditions are no one's fault and aren't the result of character flaws

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- Learning a loved one is dealing with a mental illness is a catastrophic stressor or a traumatic event

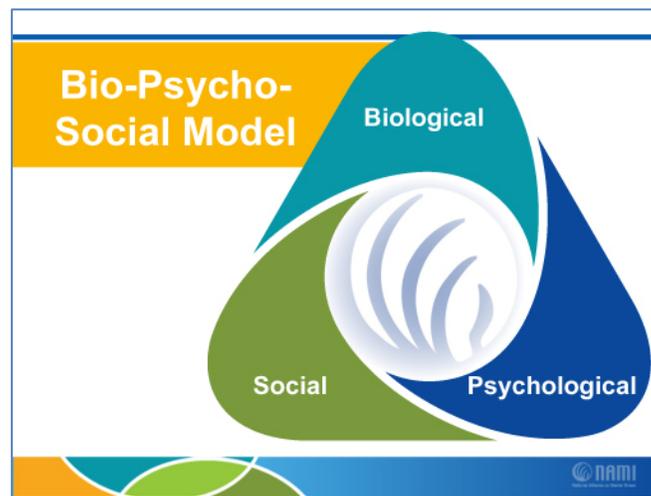
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- We need to look at the person with the condition from 3 perspectives – biological, psychological and social

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- The best care from NAMI's perspective is collaborative and involves a treatment team which we'll explain in a few minutes

### Talking Points



### Key Points

- Each of these three treatment areas are equally important. Let's review the Bio-Psycho-Social Dimensions of mental health conditions.
- The top of this image refers to the medical model or biological dimension which dominates the acute (meaning severe or critical) phases of illness
- The lower right of the image includes psychological and emotional supports necessary to assist the person as they adjust to changed life circumstances.
- The lower left refers to the social or rehabilitation and occupational interventions which help the person to create and sustain a meaningful quality of life.
- These three treatment strategies are interdependent which means we can't focus on just one area and ignore the other two. In the crisis stage, the focus will probably be biological (hospitalization and medication) but therapy (psychological) and rehabilitation (social supports) are critical for recovery.

### Talking Points



### Key Points

- The best care from NAMI's perspective is collaborative involving a team of:
  - The person with the mental health condition
  - The family or trusted friends chosen by the person seeking treatment
  - The treatment professionals (everyone – physician to direct care worker)
- **ACTIVITY:** *We've mentioned why we believe that this is important, but let's talk about why it isn't always common practice. What do you think are some of the barriers to involving family in the treatment plan or process? Possible barriers may include: resistance to change; system structures don't recognize importance of involving family members; need for education and guidance on how to involve family members; case load and time limitations; family member's distrust of the mental health system; family member burnout; person in recovery doesn't want family involved; difficult for family members to meet with their relative's mental health providers due to transportation or cost; HIPAA restrictions*
- **Transition:** Let's spend some time talking about HIPAA

### Talking Points



### Key Points

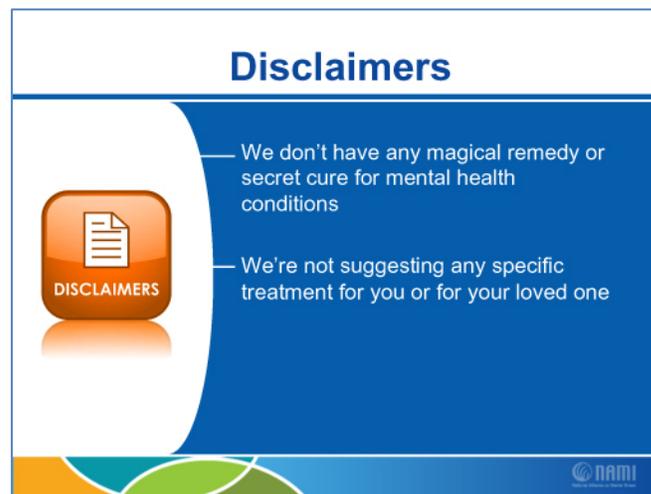
#### What is HIPAA and why is it important?

- HIPAA frequently comes up as a barrier in discussions about medical concerns especially those related to mental health.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a national standard for the protection of certain types of health care information.

#### Things to remember:

- Don't be intimidated when someone mentions **HIPAA**
- Family members need to understand what kind of information they can get regarding their relative's diagnosis, treatment plan, medications, etc.
- Getting a signed release from your loved one is one way to access this information
- HIPAA does NOT prohibit you from sharing information, observations and concerns with your loved one's treatment providers
- Your eBook/manual has more details about HIPAA, the Privacy Rule and protected health information.
- **ACTIVITY: By a show of hands, how many of your loved ones have signed a release allowing you access to their medical information? How long is the document valid? 1 year? Have any of your teenagers with mental health issues turned 18 yet? If so, what happened? If no one has experienced this, you can say that when a child turns 18 they are viewed as an adult with a right to privacy. This is true even if they are living in your home and are on your insurance.**
- Getting a signed release when things are going well can allow you and your loved one to build trust and work as a team toward recovery.

### Talking Points



### Key Points

- Earlier we shared our Beliefs and Principles, one of which was that we don't have a magical remedy for you that is the cure for mental health conditions.
- We are going to cover a variety of treatment options, including medication, and we want to make sure that you understand we will not be suggesting any specific treatment for your relative.
- We're sharing information that may be helpful to you as your loved one, in consultation with the provider, makes the best treatment decisions possible. You may be part of the decision process as part of a collaborative team or you may not have that access. In either case, it's helpful to know what treatment options are available.
- We will also provide information on where you can go to learn more about specific treatments, service providers and mental health care systems.

### Talking Points

## Seeking Treatment

- What options are available?
- Where do you start?
- Where do you go?
- Who do you talk with?
- What do you ask?



The image shows a person from a top-down perspective, sitting on a light-colored floor. They are wearing blue jeans and a grey t-shirt. They are using a laptop computer. The laptop screen displays the word 'TREATMENT?' in orange capital letters. The person's hands are on the keyboard. The background is a plain, light-colored surface.

 NAMI  
National Alliance on Mental Illness

### Key Points

- Few people would delay seeking help if they were having chest pains, since it might be a heart attack. When the pain being experienced is not associated with a visible injury, it can be mistakenly viewed as a weakness or a character flaw. We may hesitate to visit a professional about experiencing emotional difficulties.

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- Let's assume that we have gotten past the hesitation, and that our loved one has agreed that something is wrong and that they need help.

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- Let's also assume that you, as the informed family members you now are, have embraced this decision and are ready to provide the support necessary to make sure the appropriate services are received.

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- You might be thinking: What's available? Where do I start? Where do I go? Who do I talk with and what should I ask them?

### Talking Points

## Therapeutic Intervention Techniques



The most effective treatment usually involves a combination of:

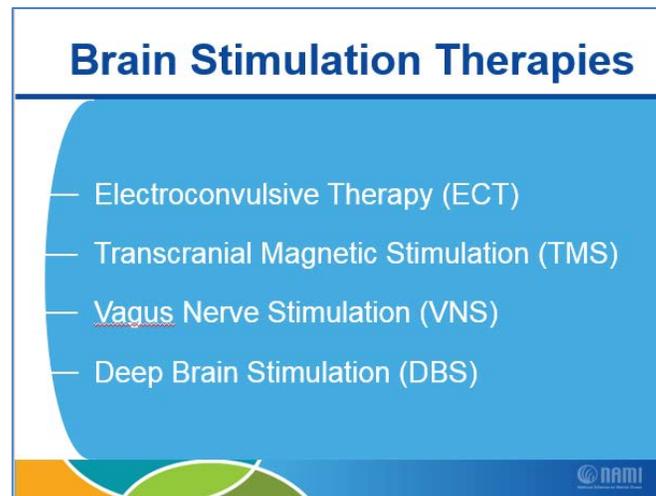
-  **Psychotherapy** - to address the psychological
-  **Medication** - to address the biological



### Key Points

- Typically, treatment usually includes talk therapy and medication.
- Different treatment settings are available.
- **Outpatient** mental health services are the least restrictive and are provided while the individual continues to live at home.
- **Inpatient** means that the individual is admitted to a hospital, a residential treatment center, or a crisis unit of some sort where the treatment is provided while the individual is on site at the treatment facility 24 hours a day.
- There are also **mixed types of treatment** settings called **day treatment**, or **partial hospitalization** programs which allow the person to go home at night, after spending the day at a facility participating in structured therapeutic activities.
- Regardless of treatment setting, there are a variety of different therapeutic techniques that can be used.
- **ACTIVITY: By a show of hands, how many of your loved ones have had Cognitive Behavioral Therapy (CBT)? Wrap Around Services? Dialectical Behavioral Therapy (DBT)? Were you aware there were so many types of talk therapy? Have any of your loved ones participated in art therapy? For those of you with younger children, has therapeutic play been used during counseling?**

### Talking Points



### Key Points

- When treatments such as medication and therapy don't relieve the symptoms of depression or another mental health condition, there are other options available. A psychiatrist might suggest a form of brain stimulation therapy which involve touching the brain directly with electricity, magnets or implants.

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- Electroconvulsive Therapy (ECT) is a procedure where controlled electric currents are passed through the brain while the person is under general anesthesia. This results in a brief, controlled seizure that affects neurons and chemicals in the brain. It's most often used to treat severe depression, depression with psychosis that has not responded to medications and in some cases of treatment resistant bipolar disorder. Once called electroshock therapy, ECT still has many negative associations. In the 1940s, it was very primitive. The reality today is different.

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- Transcranial Magnetic Stimulation (TMS) is a procedure that involves placing an electromagnetic coil on a person's forehead and directing short pulses into an area of the brain believed to control moods. TMS should **not** be used for psychotic depression, bipolar disorder or with those at a high risk of suicide.

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- Vagus Nerve Stimulation (VNS) uses a pulse generator, about the size of a stopwatch, placed in the upper left side of the chest to stimulate the vagus nerve, which carries messages to parts of the brain that control mood and sleep, with electrical impulses. VNS can be used to treat depression, as well as other medical conditions including epilepsy.

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- Deep Brain Stimulation (DBS) was originally developed to reduce tremors from Parkinson's disease. The FDA approved DBS for use in treating obsessive-compulsive disorder (OCD) and is currently being studied as treatment for Tourette's syndrome and major depression. The use of DBS for mental health, however, is largely experimental and its safety and effectiveness are unknown.

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- Like other treatments, brain stimulation therapies can have side effects. Talking to a doctor can be helpful if your loved one is considering this option.

### Talking Points



### Key Points

- In addition to interventions like therapy, medication and brain stimulation there are complementary health approaches which can include:
  - **Natural Products** - vitamins and minerals
  - **Omega-3 fatty acids** - groups of chemicals found in different foods, including fish and nuts that may help in the management of both medical and mental illnesses
  - **Folate** - a vitamin required for the human body to perform many essential processes on a day-to-day basis. Also called folic acid or vitamin B9, folate is a compound that the human body is unable to make on its own.
  - **Medical foods** - made with or without specific nutrients to treat a health condition.
  - **Mind and Body Treatments** – yoga, exercise, meditation, Tai chi
  - **Equine-Assisted Therapy** – (EAP), a form of animal-assisted therapy that teaches individuals how to groom, care for and ride horses
  - **Make sure to check with a doctor** – Over the counter or OTC medications and supplements should be reviewed by a doctor and pharmacist. Even simple vitamins can interact with medication. While something may be safe to use with one prescription medicine, it can make others less effective or toxic. Also, any new exercise or outdoor activity should be discussed with a doctor. People taking certain medicines for depression, schizophrenia or other conditions should make sure to stay cool and drink enough water to avoid heat stroke. Other medicines can lower body temperature, so special preparation may be needed for cold weather.
  - **ACTIVITY: Leader share BRIEF examples of your experiences with complementary health approaches as it relates to relieving stress as a caregiver. If someone says, “STOP MEDS AND GO HERBAL” emphasize the importance of checking with a doctor!**

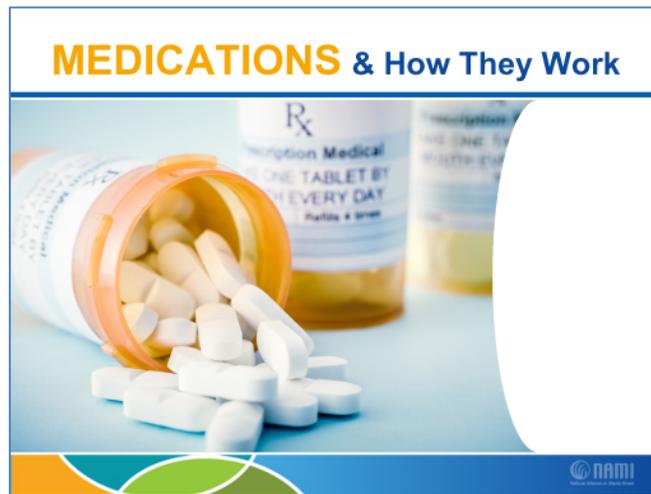
### Talking Points



### Key Points

- We don't cover every professional or treatment option you may encounter when seeking mental health services.
- As an advocate for your family member, don't be afraid to ask the person offering services about their qualifications, their licensure, their training and what type of therapeutic techniques they will be providing. Let them know that you want to be helpful and understand options.
- If a provider hesitates to answer any of these questions for your loved one or for you (if a signed release granting permission for information to be shared with you is in place), think about changing service providers. The therapeutic relationship is based on trust, and sometimes it can take several tries to find a provider that your relative is comfortable with.
- **ACTIVITY: By a show of hands, how many of your loved ones have seen a psychiatrist? Do any of your loved ones use a general practitioner, internist or pediatrician instead of a psychiatrist? Does your loved one have a case manager? A peer support specialist? A dietician? Does anyone know someone who lives in supervised or supportive housing such as a group home or apartment?**
- As you can see there are a lot of different providers who interact with people on their recovery journey.

### Talking Points



### Key Points

- We are not medical professionals or pharmacists and do not pretend to be experts on all the specifics regarding medications
- We will only be discussing general situations
- **Transition:** Let's look at how medications work in the brain.

### Talking Points



### Key Points

- There are different classes of medication including SSRIs, SNRIs, TCAs, MAOIs, antipsychotics, and benzodiazepines. We're not going to go over each type today, but you can find out more about medication on the NAMI website [nami.org](http://nami.org). Another great source of information is your local pharmacist.

### Talking Points

## Generic medication

Generic  $\neq$  Brand Name


 $=$ 


Active Chemical  $=$  Active Chemical


 $=$ 


Capsules  $=$  Capsules



### Key Points

- You should also be aware that generic medications and brand name medications are not exactly the same.

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- The FDA requires that generic medications contain the exact same active chemicals as those in brand or trade name medications and that the form they're available in whether tablets, capsules, patches or injections—is identical.

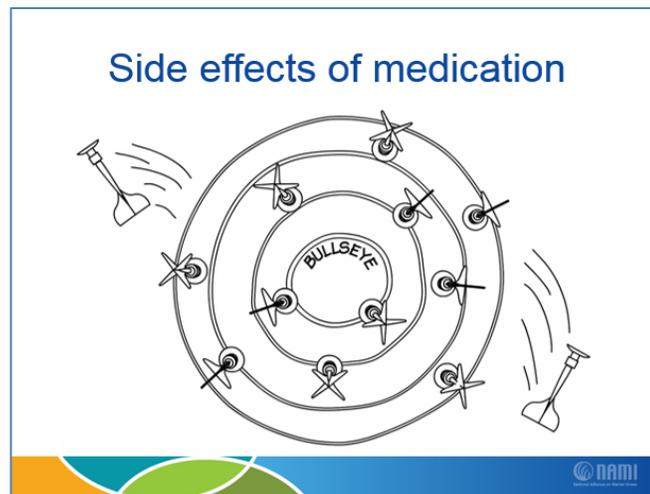
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- Other characteristics can be different, specifically inactive ingredients such as color, flavor, fillers and binders. These inactive ingredients usually vary between drug companies and can influence the way a medication works for different people.

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- If you notice changes in someone's symptoms, and the look of the generic medications they're taking has changed, tell the prescriber. The symptom changes may be caused by the differences in the generic medication and can be easily corrected.

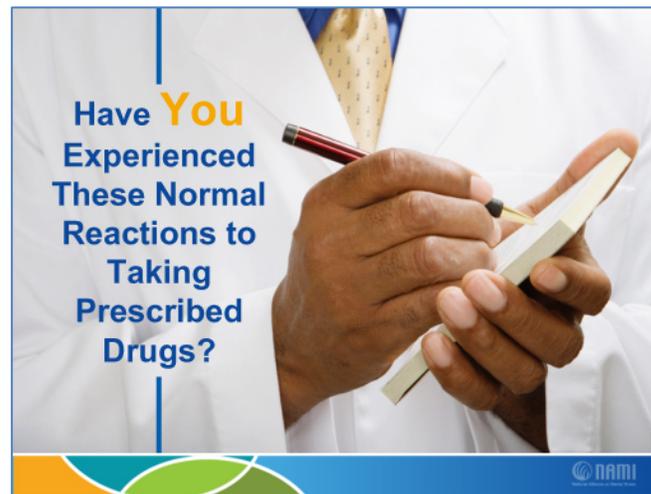
### Talking Points



### Key Points

- You've learned that inside every brain, at microscopic levels, is an impressive system of over 100 billion nerve cells communicating with each other using electrical and chemical signals. Neurotransmitters, such as dopamine and serotonin, are chemicals needed to help deliver the electrical messages between brain cells.
- It would be wonderful if psychotropic medications were miracle cures—that is, the main effect of the drug was limited to a single, specific brain area, and targeted only those neurotransmitters which controlled the unwanted symptoms.
- Unfortunately, this is not the case. These medications are more like buckshot; they hit the target and everything else around it. They block other neurotransmitters, and they impact many parts of the brain which control vital body functions.
- In some cases, cells outside of the brain use the same neurotransmitters to transmit signals; so, medications for mental health conditions also directly affect other parts of the body.
- For example, the digestive system uses serotonin to communicate between cells. That's why antidepressants that alter serotonin levels can also cause nausea or diarrhea.

### Talking Points



### Key Points

- Medications can be challenging to tolerate since many of them have side effects. For instance, some studies indicate that African Americans metabolize many medications more slowly than the general population yet are more likely to receive higher dosages. This may result in a greater chance of negative side-effects and a decreased likelihood of sticking with treatment.

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- ***ACTIVITY: By a show of hands, have you ever felt disoriented or controlled by the medication you were taking? What did you do?***

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- ***Did you ever stop taking medication when you started feeling better?***

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- ***Have you taken medication that made you feel physically sick?***

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- ***Did you continue taking it anyway?***

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- ***What would you do if a medication made you gain 45 pounds, gave you tremors, made you sleepy and blocked your sexual responses?***

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- ***Raise your hand if you usually finish a prescribed dose of medication.***

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- ***How many of us usually don't finish taking a prescribed medication?***

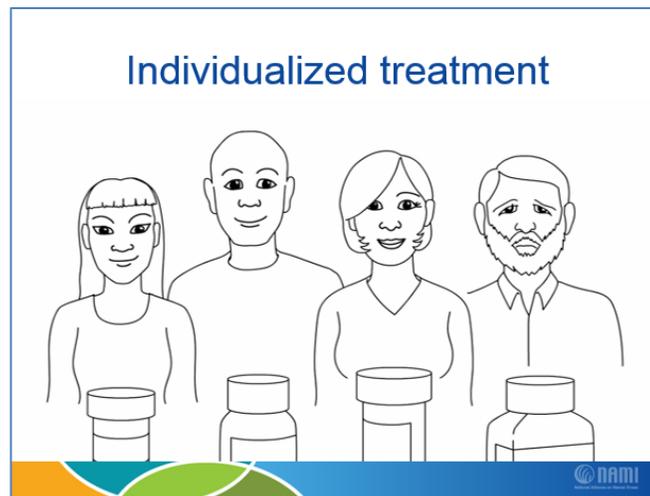
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- ***How many of us have expired medications at home?***

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- Finding the right medication takes time!

### Talking Points



### Key Points

- Medications may work well for one person but not at all for someone else—even if both people have the same diagnosis. It is difficult to predict exactly who will respond to what medication. Doctors usually review a person’s symptoms and their treatment history to see if there are reasons for recommending one type of medicine over another. Family history, ethnicity, other health conditions and side effects are also taken into consideration when prescribing medication.
- It’s not uncommon for someone with a mental health condition to be prescribed a variety of medications throughout their lifetime. Not all medicine works for everyone, so there’s often some trial and error before finding the right solution. It frequently takes a combination of medicines to treat the symptoms and side effects. Fortunately, there are a variety of effective medications available.

### Talking Points



### Key Points

- Medication side effects can make it tough to follow a treatment plan but so can other factors.
- **Lacking insight into the condition: "I'm not ill"** Inability to perceive changes in one's own feelings, behavior or personality referred to as "lack of insight" is also called **anosognosia**. When people lack insight into their condition, they may continue to believe nothing is wrong, even if their symptoms improve with treatment
- **Using denial as a protective coping strategy: "I don't need treatment"** When a person is overwhelmed or unequipped to address what's happening, they may deny that the problem exists or ignore it; choosing treatment means admitting that something is medically wrong.
- **Missing the thrill of mania: would rather feel pain than be numb or bored** Tolerating the ups and downs of their condition rather than give up feelings they're used to having which can lead people to experiment with stopping and starting medication.
- **Wishing to be seen as a person, not an illness; not wanting to be seen as broken** Many people don't like the idea of having a chronic condition that involves going to therapy or taking a medication indefinitely.
- **Being reluctant to accept things as they are, or partial acceptance** When a person is unable to accept a situation or condition, it's often because their experience feels too painful to bear. It may seem easier to disregard the problem even if there are negative consequences in the long term.

### Talking Points



### Key Points

#### Supporting Your Loved One During Treatment

- If your relative with the mental health condition is willing to discuss treatment, help them to understand how medications work and how they may help

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- You and your loved one may need to have a workable plan for monitoring medications (for treatment and safety)

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- All medication issues need to be discussed openly

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- Sometimes adherence increases by avoiding the “mental illness” connotation of these medications. Someone might be more willing to take medication for symptoms like stress or insomnia but hesitate to take an anti-psychotic.

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- It's helpful to keep written records of the medication your loved one has taken, the dosages and the side effects that have been troublesome

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- Confidentiality will not be a barrier to communication with treatment providers if your relative gives permission. If permission isn't granted you may speak to the provider but the provider cannot give you information in return.

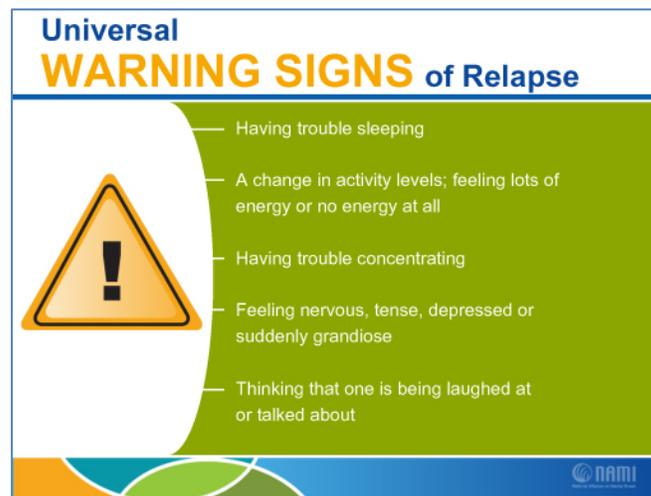
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- If your relative refuses medication or other treatment options, then you must prepare yourself for a period of crisis

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- **ACTIVITY: How many of your loved ones have stopped medication when they felt better? What happened? How many have had a medication stop working over time?**

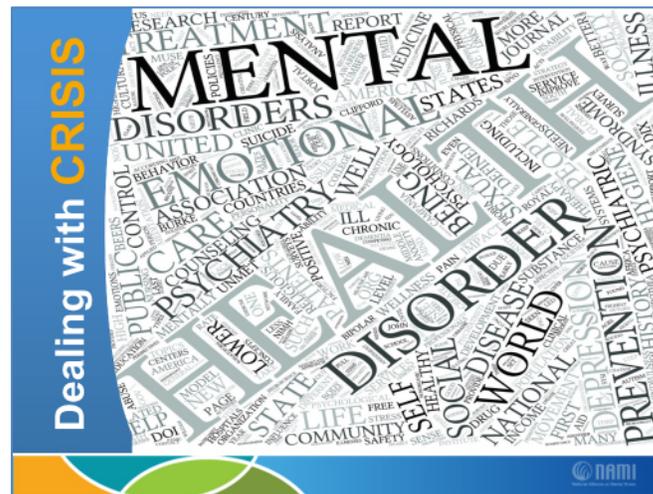
### Talking Points



### Key Points

- Because medications and other therapies don't always protect against relapse, we need to know how to recognize warning signs, even when our relatives are getting treatment.
- One study showed that 70% of people with mental health conditions can tell the early subjective changes in thoughts and behavior that signal a relapse is coming.
- 96% of family members studied can readily identify these changes, too! Knowing what to look for means we can act more swiftly to protect someone before a full-blown episode occurs.
- **ACTIVITY: By a show of hands, how many of you have gone through a relapse with your loved one? What are some of the warning signs you've seen? Share warning signs you have experienced with your own loved one (BE BRIEF)**

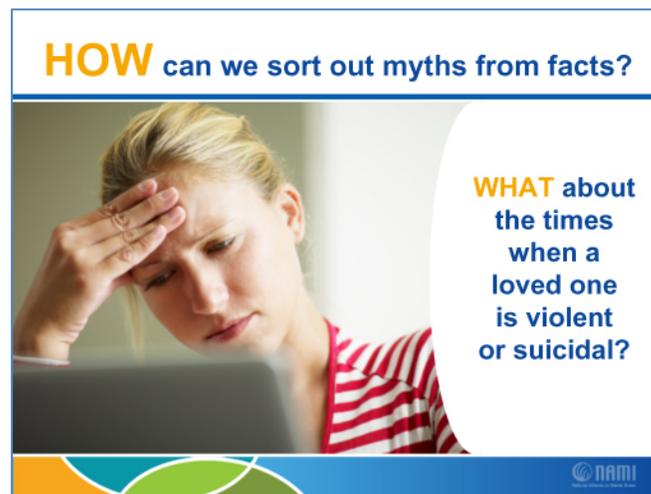
### Talking Points



### Key Points

- Lots of resources can be found on the NAMI website at [nami.org](http://nami.org)
- There you'll find material for specific populations including families of children with mental health conditions, military/Veteran families and many more as well as information for people with mental health conditions.
- There is also information about dealing with law enforcement and the justice system.
- If you must call law enforcement, request a CIT (Crisis Intervention Team) officer if one is available in your community. CIT officers have special training in verbal de-escalation techniques for use in mental health crisis situations. Tell both the 911-Dispatcher and anyone who arrives on the scene that your loved one needs a psychiatric assessment and that you've called them for help. Attempt to prepare law enforcement for what to expect so that your relative and the officer are safe during their interaction.

### Talking Points

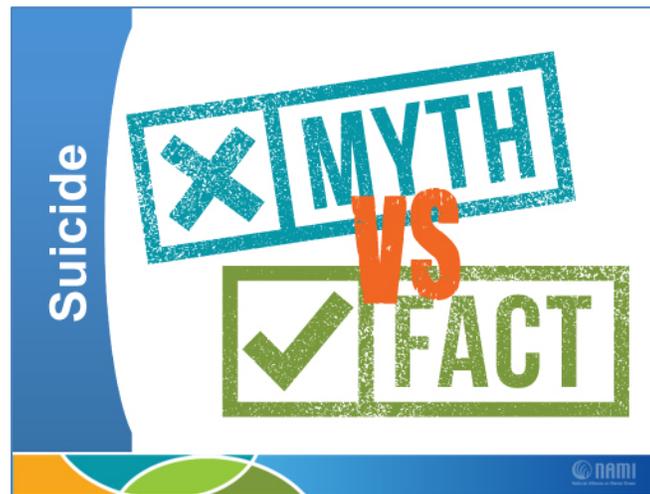


**Key Points**

- Those with schizophrenia and mania who take medication regularly and who do not abuse alcohol/ other drugs are no more violent than the rest of the population
- The combination of major mental health conditions and substance abuse is a significant predictor of aggressive behavior
- The likelihood of violence is greatest among males in their late teens or early 20's
- The best prediction of future behavior is past behavior
- If your loved one is experiencing auditory hallucinations—such as voices—they may be hearing life-threatening commands; messages may be coming from the television; the room may be filled with poisonous fumes; they may believe their food is being poisoned; snipers may be lurking in public places; random authority figures may be thought of as the enemy.
- Your loved one is probably terrified by the experience of losing control over their thoughts and feelings.

**Talking Points**





**Key Points**

- **ACTIVITY:** Now my co-leader and I are going to read you some myths and facts about suicide that come from the American Association of Suicidology.

**ACTIVITY:** Leader reads the myth and the second leader responds with the fact until entire list is shared.

- **MYTH:** People who talk about suicide never attempt it.
- **FACT:** Most of the time, people who attempt suicide have provided clues to their intentions.
  
- **MYTH:** Talking about suicide with someone may give them ideas.
- **FACT:** Talking about suicide with a loved one gives them an opportunity to express thoughts and feelings about something they may have been keeping secret. Discussion brings it into the open and provided an opportunity for intervention.
  
- **MYTH:** Only certain “types” of people die by suicide.
- **FACT:** There is no specific type. While some demographic factors contribute to higher risk for suicide, it is important to remember that suicide does not discriminate. People of all genders, races, ethnicities, ages, upbringings and socio-economic statuses kill themselves. Pay attention to what the person says and does – not what he/she looks like or how you believe that person should think, feel or act.
  
- **MYTH:** Suicidal people overreact to life events.
- **FACT:** Problems that may not seem like a big deal to one person, may be causing a great deal of distress for someone else. For example, a teen may have a strong reaction to an issue that an adult considers minor; a family member may not realize the impact “invisible wounds” like PTSD, TBI or **moral injury**\* have on a Veteran. We must remember the perceived crises are just as concerning and predictive of suicidal behavior as actual crises.

**\*NOTE: Leaders don’t need to read this definition, it’s included for clarity**

**Definition of moral injury:** “Like psychological trauma, **moral injury**...describes extreme and unprecedented life experience including the harmful aftermath of exposure to such events. Events are considered morally injurious if they ‘transgress (violate) deeply held moral beliefs and expectations’ (1). The key precondition for moral injury is an act of transgression (violation or wrongdoing), which shatters moral and ethical expectations that are rooted in religious or spiritual beliefs, or culture-based, organizational, and group-based rules about fairness, the value of life, and so forth.” (Moral Injury in the Context of War, National Center for PTSD, [www.ptsd.va.gov](http://www.ptsd.va.gov), retrieved 6/15/18)

- **MYTH:** Suicide is an act of aggression, anger or revenge.
- **FACT:** Most people who kill themselves do so because they feel they do not belong or are a burden on others. They think that their death will free their loved ones of this burden. Many suicides occur in ways and in places that the person hopes will ease the shock and grief of those they left behind.
  
- **MYTH:** Nothing can stop someone once they’ve decided to take their own life.
- **FACT:** Most people who contemplate suicide are torn. They are in pain and want their suffering to end. They don’t necessarily want to die to make that happen. But they can’t conceive of another way, and too often their cries for help go unheard.

**ACTIVITY:** After you’ve read the list, ask the participants: **Did any of the myths surprise you?**



### Key Points

- We lose far too many young people of all backgrounds to suicide
- The number of Veterans and military service members who die by suicide is also staggering
- Some in the LGBTQ community are at a higher risk for suicide because they may lack peer support and face harassment. Rates of mental health conditions and substance abuse increase with isolation. For LGBTQ people aged 10–24, suicide is one of the leading causes of death. LGBTQ youth are 4 times more likely and questioning youth are 3 times more likely to attempt suicide, experience suicidal thoughts or engage in self-harm than straight people. Between 38-65% of transgender individuals experience suicidal ideation.
- In addition to Myths and Facts about suicide, the eBook/manual contains more information about warnings signs and a suicide prevention checklist developed by a father in Oregon who lost his daughter to suicide.

### Talking Points

**What should YOU do?**

Take warning signs seriously, **take action IMMEDIATELY**

- Ask the question
- Don't leave them alone
- Call a suicide crisis line
- Go to an emergency room or call 911
- Don't keep suicide warning signs a secret

NAMI

**Key Points**

- If you're concerned about someone's safety, there are actions you can take listed in your manual.

**An important step is to ask questions!**

- Have you been feeling sad or unhappy?
- Do you ever feel hopeless? Does it seem as if things will never get better?
- Do you think about dying?
- Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?
- Do you have any actual plans to kill yourself?
- If so...when do you plan to kill yourself?
- Is there anything that would help you reconsider, such as the effect on someone in our family, or a pet or your religious convictions?
- Have you ever made a suicide attempt in the past?
- Would you be willing to talk to someone or ask for help if you felt desperate? Is there a person you could talk to?

**Talking Points**



### Key Points

The eBook/manual lists suggestions for managing crisis, which include:

- Family members or close friends will see signs of crisis or relapse like sleeplessness, ritualistic preoccupation with certain activities, suspiciousness/paranoia, unpredictable outbursts, and so on.

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- The goal during a crisis is to prevent things from getting worse and to provide immediate protection and support to the person experiencing the crisis.

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- Addressing early warning signs can often prevent a full-blown crisis.

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- Trust your intuition. If you're feeling frightened or panicked, the situation calls for immediate action. Remember, your primary task is to help your family member regain control, to keep everyone safe and to not escalate the situation.

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- Remain calm. If you're alone, contact someone to join you until professional help arrives.

---

- **ACTIVITY: Perhaps you've never needed one but, what kind of crisis plan do you have in place at your house? Do you have an agreement with your loved one about what you will do if you are concerned about safety?**

---

- You'll find suggestions for a crisis plan and a relapse plan in the eBook/manual.

### Talking Points



### Key Points

- Your relative may need hospitalization to recover from these episodes. If so, talk to him or her about going voluntarily and avoid being patronizing or authoritative.
- Explain that the hospital will provide relief from the symptoms and that he or she probably won't be admitted if treatment can be continued at home or outside the hospital in some other protected environment.
- Having a mental health crisis can be frightening for both the individual and their family. Being hospitalized often makes people feel powerless and threatened, so whenever it's **safe** to do so allow your relative to make choices. For example, if there are different ways to go to the hospital, you may ask how they prefer to travel (ambulance vs. you driving them). Or if there's more than one reasonable option, ask them which hospital they would prefer.

### Talking Points



### Key Points

#### Guidelines to help de-escalate a crisis:

- **Don't threaten.** This may be interpreted as a power play and increase fear or lead to a violent reaction

---

- **Don't shout.** If the person with the symptoms of a mental health condition seems not to be listening, it isn't because he or she is hard of hearing. Other "voices," thoughts, anxieties or paranoia may be interfering or dominating.

---

- **Don't criticize.** It will only make matters worse; it can't possibly make things better

---

- **Don't argue with other family members** over "best strategies" or who is to blame. This is no time to prove a point.

---

- **Don't aggravate or provoke your loved** into acting on threats; the consequences could be tragic

---

- **Don't stand over your loved one** if he or she is seated since this may be experienced as threatening. Instead, seat yourself. However, if a person with a mental health condition is getting increasingly upset and stands up, consider standing up so that if you feel threatened or unsafe, you can quickly leave the room.

---

- **Avoid direct, continuous eye contact or touching your loved one.** Comply with requests that are reasonable and safe. This provides the person in crisis with an opportunity to feel somewhat "in control."

---

- **Don't block the doorway.** Don't try to keep you relative in the room if they want to leave. If possible, stay calm. Research suggests that strong expressions of negative emotion may further destabilize individuals with a mental health condition.

---

- Record keeping can make crisis management much easier. You'll find suggestions about record keeping in the eBook/manual.

### Talking Points



### Key Points

- Each of you has a connection to mental illness. Which family member do you represent?

---

- **ACTIVITY:** *Each leader remind audience of their loved one and role (my son has bipolar disorder so I'm a parent, etc.).*

---

- Some of us have more than one person in our lives affected by mental illness.

---

- **ACTIVITY:** *By a show of hands, how many of you are parents of someone with a mental health condition? Spouses or partners? Siblings? Adult children of a parent with a condition? Grandparents? Grandchildren? Friends? We have lots of connections to mental health!*

---

- Your eBook/manual has information about family roles, living a balanced life, setting limits and letting go

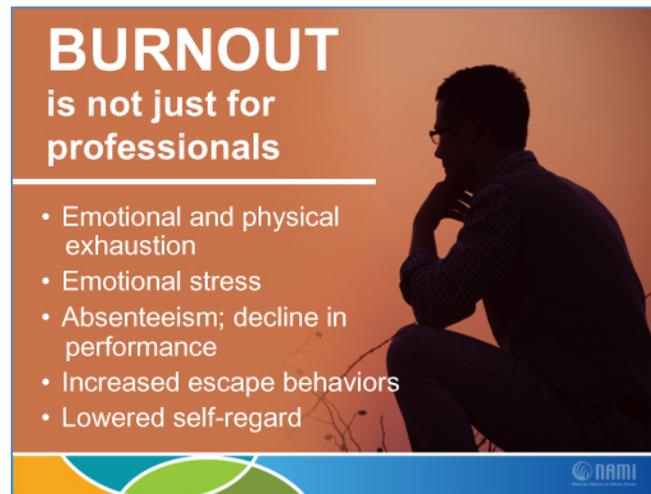
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- **Transition:** Family members and caregivers must take care of their brains too!

---

- **ACTIVITY:** *What happens if we don't take care of ourselves? Wait for someone to mention BURNOUT and move to the next slide*

### Talking Points



**Key Points**

- Sometimes it feels like we are **professional caregivers** since we gain a lot of knowledge over time about systems, services, talk therapy and medication. Being a caregiver can be stressful!

**Caregiver burnout can include:**

- Emotional exhaustion – depression, boredom, apathy, indecisiveness
- Physical exhaustion – headaches, muscle tension
- Emotional stress – signs include insomnia, irritability, increased anxiety, hopelessness
- Being absent – not participating at work, as a volunteer or even in family activities; worsening performance at duties
- Increase in "escape" activities – smoking, over-eating, excessive drinking
- Lowered self-regard – signs include self-doubt, self-blame, blaming others

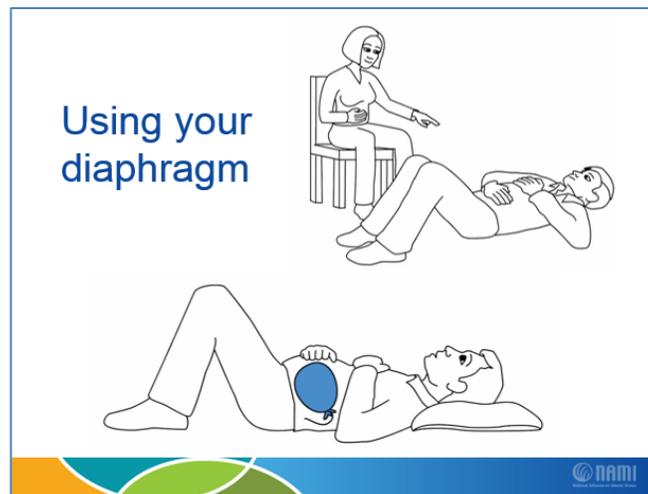
**Talking Points**



### Key Points

- One way to combat burnout and calm yourself is to breathe deeply!

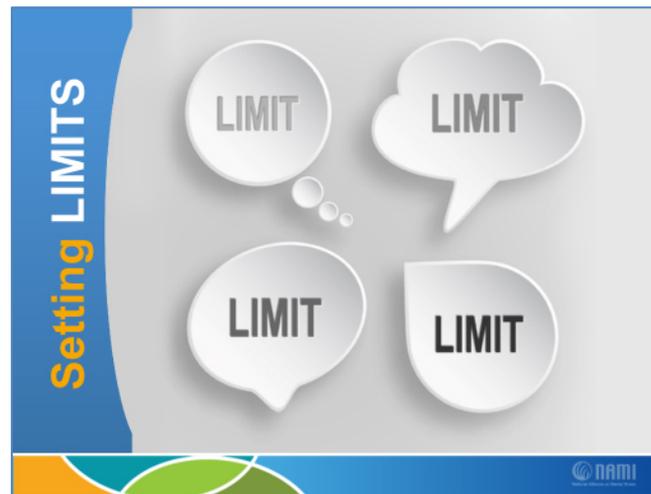
### Talking Points



### Key Points

- Many people are shallow breathers. If, when you breathe in deeply and let it out, you see your shoulders go up and down and your chest expand, you're a shallow breather. Shallow breathers only use the top of their lungs. The diaphragm is a large, dome-shaped muscle located below the rib cage that helps push the air in and out of the lungs. Using the diaphragm lets you use the full power of your breath.
- It is best to either sit in a chair with one hand on your upper chest and the other on your stomach. Or you can lie on the floor with your knees bent.
- Begin by taking a deep breath and watching which hand moves. Now imagine that you have a balloon in your stomach that you can inflate with your breathing. When you inhale through your nose, push your stomach out and hold your breath for just a second or two. Now exhale by pulling your stomach in and letting the air escape from your mouth. Try it again. Only the hand on your stomach should be moving. The one on your chest should remain still.
- For additional relaxation, try counting while you practice your diaphragmatic breathing. Breathe in for a count of 4, hold your breath for a count of 4 and then exhale through your mouth for a count of 8.
- Research is indicating that diaphragmatic breathing can lower the body's stress levels by releasing neurotransmitters that decrease anxiety, and, used often, may even change how the body reacts to stress.

### Talking Points



### **Key Points**

**Sometimes we must set limits, so remember:**

- You are not alone
- Ask for help from family, friends or authorities
- Create and honor healthy boundaries when it comes to psychotic symptoms or behaviors
- Set limits on psychotic behavior and have a plan for what you will and won't tolerate
- Trust your instincts
- Don't ignore concerns about violence and suicide
- Even if you are terrified or angry, approach your relative with respect
- Acting to protect our relatives with mental health conditions is the highest form of caring for them
- Acting to keep ourselves clear of danger is the highest form of self-care

### **Talking Points**

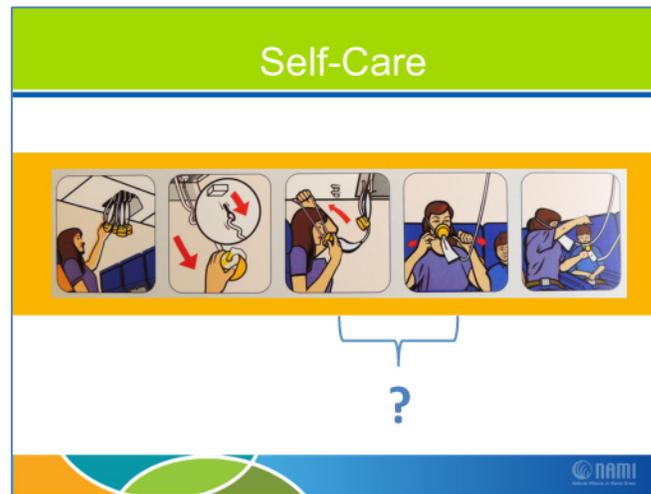


### Key Points

#### To Let Go:

- Is not to cut myself off, but to realize I can't control another person
- Is not to stop caring, but to realize I can't do it for someone else
- Is to allow someone to learn from natural consequences
- Is to recognize when the outcome is not in my hands
- Is not to care for, but to care about
- Is not to fix, but to support
- Is not to judge, but to allow another to be a human being
- Is not to criticize or regulate anybody, but to try to become what I dream I can be
- Is not to expect miracles, but to take each day as it comes, and cherish myself in it
- Is not to regret the past, but to grow and live for the future; to let go is to fear less and love more

### Talking Points



### Key Points

- What do flight attendants tell us when we prepare for take-off?
- Put your oxygen mask on **before** you help your child or neighbor!
- Why? So you don't pass out before you can assist others!
- **Transition:** A great way to take care of yourself is to attend a NAMI class, support group or presentation like this! We'd like to tell you more about what NAMI has to offer.

### Talking Points



### Key Points

- Now we'd like to share some NAMI resources with you! **ACTIVITY:** Describe any NAMI National Education Programs offered by your affiliate using the descriptions on the opposite page. Let attendees know if you're a teacher, facilitator or presenter for any of the programs and share brochures and information about how to register/attend. If your affiliate doesn't offer one of the programs you don't need to talk about it in detail. Remind people about the resource table.

### Talking Points

**CLASSES:** NAMI classes offer information, resources and a community of support. They aim to increase understanding of mental health, improve coping skills and empower participants to advocate for themselves or their loved one.

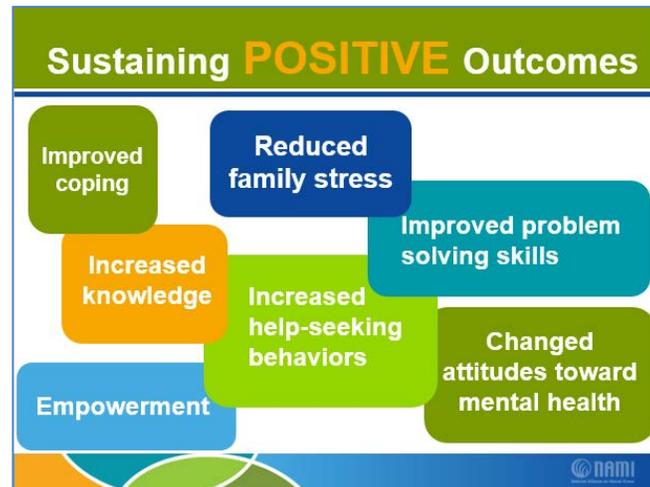
- **NAMI Basics** is for parents, guardians and other family who provide care for youth with mental health symptoms. Available in Spanish: Bases y Fundamentos de NAMI
- **NAMI Family-to-Family** is for families, partners and friends of people who have mental health conditions. This program was designated as an evidence-based program by SAMHSA. Available in Spanish: De Familia a Familia de NAMI
- **NAMI Homefront** is for families, partners and friends who provide care for Service Members/Veterans experiencing mental health symptoms. Available in-person and online.
- **NAMI Peer-to-Peer** is for anyone who is experiencing or has experienced a mental health challenge. Available in Spanish: De Persona a Persona de NAMI
- **NAMI Provider** offers 12.5 hours of in-service training to line staff at facilities providing mental health treatment services. The course aims to expand participants' compassion for clients and their families and to promote a collaborative model of care.

**PRESENTATIONS:** NAMI presentations give audiences the opportunity to hear stories of direct experiences of mental health conditions. They aim to create awareness, reduce stigma and increase empathy.

- **NAMI Ending the Silence** is a presentation about mental health conditions in youth. Available for three audiences: students, families and school staff. All versions educate about warning signs, what to do and the importance of early intervention.
- **NAMI In Our Own Voice** is for the general public. It uses personal stories to promote awareness of mental health conditions and of the possibility of recovery. Available in Spanish: En Nuestra Propia Voz de NAMI
- **NAMI Provider Seminar** is a 4-hour presentation for staff at facilities providing mental health treatment services. It introduces audiences to NAMI and to the unique perspectives of people affected by mental illness.

**SUPPORT GROUPS:** NAMI support groups offer participants an opportunity to share their experiences and gain support from other attendees.

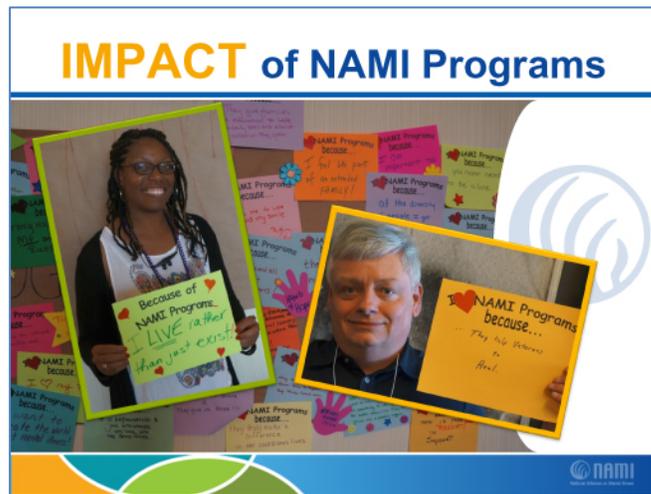
- **NAMI Connection Recovery Support Group** is for people with mental health conditions. Available in Spanish: NAMI Conexión Grupo de Apoyo y Recuperación
- **NAMI Family Support Group** is for family members, partners and friends of people with mental health conditions. Available in Spanish: Grupo de Apoyo para Familiares de NAMI



### Key Points

- Class evaluations and academic research have found that NAMI programs are effective.
- The **NAMI Family-to-Family** program showed significant lasting (at least 6 months) reductions in family member distress, and improvements in family problems solving, coping, knowledge and empowerment in family members of adults with mental illnesses (Lucksted, et al., 2013). After extensive research, it was designated an evidence-based practice by SAMHSA (Substance Abuse and Mental Health Services Administration) in 2013.
- Research done on **NAMI Basics** showed significant improvements in self-care, empowerment, and “incendiary” (aggressive or provocative) family communication after participation in the program. Results suggest that NAMI Basics may improve both parental functioning and familial processes. (Brister, et al., 2011)
- A study recently completed on **NAMI Ending the Silence** found that middle and high school students had improved attitudes toward mental health, increased knowledge and utilized help-seeking behaviors (Wahl, 2016)
- Research on the impact of other NAMI programs is currently underway.

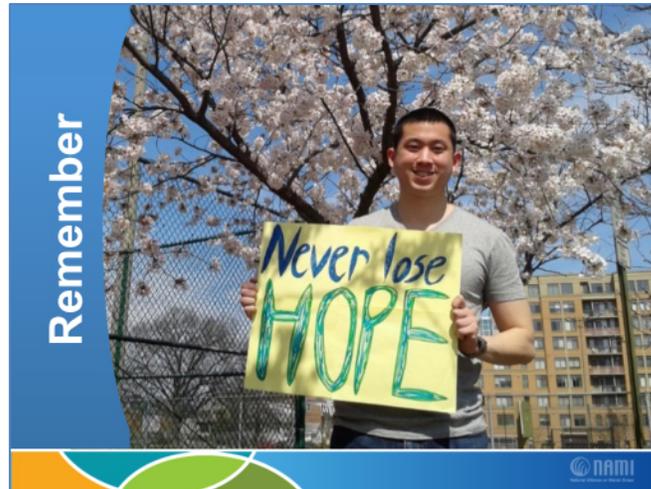
### Talking Points



### Key Points

- **ACTIVITY:** Each leader explains briefly how a NAMI program impacted their life. Mention what it was like to be in crisis and find NAMI and what made you decide to volunteer.
- Before we leave, we want to remind you of some things we covered today.

### Talking Points



### Key Points

#### Remember:

- **YOU ARE NOT ALONE!**
- Mental health conditions are **MEDICAL ILLNESSES**
- It's **NOT** anyone's fault
- Learn the **WARNING SIGNS**
- **RECOVERY** is possible, there is **HOPE**
- **LANGUAGE MATTERS!** You can fight stigma by changing how you talk about mental health conditions. Instead of saying "she is bipolar," you can say "she has bipolar." As we know, a person is more than their diagnosis!

#### Next steps:

- **ACTIVITY:** *Hand out paper manuals if your affiliate provides them and encourage people to download the eBook if they haven't already.*
- Explore the resources in the eBook or manual

### Talking Points

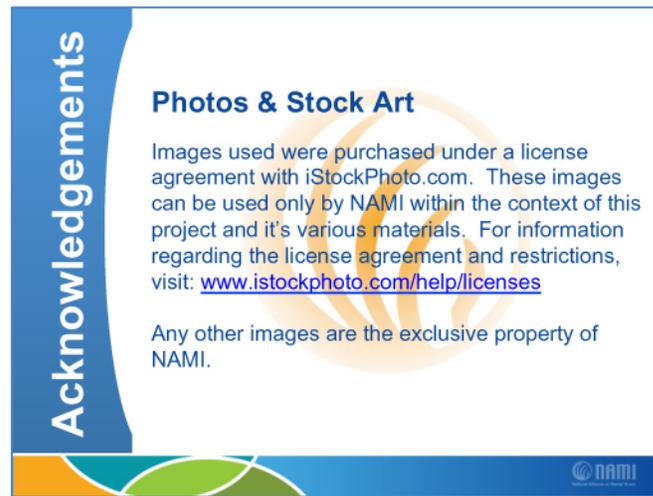


## Key Points

### Membership:

- Become a member of NAMI either online via [nami.org](http://nami.org) or take a brochure from the resource table to learn more.
- When you join NAMI, you receive national, state and local membership benefits including the quarterly NAMI Advocate magazine from headquarters and are entitled to other publications and email alerts by request.
- You'll also have access to special sections of the NAMI Website and you'll receive publications from your NAMI State Organization and local NAMI Affiliate.
- Sign up for a NAMI class, join a NAMI support group or attend a NAMI presentation!
- We appreciate your attendance and hope that you will complete the evaluation that will arrive by email. We value your feedback and want to know how we can improve the seminar.
- Thanks for coming and travel safely!

## Talking Points



**Acknowledgements**

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 NAMI  
National Alliance for Mental Illness

## Key Points

## Talking Points

[INSERT]  
90-minute  
Seminar  
Tab



## Seminar Time Frame (90-minute version)

### The 90-minute seminar includes:

**F&F Presentation ..... 1 hour & 10 minutes**

The F&F seminar teaches participants about the warning signs of mental health conditions, treatment options, communication strategies, crisis preparation, coping techniques and empathy. The presentation includes a PowerPoint slide deck, activities and discussion. **Time management is crucial!** Don't go over the time limits for any part of the presentation.

**Presenter Stories .....10 minutes (see note)**

This is always the most powerful portion of the presentation. Each presenter shares the mental health journey of their loved one, the impact it's had on the whole family (the person with the condition and others), what the presenter has done to care for themselves (self-care strategies) and what things are like now (see guidelines for developing your personal story in the **Presenter Tips** section of the manual on pages PT.3 – PT.11). **NOTE: The 90-minute version of the seminar requires two leaders. Each presenter has 5-minutes to tell their story.**

**Q&A, Evaluations and Farewell ..... 10 minutes**

People are usually eager to ask presenters questions and/or share their personal experiences. When the Q&A is complete, presenters will remind participants that they will receive an email with a link to the evaluation.

---

***TIP FROM THE FIELD:*** *It's helpful to have extra NAMI leaders in the room to support anyone who becomes upset during the seminar, to talk with participants individually at the end and assist with clean up.*

---





### Key Points

- **ACTIVITY:** Set up the room in advance. Place NAMI brochures on the resource table. Be sure to have the materials for the voices exercise ready (pens, index cards and scripts). If you are providing pens and paper for taking notes have them available for participants on the resource table. **Note:** Check with your coordinator to determine if a paper manual will be provided. If so don't hand them out until the **END** of the seminar. Greet people as they arrive, take attendance (using the NAMI Portal or a sign-in form) and show them the resource table. Start on time!

---

- Welcome everyone and let them know that we won't be using the eBook/manual during the seminar, it's for future reference.

---

- **ACTIVITY:** Each presenter gives an enthusiastic introduction of themselves. Include first name, a fun fact about you (hobby, pets, career, etc.), how long you've been active with NAMI, your role as the family member of someone with a mental illness (**DON'T** mention your loved one's diagnosis here). **BE BRIEF** – no more than 1 minute per presenter the details come later!

---

- Tell participants where the restrooms and drinking fountain are. Request that phones are turned off or silenced, ask that calls are taken outside of the room. Introduce any NAMI representatives and volunteers present, point out the materials on the resource table. Tell participants there will be breaks during the seminar (mention snacks if they'll be provided) and an opportunity to ask questions at the end.

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- The purpose of this presentation is to share general information about mental health as well as skills you can use at home that can help with communication, managing stress, self-care and crisis preparation.

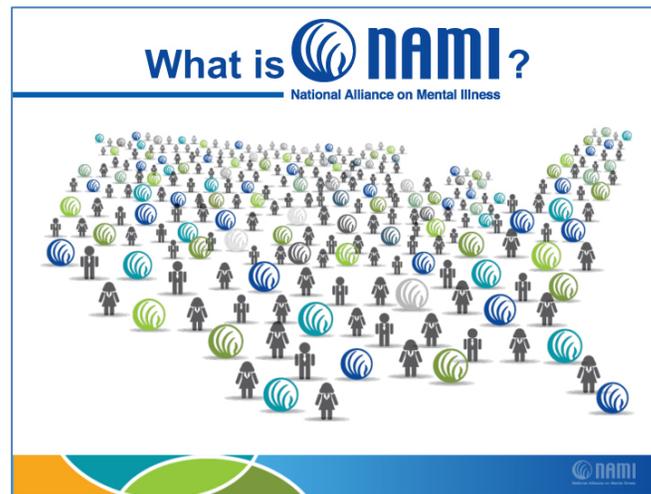
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- You'll also learn about programs and resources NAMI offers.

---

- **Disclaimer:** We are not psychiatrists or social workers or therapists. But we know what it's like to have a family member with a mental health condition. We call this "lived experience."

### Talking Points



### Key Points

- **ACTIVITY: By a show of hands, does anyone know what the acronym NAMI stands for?** Take suggestions until someone gives the correct name...thank them for their answers...restate the name National Alliance on Mental Illness.
- NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization. NAMI provides advocacy, education, support and public awareness so that all individuals and families affected by mental health conditions can build better lives.
- NAMI is the foundation for NAMI State Organizations, 700+ NAMI Affiliates and thousands of leaders who volunteer in local communities across the country to raise awareness and provide essential education, advocacy and support group programs at no cost to participants.
- **ACTIVITY: By a show of hands, is anyone a leader or volunteer with NAMI?** Tell the group that you'll share information about NAMI programs later in the seminar.

### Talking Points



### Key Points

- **Education** – NAMI offers classes, presentations and an annual convention
- **Advocacy** – NAMI advocates for state and federal legislation and policies, NAMI State Organizations and affiliates advocate on behalf of people in recovery and their families. NAMI encourages research on the prevention, causes and effective interventions related to mental health conditions.
- **Support** – NAMI staffs a HelpLine at the national office and so do many NAMI state and local affiliates. NAMI also has support groups run by and for people with mental health conditions as well as groups run by and for family members.
- **Awareness** – NAMI fights stigma and discrimination through individual advocacy and community events like Mental Illness Awareness Week and NAMI Walks. NAMI also produces publications including our quarterly magazine the Advocate, brochures and policy reports.

### Talking Points

## WHY is this important?

- **Anyone** can be affected by a mental health condition
- **Suicide** is the 2<sup>nd</sup> leading cause of death in the U.S. in people 15-24 years old
- **Recovery** is possible

### Mental Health Facts

MULTICULTURAL

Fact: Mental health affects everyone regardless of culture, race, ethnicity, gender, or sexual orientation.



1 in every 5 adults in America experience a mental illness.



Nearly 1 in 25 (39 million) adults in America live with a serious mental illness.



One-half of all chronic mental illness begins by the age of 14, three-quarters by the age of 24.



### Key Points

- You may have heard these statistics, two of which can be upsetting
- One of the major goals of this seminar is to emphasize, through our stories, that recovery is possible. Mental health conditions can be unpredictable but there is hope!
- You'll learn **FACTS** about diagnoses and treatment options from reliable sources including NIMH which is the National Institute of Mental Health, SAMHSA which is the Substance Abuse and Mental Health Services Administration, the Veteran's Administration (VA) for military or Veteran families and many more.
- You'll learn **SKILLS** in the areas of communication, recognizing signs and symptoms of relapse and we'll share tips for managing crises
- You'll receive **RESOURCES** that may help you, your family and your loved with a mental health condition

### Talking Points

## What are mental health conditions?



- Mental health conditions **ARE**:
  - Medical illnesses that change how people think, feel and act
  - Something common and treatable
- Mental health conditions **ARE NOT**:
  - Anyone's fault or something to be ashamed of
  - The end – you can achieve goals



### Key Points

- NAMI advises anyone experiencing new symptoms to seek a full physical evaluation
- Mental health conditions are medical illnesses, like any other physical illness
- They are treated with medication and therapy much like heart disease, cancer, diabetes and injuries
- They aren't the fault of the person experiencing symptoms or their family (we'll talk about the impact that the environment and trauma can have a bit later)
- Mental health conditions aren't something to be ashamed of, anyone can have a mental health condition
- A mental health condition doesn't mean a person can't have a good life or achieve goals

### Talking Points

**Facts**

1 in 5 **ADULTS** in the U.S. experience a mental health condition in any given year and 1 in 5 **YOUTH** (aged 13-18) have experienced a mental health condition at some point in their life.

Nearly 60% of **ADULTS** and 50% of **YOUTH** (aged 8-15) with a mental health condition don't receive treatment

**STIGMA** is a major reason people don't seek help

NAMI

**DATA SOURCES:**

1. Ahrensbrak et al., "Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017.
2. Merikangas et al., "Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement (NCS-A)," *Journal of the American Academy of Child and Adolescent Psychiatry*, 2010 Oct;49(10):980-9.

**Key Points**

- 1 in 5 adults experience a mental health condition in any given year and 1 in 5 youth (aged 13 – 15) have experienced a mental health condition at some point in their life.

**Many people don't get help or treatment for reasons that can include:**

- Lack of insurance or the cost of assessment or treatment
- Limited access to mental health providers (shortage of psychiatrists)
- Shame, fear and stigma associated with mental health conditions

**Ethnic and cultural groups can experience other forms of stigma:**

- **LGBT** (lesbian, gay, bisexual and transgender) people may confront bullying, stigma and prejudice based on their sexual orientation or gender identity while also dealing with the societal bias against mental health conditions.
- In the United States, only about 25% of **African Americans** seek mental health care, compared to 40% of **white adults**. As a community, **Latinos** tend not to talk about mental health issues and are less likely to seek mental health treatment. **Asian Americans** also seek mental health care at lower rates than **whites**.
- Possible reasons for these differences include distrust attributed to prejudice and discrimination in the health care system, language barriers, cultural differences and lack of mental health professionals with similar cultural or ethnic backgrounds.
- The experiences of **Military personnel, Veterans** and their families must also be handled with sensitivity. Stigma often discourages active duty Service Members from seeking treatment for PTSD or other conditions, for fear of jeopardizing their military careers. Even Veterans may not seek treatment for fear of appearing weak.
- **Transition:** Let's talk a bit more about stigma

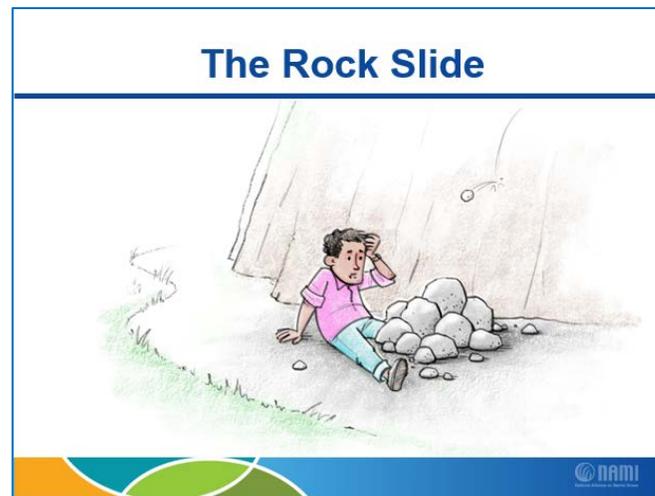
**Talking Points**



### Key Points

- Stigma can include stereotyping, labeling, bullying and discrimination
- Many people mistakenly believe that people with mental health conditions are dangerous or violent—this is also an example of stigma. The truth is, people with mental health conditions are more likely to be victims of violence.
- **ACTIVITY: Let's do a comparison. What do people do when someone they know gets a cancer diagnosis?** Answers may include: mow lawn, bring dinner, shovel snow, run errands, walk the dog, carpool kids, babysit, drive person to chemo/radiation, etc. **What happens or what do you imagine happens when people hear someone has been hospitalized with a mental illness?** Answers may include: silence, don't want to upset or embarrass the family, don't know what to say or do, afraid they will make things worse if they reach out, etc. Share personal experiences that apply here.
- In the U.S. we say mental health conditions tend NOT to be “casserole illnesses,” meaning people don't bring meals when your loved one is in a hospital or jail because of a mental illness.

### Talking Points



### Key Points

- Mental health conditions bring unwanted symptoms and take away or diminish characteristics at the same time.
- Think of the impact of mental illness as a rock slide.
- Let's use a physical injury as an example. This person was walking when some rocks rolled down a hill onto his leg. Now he has the unwanted "symptoms" of pain, being trapped and having a broken foot! He'll probably need help moving the rocks and getting to a hospital. He may require surgery to repair the bone and a cast to protect his leg. He'll probably need crutches to move around until he's healed. Because of his injury there may also be things he can't do like drive his car, walk his dog or work because he must carry things at his job. The injury is painful, requires expensive treatment and has an impact on his daily life.
- Whether a condition is mental or physical, we may have no control over the severity of symptoms that appear. Recovery will require treatment, such as therapy and medication, and social support from family and friends.
- Just like a rock slide, we can't control the severity of mental health conditions. They are disorders of the brain and the symptoms are expressed as complex, often unwanted behaviors.
- **Transition:** Let's talk about some of the changes that occur when a person has symptoms of a mental illness.

### Talking Points



### Key Points

- In the eBook/manual, there are lists of behaviors and characteristics that can change when a person develops symptoms of a mental health condition. Mental health conditions may deeply alter the personality and behavior of the people we care about.
- It may seem like our loved one should be able to control or stop these behaviors, but they can't. Knowing this will help us to separate the person we love from the symptoms of the condition.
- **Positive symptoms** are behaviors you never saw before, which may be **Added** to your loved one including:
  - Unpredictable over-reaction to things
  - Uncontrollable sadness, crying, anger or paranoia
  - Inappropriate and bizarre behaviors
  - A need to withdraw and isolate
- **Negative Symptoms** are behaviors you've always counted on which may be **Taken Away** from your loved one including:
  - Ability to focus and concentrate
  - Ability to cope with minor problems
  - Enjoyment of family, friends, work
  - Optimism, faith, belief in the future

### Talking Points



### Key Points

- We each have many reactions to mental health conditions when they hit someone we love.
- We may feel traumatized. There can be overwhelming stress and anxiety and we need to learn about the impact this takes on our emotions.
- We rarely get a chance to talk about these feelings with people in the mental health system. However, with other family members, like the participants in this seminar, we can talk openly about our feelings and reactions.
- **ACTIVITY:** Review the list and confirm that what participants are feeling is common. Ask to your co-presenter: **What was your experience with these feelings?** Both presenters share their experience with one of two of the feelings. You'll help the participants feel more comfortable about their reactions.

### Talking Points



# TRAUMA

## Catastrophic Stressor

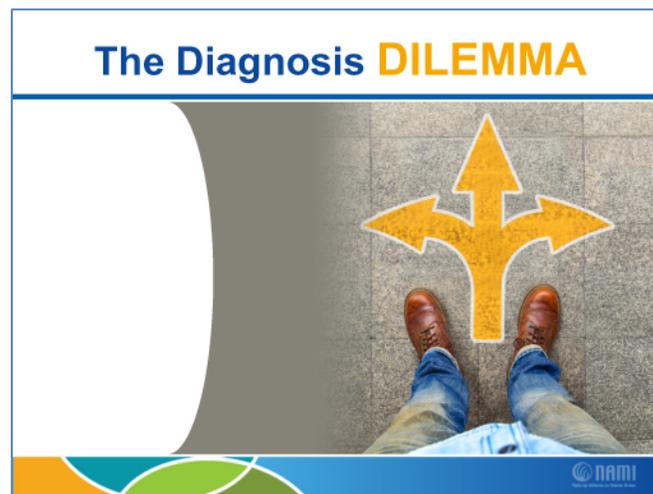
- Is generally an unanticipated event
- There is little time to prepare for it
- One has little previous experience and few sources of guidance
- It has a huge emotional impact
- Involves threat or danger to self or others



### Key Points

- The word “trauma” has a variety of meanings and implications. The DSM-5 (Diagnostic Statistical Manual used by clinicians to diagnose mental health conditions) classifies trauma this way: “A person “exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence” has experienced trauma.
- Another way to view this type of trauma is as a “catastrophic stressor.”
- Families agree that this definition accurately describes the experience of having a mental health episode happen in their family. It is a catastrophe, and the first time it happens it creates acute panic, fear and disbelief. It’s an extreme, destructive source of stress.

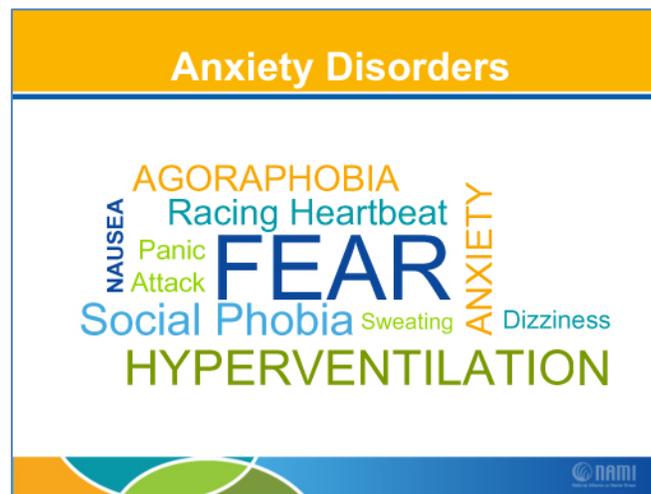
### Talking Points



### Key Points

- With children and adults, it's essential for people experiencing symptoms to ask for, and get, a complete physical as part of their diagnostic work-up. The “body” signs of depressive conditions can mimic illnesses of the thyroid and adrenal glands while anxiety can feel like a heart attack, so various physical disorders may need to be ruled out. Screening for traumatic brain injury, Lyme disease, dementia, cancer or other issues may also be needed to determine what your loved one is experiencing. Sharing your observations with the provider can help determine a diagnosis.
- Information about family history and other health conditions that your relative can provide to a mental health provider (psychiatrist, nurse practitioner, therapist, counselor, etc.) will help them diagnose the condition and recommend effective treatment.
- It will take time to get an accurate diagnosis because symptoms overlap
- Educate yourself so that you can help your relative as they navigate the “new normal” we mentioned earlier when we talked about trauma.
- We're going to talk about the most common diagnoses today. There is information about other mental health conditions on [nami.org](http://nami.org) and in the eBook/manual.

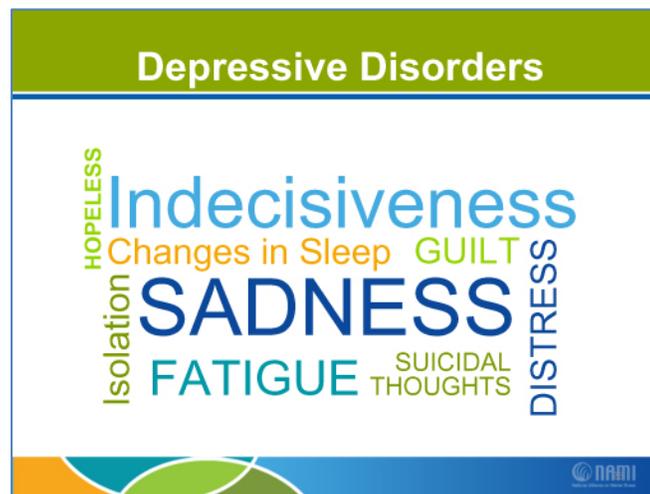
### Talking Points



### Key Points

- Nearly everyone experiences anxiety. Speaking in front of a group makes most of us anxious, but that motivates us to prepare. Driving in heavy traffic is a common source of anxiety, but it keeps us alert and cautious to avoid accidents. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday things, an anxiety disorder may be the cause.
- **ACTIVITY: Most specific phobias that raise our anxiety levels don't require medical attention. What are some common phobias or fears you can think of?** Answers may include heights, spiders/bugs, flying, water/swimming, birds, bears, cats, snakes, etc. Add something silly to help get the suggestions started.
- Anxiety disorders are the most common mental health concern in the United States.
- An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder and approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home.
- Most people develop symptoms of anxiety disorders before age 21 and women are 60% more likely to be diagnosed with an anxiety disorder than men.
- **ACTIVITY: Leader insert your 5-minute family story here if your loved one has anxiety (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).**

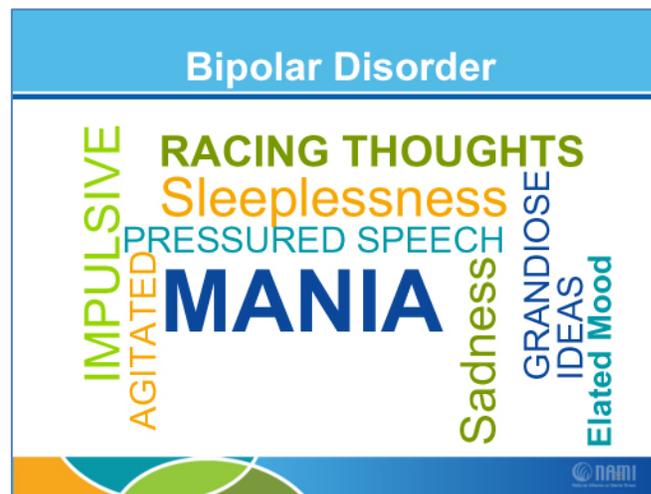
### Talking Points



### Key Points

- Depression is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding, treatment and a good recovery plan. With early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people get better. Left untreated, depression can be devastating, both for the people who have it and for their families. Some people have only one episode in a lifetime, but for most people depression recurs. Without treatment, episodes may last a few months to several years. People with severe depression can feel so hopeless that they become a risk for suicide.
- An estimated 16 million American adults—almost 7% of the population—had at least 1 major depressive episode last year. People of all ages and all racial, ethnic and socioeconomic backgrounds can experience depression, but it does affect some groups of people more than others.
- Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.
- **ACTIVITY:** *Leader insert your 5-minute family story here if your loved one has depressive disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).*

### Talking Points



### Key Points

- A person with bipolar disorder may have distinct manic or depressed states. A person with mixed episodes experiences both extremes simultaneously or in rapid sequence. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. Someone who is manic might believe she has special powers and may display risky behavior. Someone who is depressed might feel hopeless, helpless and be unable to perform normal tasks. People with bipolar disorder who have psychotic symptoms may be wrongly diagnosed with schizophrenia.
- People's symptoms and the severity of their mania or depression vary widely. Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally. (from NAMI website)
- **ACTIVITY:** Leader insert your 5-minute family story here if your loved one has bipolar disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

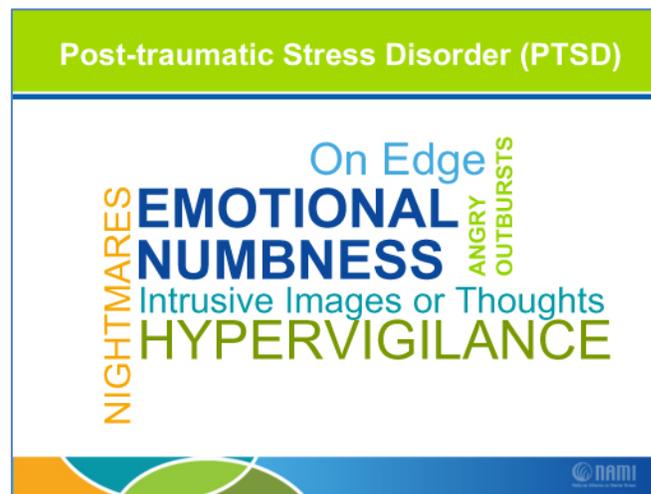
### Talking Points



### Key Points

- Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them.
- The compulsive physical (hand washing, repetitive touching, etc.) or mental (silently repeating special words, images or numbers, etc.) acts are aimed at preventing or reducing the anxiety generated by the obsessive thoughts.
- Symptoms typically begin during childhood, the teenage years or young adulthood, although males often develop them at a younger age than females. More than 2% of the U.S. population (nearly 1 out of 40 people) will be diagnosed with OCD during their lives.
- **ACTIVITY: By a show of hands, how many of you are neat and like things in order and put away in the proper place? How many of you are pile people who may have stacks of papers and stuff? Guess what...neatness doesn't mean you have a bit of OCD and piles don't mean you are a hoarder. We should tell you that hoarding was once considered a symptom of OCD but is now classified as a distinct condition.**
- **ACTIVITY: Leader insert your 5-minute family story here if your loved one has OCD (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).**

### Talking Points



### Key Points

- Traumatic events, such as military combat, assault, an accident or a natural disaster, can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms long after the traumatic event is over.
- Because the body is busy increasing the heart rate, pumping blood to muscles for movement and preparing the body to fight off infection and bleeding in case of a wound, all bodily resources and energy get focused on physically getting out of harm's way. This resulting damage to the brain's response system is called posttraumatic stress response or disorder, also known as PTSD.
- PTSD affects 3.5% of the U.S. adult population—about 7.7 million Americans—but women are more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is in a person's early 20s.
- **ACTIVITY:** Leader insert your 5-minute family story here if your loved one has PTSD (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

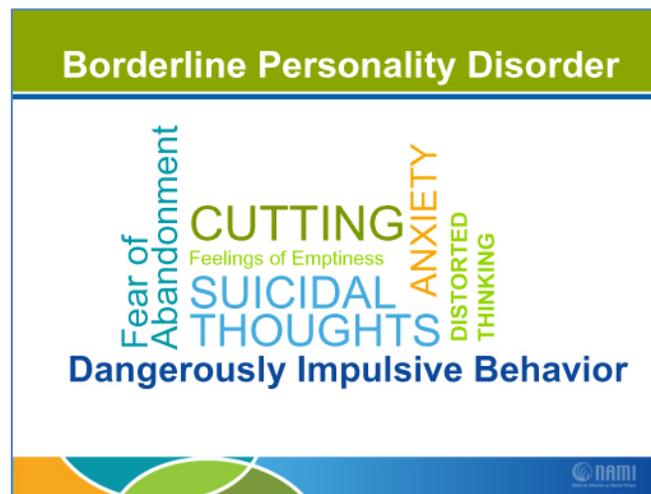
### Talking Points



### Key Points

- Schizophrenia is a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others.
- It is a complex, long-term medical illness, affecting about 1% of Americans.
- Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early 20s for men, and the late 20s to early 30s for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
- Some symptoms can be categorized as **thinking** which can include delusions, paranoia, suspiciousness, disorganized speech or **sensory** meaning the senses are more acute, the person is easily overwhelmed by stimuli and hallucinations featuring one or more of the senses may occur. Some helpful definitions from MedicineNet.com are:
  - **Hallucination:** A profound distortion in a person's perception of reality, typically accompanied by a powerful sense of reality. Hallucinations may be sensory experiences in which a person can see, hear, smell, taste, or feel something that is not there. (Retrieved from MedicineNet.com, owned and operated by WebMD, 2018)
  - **Delusion:** A false personal belief that is not subject to reason or contradictory evidence and is not explained by a person's usual cultural and religious concepts (so that, for example, it is not an article of faith). A delusion may be firmly maintained in the face of incontrovertible evidence that it is false. (Retrieved from MedicineNet.com, owned and operated by WebMD, 2018)
- **ACTIVITY:** Leader insert your 5-minute family story here if your loved one has Schizophrenia (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

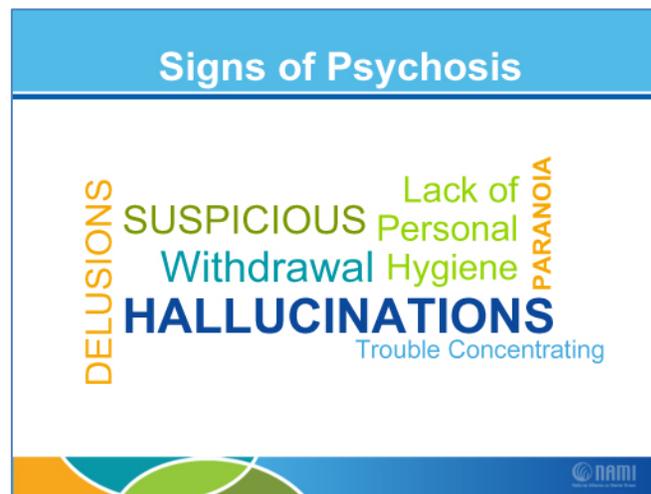
### Talking Points



### Key Points

- Borderline personality disorder (BPD) is a condition characterized by difficulties in regulating emotion. This difficulty leads to severe, unstable mood swings, impulsivity and instability, poor self-image and stormy personal relationships. People may make repeated attempts to avoid real or imagined situations of abandonment. People with BPD may experience a level of distress that leads to destructive behavior, such as self-harm (cutting) or suicide attempts.
- It's estimated that 1.6% of the adult U.S. population has BPD but it may be as high as 5.9%. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. In the past, men with BPD were often misdiagnosed with PTSD or depression.
- **ACTIVITY:** Leader insert your 5-minute family story here if your loved one has a personality disorder (see guidelines on pages PT.3 – PT.11 of Presenter Tips section).

### Talking Points



### Key Points

- Most people think of psychosis as a break with reality. Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing and believing things that aren't real or having strange, persistent thoughts, behaviors and emotions. While everyone's experience is different, most people say psychosis is frightening and confusing.
- Psychosis is a symptom, not an illness, and it's more common than you may think. In the U.S., approximately 100,000 young people experience psychosis each year. As many as 3 in 100 people will have an episode at some point in their lives.
- Early or first-episode psychosis (FEP), refers to when a person first shows signs of beginning to lose contact with reality. We are still learning about how and why psychosis develops. It's thought to be triggered by a mix of genetics (family history), and life stressors during critical stages of brain development.
- Sometimes psychosis can be the start of a more serious condition like schizophrenia or bipolar disorder. Risk factors that may contribute to the development of psychosis include stressors such as physical illness, substance use (marijuana, hallucinogens and stimulants) and psychological or physical trauma.
- **Emphasize:** Psychosis can occur in different mental health conditions. If a person has untreated schizophrenia, bipolar disorder, depressive disorder, PTSD, OCD, etc. or if a treatment stops working or is suddenly discontinued.

### Talking Points



### Key Points

- Dual diagnosis, also called co-occurring diagnoses, is a term for when someone experiences a mental health condition and a substance abuse problem simultaneously. You may have heard this referred to as co-occurring disorders.
- This is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when that person uses heroin during periods of mania.
- It doesn't matter which condition developed first.
- People experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to get relief from the troubling symptoms they experience. Research shows though that drugs and alcohol make the symptoms of illness worse.
- Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.
- **ACTIVITY: By a show of hands, how many have had a loved one self-medicate? Has anyone's loved one experienced substance use or abuse? How many have a loved one that is diagnosed with a co-occurring mental health and substance use disorder?**

### Talking Points



### Key Points

- **ACTIVITY:** Pause a few seconds to allow the audience time to read the names on the slide.
- Many people affected by mental health conditions, not just the famous names you may recognize on this slide, are able to live well and succeed.
- Having a mental health condition doesn't mean a person can't achieve goals and live a wonderful life. Goals and timelines may be changed by mental illness. Everyone won't become rich and famous but each of us has something valuable to contribute, whether it's as an employee, a dedicated volunteer or a caring friend.
- Never give up hope!
- **ACTIVITY:** Mention some of the famous people on the slide using the details listed on the opposite page. Talk about what made the person famous, their connection to mental illness (individual with symptoms/diagnosis or family member) and the condition that has had an impact on them.

### Talking Points

## Famous people with mental health conditions

<b>Alicia Keys (has depression)</b> – Grammy-winning singer, songwriter
<b>Buzz Aldrin (has depression and alcoholism)</b> – USAF fighter pilot in the Korean War, engineer, astronaut and 2 <sup>nd</sup> man on the moon
<b>Michael Phelps (has ADHD and depression)</b> – Swimmer and Olympic champion
<b>Carrie Fisher (had bipolar disorder and addiction)</b> – Actress and author, best known as Princess Leia in the <i>Star Wars</i> films
<b>Will Smith (has ADHD)</b> – Oscar-nominated Actor and Grammy-winning rapper
<b>Cheryl Stayed (has depression)</b> – Author best known for the book <u>Wild</u>
<b>Adele (has generalized anxiety disorder)</b> – Grammy-winning singer, songwriter
<b>Emma Stone (had childhood panic disorder)</b> – Actress best known for Oscar-winning performance in <i>La Land</i> and films <i>Easy A</i> and <i>Crazy, Stupid, Love</i>
<b>Dwayne “The Rock” Johnson (had depression)</b> – Actor, singer and retired wrestler
<b>Margaret Cho (has Depression)</b> – Comedian, actress and author
<b>Bruce Springsteen (has depression)</b> - Grammy-winning singer, songwriter
<b>JK Rowling (has depression)</b> – Author best known for the Harry Potter series
<b>Lady GaGa (has depression)</b> – Singer, actress, founder Born this Way Foundation
<b>John Nash (had schizophrenia)</b> – Nobel Prize winning mathematician, portrayed by Russell Crowe in the movie <i>A Beautiful Mind</i>
<b>Terry Bradshaw (has depression)</b> – NFL Hall of Fame quarterback, won 4 super bowls with the Pittsburgh Steelers, current football analyst and occasional actor
<b>Abraham Lincoln (believed to have had depression)</b> – 16 <sup>th</sup> President of the U.S.
<b>Brian Wilson (has schizoaffective disorder)</b> – Singer, co-founder of the Beach Boys
<b>Demi Lovato (has bipolar disorder and addiction)</b> – Singer, songwriter and actress
<b>Brandon Marshall (has borderline personality disorder)</b> – NFL All-Pro wide receiver, mental health activist #StrongerThanStigma
<b>Patrick Kennedy (has bipolar disorder and addiction disorder)</b> – Former U.S. Representative and founder of the Kennedy Forum
<b>David O. Russell (family member whose son has bipolar disorder)</b> – Director, screenwriter known for <i>The Fighter</i> , <i>Silver Linings Playbook</i> , <i>American Hustle</i> and <i>Joy</i>
<b>Glenn Close (family member whose sister has bipolar disorder and whose nephew has schizoaffective disorder)</b> – Actress, co-founder of BringChange2Mind
<b>Rick Warren (family member whose son had depressive disorder and died by suicide)</b> – Pastor and author of <u>The Purpose Driven Life</u>
<b>Utkarsh Ambudkar (Oot-karsh Am-bood-car) (has anxiety and depression)</b> – Actor, singer, rapper best known for the film <i>Pitch Perfect</i>
<b>Clark Gregg (has anxiety and addiction)</b> – Actor, writer best known as Agent Phil Coulson in the Marvel Comics world and for the TV show <i>The New Adventures of Old Christine</i>
<b>Mayim Bialik (family member)</b> – Actress, PhD neuroscientist best known for <i>Big Bang Theory</i> , <i>Blossom</i> and the film <i>Beaches</i>
<b>AJ Mendez Brooks (has bipolar disorder)</b> – Retired WWE (World Wrestling Entertainment) star, NYT bestselling author of <u>Crazy is My Superpower</u>

**The BIOLOGY of Mental Health Conditions**



“What we have to get across, is how it is that people get mental illness. Nobody is to blame. This is not a mental weakness. These are diseases just like any other neurobiological disorders. They just happen to affect complex behaviors.”

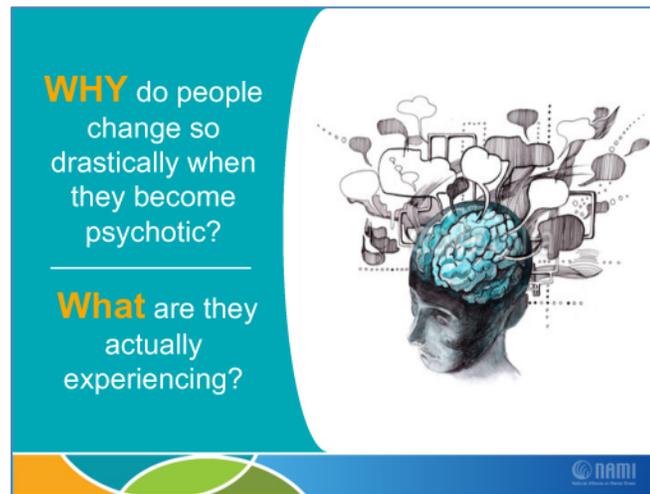
Dr. Steven Hyman, former Director of the National Institute of Mental Health (NIMH)



### Key Points

- Researchers are exploring how a gene's composition and function may change over time. This type of research is called epigenetics. For mental health conditions, this research is showing that something is transmitted genetically, but it's not enough to guarantee that a mental health condition will develop. Something else needs to occur for mental health distress to begin. There are two major thoughts on what that something else might be.
- Biological scientists call it a “second hit” and believe it may come from a virus, an injury in the womb or during birth, exposure to toxic substances or problems with the immune system. Even though this “second hit” may occur before birth or in infancy, the distress and behaviors that result don't begin to show until the child enters the developmental stage of adulthood.
- Social scientists look for how social and cultural environments impact the development of mental health conditions. They look at the neighborhood a person lives in, their health habits, other medical conditions they may have, any traumatic events they have experienced, and every other social aspect of the person's life.
- It's important for you to know that someone who has both a genetic predisposition to a mental health condition and a stressful environment, is NOT guaranteed to develop symptoms. The opposite is also true. Someone without a known family history and without a traumatic life experience MAY develop a mental health condition.
- **Transition:** Now we'd like to talk about what people may experience when they become psychotic.

### Talking Points



### Key Points

- Regardless of the diagnosis, intrusive or compulsive thoughts, fears or even hallucinations can all interfere with the individual's ability to think and relate to others. Before we review communication skills, we want to provide a picture for you of what it can be like for someone with symptoms of a mental health condition.
- Now we want to take you through an activity, so you can experience what it feels like for a person with a thought disorder.
- **Transition:** This is what we call an **empathy exercise**.
- **Note:** Review tips for how do conduct empathy exercise in auditorium settings (see page P.4 in Presentation Prep section). Have pens, index cards and scripts ready for voices exercise.

### Talking Points

### **Setting up the exercise**

- *Have index cards and pens/pencils available.*
- **Leader #1** *will ask for 4-8 volunteers (depending on the size of the seminar attendees) to be the patient.*
  - **Leader # 1** *stays in the room with the seated patients and has them sit next to one another in a line. Explain that they will be asked to do a simple drawing exercise. Hand out index cards and pens.*
- **Leader #2** *will ask for the same number of volunteers and will take them out of the room for instructions*
  - **Leader #2** *will explain that they will stand behind the patient's chairs and be a "chorus" of:*
    - *the "voices" in the head of each patient*
    - *random noises in the environment*
  - *Give each person a "Voices" Role Play Card. Confirm the statement on the card is okay for them to read and let them know they don't need to act out the voice. Ask them to speak in a normal voice repeating the message on their card.*
  - *Tell them to wait for **Leader #2's** cue before they start to read and to continue reading until **Leader #2** says "STOP."*
  - **Leader # 2** *brings the voices back into the room and asks them to line up*

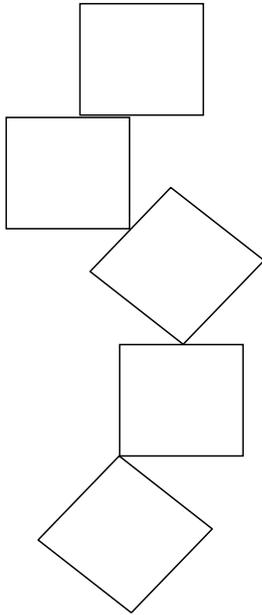
### **Doing the exercise**

- *Once the patients are seated and the voices are lined up behind them:*
  - **Leader #1** *will give the seated patients the drawing instructions.*
  - **Leader #2** *will cue the voices once the first instructions are given.*

**Leader #1** reads the instructions below in a strong voice, without expression

This is not a test. No one will be checking your performance, but there are a few rules:

1. Please don't ask questions.
2. Please don't look at your neighbor's paper.
3. Please don't interrupt me, or make any comments until after I call "Stop"



1. All right, let's begin
2. Draw a square.
3. Draw a second square, lining up its right side with the midpoint of the bottom of the first square.
4. Draw a third square turned at an angle, so that the midpoint of one side meets the right bottom point of the second square.
5. Draw a fourth square, lining up the midpoint of its top with the lowest point of the third square.
6. Draw a fifth square, placing its top point on the bottom left hand point of the fourth square.
7. **Call STOP!**

### ***Debriefing the exercise***

- *Ask for people's reactions to the exercise, starting with the group sitting down who played the patients.*
- *Ask seated people what they felt:*
  - *Uncertainty? Confusion? Anxiety? Did they tune out, give up, not try at all? Did they feel disoriented? Frustrated?*
  - *Point out that their reactions are like those of people with symptoms of a mental health condition*
- *Ask the voices about their experience.*
- *Did everyone get a sense of how difficult it is to focus with this distraction?*
- *Have the volunteers move back to their seats.*



## **Empathy Exercise (Voice 1)**

Don't trust the people leading this exercise.  
They're trying to trick you so they can lock you  
up. They're all trying to make it look like you're  
crazy.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 2)**

You've got to get away. If you stay here in this room they'll hurt you! Hurry! You should run while they're not looking!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 3)**

Everyone in this room is staring at you. You can't trust any of them; they just pretend to care. You've got to get away!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 4)**

This is what they warned us about—people giving you directions that don't make any sense, they're trying to confuse you. You can't trust these people. It's all a trick!

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 5)**

This is the weather report for the city. The barometer is rising and today will be milder with a high of 55, with clouds tomorrow.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 6)**

I looked in on the patient today and he still seems psychotic. He's not responding fully to the medication...let's take the dose up to the next level.

(Repeat until the exercise stops)



## **Empathy Exercise (Voice 7)**

This person is evil. The devil has sent this person to get you to do bad things. Don't do what they are asking you. You will go to eternal damnation.

(Repeat until the exercise stops)

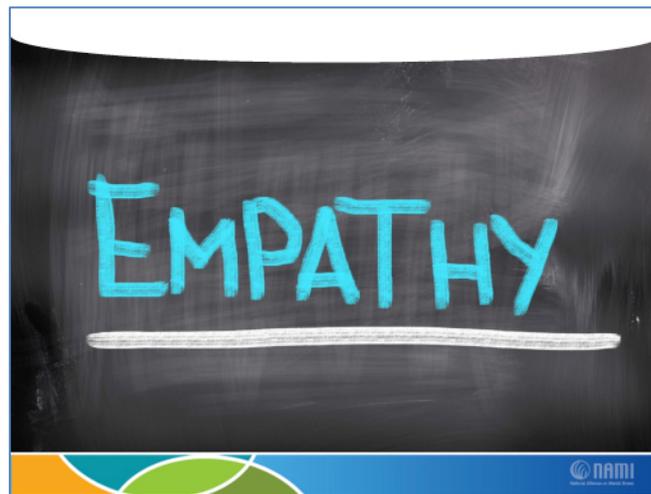


## **Empathy Exercise (Voice 8)**

Hello dear! I wanted to call to see how you're doing. Is the medication working? We sure hope it will help. Do you need clean clothes? We're coming to take you to lunch on Sunday.

(Repeat until the exercise stops)





### Key Points

- **ACTIVITY:** *By a show of hands how many of you trying to draw found that frustrating?*

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- That last exercise was exaggerated but we did that to make a point. Having a mental health condition is tough! Unwanted symptoms and feelings can take over which frustrates us and our loved one. Fears, anxiety and other frightening thoughts can be just as disabling and disruptive to a person's ability to pay attention and interact with others as hallucinations are. The voices exercise can give us empathy for what our relative may be experiencing.

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- If your loved one is anxious around crowds, looking for the exit in every room, or experiencing other intrusive (meaning disturbing and unwanted) thoughts, it limits their ability to interact with the outside world—including you and the other people they love. As difficult as it may be for you, don't take it personally; they're not choosing to behave this way. At NAMI we like to say love the person, hate the illness.

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- Empathy is the capacity to recognize emotions that are being experienced by someone else. We are trying to learn about our relatives by understanding their world. If we have empathy, we'll be aware of the difficulties they're experiencing and we'll no longer expect them to respond as if nothing was happening.

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- **Transition:** The voices exercise reminds us of how difficult communication can be for someone experiencing symptoms of a mental illness. We want to share some tips that may make talking to your loved one easier.

### Talking Points



### Key Points

- Use short, clear, direct sentences. Long, complicated explanations can be difficult for people experiencing mental health symptoms to follow. They may stop listening.
- Keep the content of what you say simple. Discuss only one topic at a time and give only one direction at a time. Be as concrete as possible.
- Keep the level of stimulation as low as possible so your loved one will be able to listen and understand you. Keep your voice low and calm, keep your body language calm and still, and speak respectfully and carefully rather than accusing or criticizing.
- If your loved one seems withdrawn and reluctant to talk, pause the conversation and give them space for a while. Don't try to force a conversation. You'll have a better chance of getting the response you want when your loved one is ready to interact with you.
- Assume that your loved one may not be able to absorb or understand some of what you say to them. You may need to repeat instructions and directions. Be patient.
- Be pleasant and firm.
- Saying things that contradict each other, or saying one thing and doing the opposite, makes it hard for your loved one to understand and trust you. When you communicate clearly and well, you show your loved one respect and create clear boundaries around what you can and will tolerate (yelling, cussing, etc.).
- Emphasize that these skills are even more important in times of stress or crisis
- **Transition:** Now let's look at two different techniques you can use when communicating with a person who is experiencing symptoms of a mental health condition

### Talking Points

**I-Statements**

- I am speaking in a very specific, direct manner
- I am at the center of the communication
- I take complete responsibility for my feelings and opinions
- I don't waiver
- I say what I mean

**Example:** "I don't like it when there's smoking in the house."





### Key Points

- I-statements focus on the facts, without blaming anyone. They allow you to express your personal feelings about what your loved one has chosen to do and say.
- Using I-statements regularly can change the atmosphere in your home. If one person changes their communication style, it will absolutely influence how the rest of the family communicates, too.
- When you get used to using I-statements, don't make the mistake of undoing their impact by expressing doubt or by adding something that reverses the point you just made. Say what you mean, and mean what you say, period.
- Remember, our relative's thinking is often distracted, disorganized and disturbing. It helps them when we are clear, calm and concise. I-statements can also help you request something of your relative and give them positive feedback, like praise.

### Talking Points

**YOU – Statements**

When we move away from I-Statements with our loved one, we tend to:

- Feel defensive
- Blame and become judgmental
- Make assumptions about the other person's motives
- Generalize a specific problem to other situations and accusations begin to snowball
- Vent our negative feelings





### Key Points

- That I-statement conversation might not sound familiar to you because we usually have “you” conversations with our loved ones. So, let’s hear the exact same conversation using the pronoun “you” instead of “I” and see what we notice (*use script on facing page.*)
- Do you hear the difference? The conversation using you-statements sounds full of attacking and blaming. Anyone in this type of conversation will probably get defensive. When people communicate this way, the interaction becomes extremely tense very quickly.
- In short, without I-Statements, discussions can become arguments. We get more frustrated and our loved one feels defeated. We voice our anger and frustration in a way that makes the conversation deteriorate quickly.
- Before leaving I-Statements, we need to mention they’re also great for making requests and giving positive feedback. I-Statements are a direct form of communication that may feel awkward but can be effective. Mental health conditions require us to do things differently to support our loved ones.
- **ACTIVITY: How many of you thought these examples would have been more realistic with cussing? We kept them simple to show you how to use the skill. I-statements may not work all the time, but they will help you stay calm and on topic when conversations get heated.**

### Talking Points



### Key Points

- A central part of reflective responses is staying with the emotional content of what your relative says, instead of arguing with them about how they see the situation.
- Don't try to convince your relative of what you think is true. Instead acknowledge what is real to them.
- With mental health conditions, we're dealing with a unique set of behaviors in our relative. How do we cope with someone who blames us for everything we try to do to help and protect them, who may be experiencing paranoia, whose descriptions of reality might appear delusional?
- We tend to avoid talking to our relatives about their behavior and troubled feelings because we're afraid that mentioning them will only make things worse.
- The opposite is true. When we can reflect what our relatives are feeling back to them, it often reduces those feelings and makes it easier to communicate with them.
- Reflective Responses are useful whenever our family member is communicating something unusual to us, when they're being oppositional, or when we're being challenged for some action we had to take that makes them angry.

### Talking Points



### Key Points

- Asking for help is difficult and intimidating. When the person seeking services encounters resistance from the treatment providers—a rude receptionist, canceled or rescheduled appointments, lots of eligibility paperwork—a common response is to get frustrated and give up.

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- This is a normal response, but extremely unfortunate because it only delays the recovery process.

---

- Across systems, a lack of understanding about ethnicity, culture, traditions, customs (including those associated with the military and Veterans), can further complicate treatment.

### Talking Points



### Key Points

- According to the American Psychiatric Association, mental illnesses are health conditions involving changes in thinking, emotion or behavior (or a combination of these). They can be severe or mild and are associated with distress and/or problems functioning in social, work or family activities (source APA website)

---

- Before we talk about treatment and recovery, we want to remind you about the key concepts. NAMI believes that:

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- Mental health conditions are no one's fault and aren't the result of character flaws

---

- Learning a loved one is dealing with a mental illness is a catastrophic stressor or a traumatic event

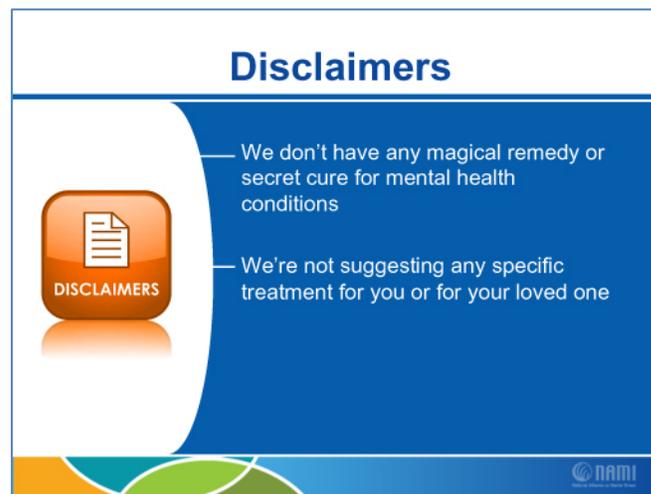
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- We need to look at the person with the condition from 3 perspectives – biological, psychological and social

---

- The best care from NAMI's perspective is collaborative and involves a treatment team which we'll explain in a few minutes

### Talking Points



### Key Points

- We are going to cover a variety of treatment options, including medication, and we want to make sure that you understand we will not be suggesting any specific treatment for your relative.
- We're sharing information that may be helpful to you as your loved one, in consultation with the provider, makes the best treatment decisions possible. You may be part of the decision process as part of a collaborative team or you may not have that access. In either case, it's helpful to know what treatment options are available.
- We will also provide information on where you can go to learn more about specific treatments, service providers and mental health care systems.

### Talking Points

## Seeking Treatment

- What options are available?
- Where do you start?
- Where do you go?
- Who do you talk with?
- What do you ask?





### Key Points

- Few people would delay seeking help if they were having chest pains, since it might be a heart attack. When the pain being experienced is not associated with a visible injury, it can be mistakenly viewed as a weakness or a character flaw. We may hesitate to visit a professional about experiencing emotional difficulties.

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- Let's assume that we have gotten past the hesitation, and that our loved one has agreed that something is wrong and that they need help.

---

- Let's also assume that you, as the informed family members you now are, have embraced this decision and are ready to provide the support necessary to make sure the appropriate services are received.

---

- You might be thinking: What's available? Where do I start? Where do I go? Who do I talk with and what should I ask them?

### Talking Points

## Therapeutic Intervention Techniques



The most effective treatment usually involves a combination of:

-  **Psychotherapy** - to address the psychological
-  **Medication** - to address the biological



### Key Points

- Typically, treatment usually includes talk therapy and medication.
- Different treatment settings are available. There's **outpatient** (typical medical and therapy appointments), **inpatient** (usually in a hospital or residential treatment center) and **day treatment** or **partial hospitalization** (involving spending the day at treatment facility for therapeutic activities).
- Regardless of treatment setting, there are a variety of different therapeutic techniques that can be used in addition to talk therapy and medication.
- These techniques may include brain stimulation therapies like Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Vagus Nerve Stimulation (VNS) or Deep Brain Stimulation (DBS). Like other treatments, brain stimulation therapies can have side effects. Talking to a doctor can be helpful if your loved one is considering brain stimulation.
- Other options include complementary health approaches like vitamins and minerals; medical foods; mind/body treatments like yoga or meditation; animal-assisted therapy such as teaching individuals how to groom, care for and ride horses.
- You can learn more about treatment options in the eBook or on the NAMI website **nami.org**.

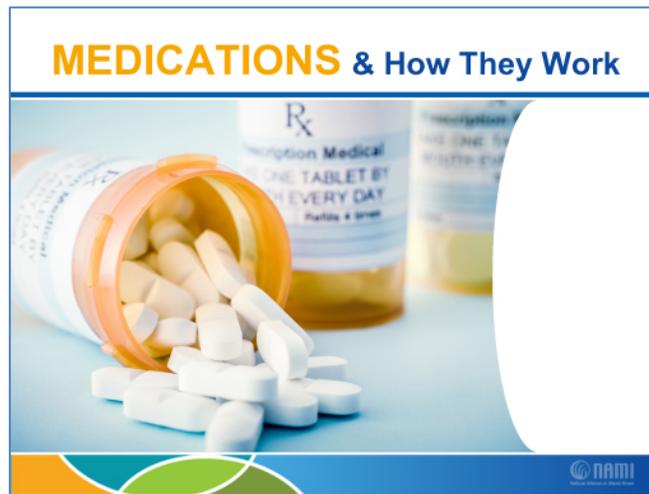
### Talking Points



### Key Points

- We don't cover every professional or treatment option you may encounter when seeking mental health services.
- As an advocate for your family member, don't be afraid to ask the person offering services about their qualifications, their licensure, their training and what type of therapeutic techniques they will be providing. Let them know that you want to be helpful and understand options.
- If a provider hesitates to answer any of these questions for your loved one or for you (if a signed release granting permission for information to be shared with you is in place), think about changing service providers. The therapeutic relationship is based on trust, and sometimes it can take several tries to find a provider that your relative is comfortable with.
- **ACTIVITY: By a show of hands, how many of your loved ones have seen a psychiatrist? Do any of your loved ones use a general practitioner, internist or pediatrician instead of a psychiatrist? Does your loved one have a case manager? A peer support specialist? A dietician? Does anyone know someone who lives in supervised or supportive housing such as a group home or apartment?**
- As you can see there are a lot of different providers who interact with people on their recovery journey.

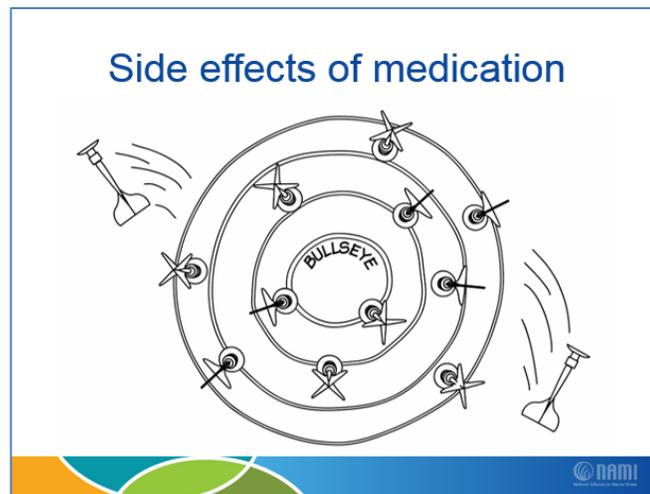
### Talking Points



### Key Points

- We are not medical professionals or pharmacists and do not pretend to be experts on all the specifics regarding medications
- We will only be discussing general situations
- **Make sure to check with a doctor** – Over the counter or OTC medications and supplements should be reviewed by a doctor and pharmacist. Even simple vitamins can interact with medication. While something may be safe to use with one prescription medicine, it can make others less effective or toxic. Also, any new exercise or outdoor activity should be discussed with a doctor. People taking certain medicines for depression, schizophrenia or other conditions should make sure to stay cool and drink enough water to avoid heat stroke. Other medicines can lower body temperature, so special preparation may be needed for cold weather.
- **Transition:** Let's look at how medications work in the brain.

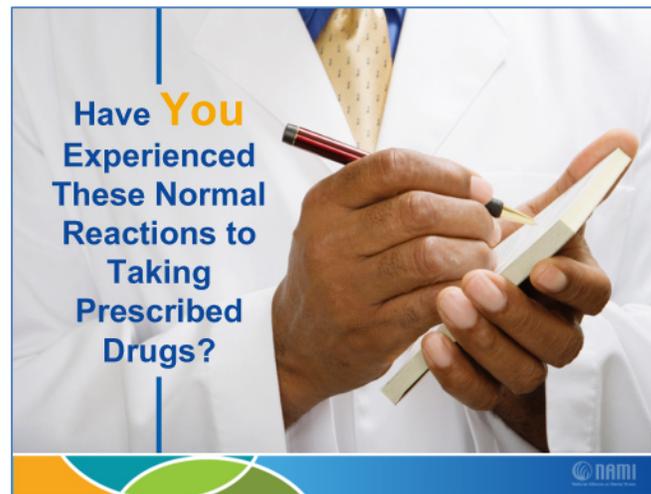
### Talking Points



### Key Points

- Inside every brain, at microscopic levels, is an impressive system of over 100 billion nerve cells communicating with each other using electrical and chemical signals. Neurotransmitters, such as dopamine and serotonin, are chemicals needed to help deliver the electrical messages between brain cells.
- It would be wonderful if psychotropic medications were miracle cures—that is, the main effect of the drug was limited to a single, specific brain area, and targeted only those neurotransmitters which controlled the unwanted symptoms.
- Unfortunately, this is not the case. These medications are more like buckshot; they hit the target and everything else around it. They block other neurotransmitters, and they impact many parts of the brain which control vital body functions.
- In some cases, cells outside of the brain use the same neurotransmitters to transmit signals; so, medications for mental health conditions also directly affect other parts of the body.
- For example, the digestive system uses serotonin to communicate between cells. That's why antidepressants that alter serotonin levels can also cause nausea or diarrhea.

### Talking Points



### Key Points

- Medications can be challenging to tolerate since many of them have side effects. For instance, some studies indicate that African Americans metabolize many medications more slowly than the general population yet are more likely to receive higher dosages. This may result in a greater chance of negative side-effects and a decreased likelihood of sticking with treatment.

---

- ***ACTIVITY: By a show of hands, have you ever felt disoriented or controlled by the medication you were taking? What did you do?***

---

- ***Did you ever stop taking medication when you started feeling better?***

---

- ***Have you taken medication that made you feel physically sick?***

---

- ***Did you continue taking it anyway?***

---

- ***What would you do if a medication made you gain 45 pounds, gave you tremors, made you sleepy and blocked your sexual responses?***

---

- ***Raise your hand if you usually finish a prescribed dose of medication.***

---

- ***How many of us usually don't finish taking a prescribed medication?***

---

- ***How many of us have expired medications at home?***

---

- Finding the right medication takes time!

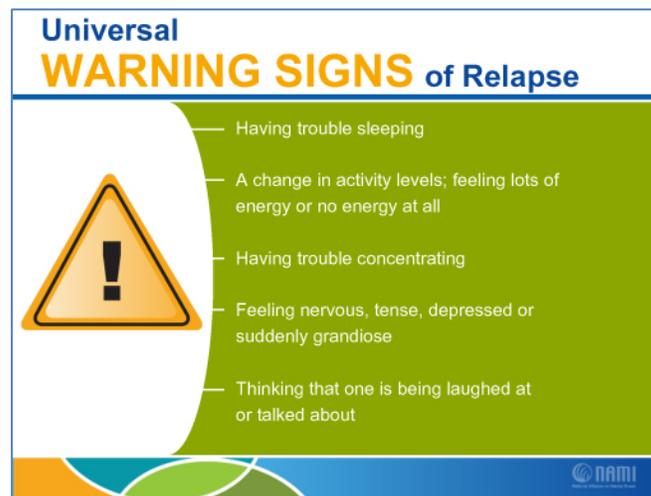
### Talking Points



### Key Points

- Medications may work well for one person but not at all for someone else—even if both people have the same diagnosis. It is difficult to predict exactly who will respond to what medication. Doctors usually review a person’s symptoms and their treatment history to see if there are reasons for recommending one type of medicine over another. Family history, ethnicity, other health conditions and side effects are also taken into consideration when prescribing medication.
- It’s not uncommon for someone with a mental health condition to be prescribed a variety of medications throughout their lifetime. Not all medicine works for everyone, so there’s often some trial and error before finding the right solution. It frequently takes a combination of medicines to treat the symptoms and side effects. Fortunately, there are a variety of effective medications available.

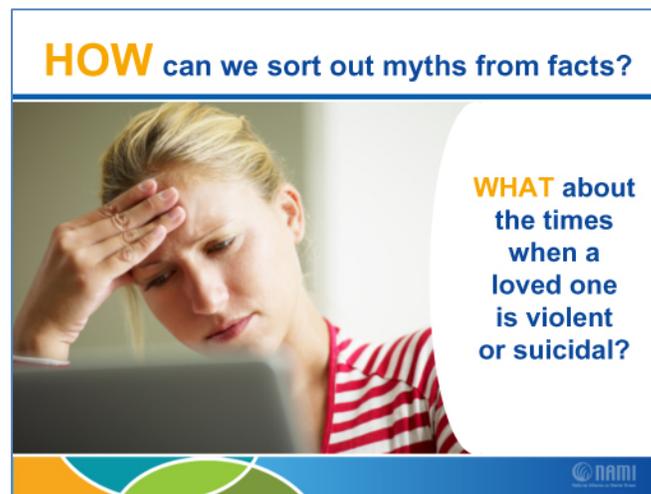
### Talking Points



### Key Points

- Because medications and other therapies don't always protect against relapse, we need to know how to recognize warning signs, even when our relatives are getting treatment.
- One study showed that 70% of people with mental health conditions can tell the early subjective changes in thoughts and behavior that signal a relapse is coming.
- 96% of family members studied can readily identify these changes, too! Knowing what to look for means we can act more swiftly to protect someone before a full-blown episode occurs.
- **ACTIVITY: By a show of hands, how many of you have gone through a relapse with your loved one? What are some of the warning signs you've seen? Share warning signs you have experienced with your own loved one (BE BRIEF)**

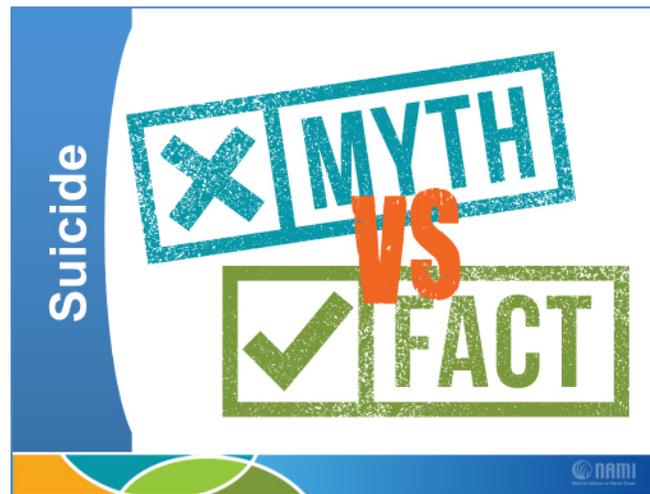
### Talking Points



**Key Points**

- Those with schizophrenia and mania who take medication regularly and who do not abuse alcohol/ other drugs are no more violent than the rest of the population
- The combination of major mental health conditions and substance abuse is a significant predictor of aggressive behavior
- The likelihood of violence is greatest among males in their late teens or early 20's
- The best prediction of future behavior is past behavior
- If your loved one is experiencing auditory hallucinations—such as voices—they may be hearing life-threatening commands; messages may be coming from the television; the room may be filled with poisonous fumes; they may believe their food is being poisoned; snipers may be lurking in public places; random authority figures may be thought of as the enemy.
- Your loved one is probably terrified by the experience of losing control over their thoughts and feelings.

**Talking Points**



**Key Points**

- ***ACTIVITY: Now my co-leader and I are going to read you some myths and facts about suicide that come from the American Association of Suicidology.***

**ACTIVITY:** Leader reads the myth and the second leader responds with the fact until entire list is shared.

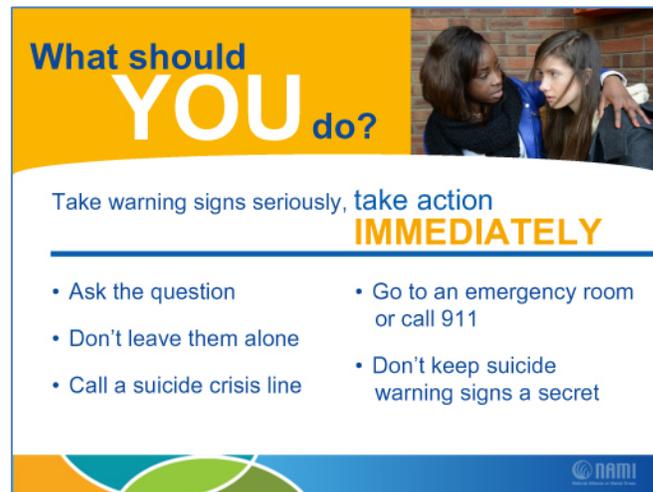
- **MYTH:** People who talk about suicide never attempt it.
- **FACT:** Most of the time, people who attempt suicide have provided clues to their intentions.
  
- **MYTH:** Talking about suicide with someone may give them ideas.
- **FACT:** Talking about suicide with a loved one gives them an opportunity to express thoughts and feelings about something they may have been keeping secret. Discussion brings it into the open and provided an opportunity for intervention.
  
- **MYTH:** Only certain “types” of people die by suicide.
- **FACT:** There is no specific type. While some demographic factors contribute to higher risk for suicide, it is important to remember that suicide does not discriminate. People of all genders, races, ethnicities, ages, upbringings and socio-economic statuses kill themselves. Pay attention to what the person says and does – not what he/she looks like or how you believe that person should think, feel or act.
  
- **MYTH:** Suicidal people overreact to life events.
- **FACT:** Problems that may not seem like a big deal to one person, may be causing a great deal of distress for someone else. For example, a teen may have a strong reaction to an issue that an adult considers minor; a family member may not realize the impact “invisible wounds” like PTSD, TBI or **moral injury\*** have on a Veteran. We must remember the perceived crises are just as concerning and predictive of suicidal behavior as actual crises.

**\*NOTE: Leaders don’t need to read this definition, it’s included for clarity**

**Definition of moral injury:** “Like psychological trauma, **moral injury**...describes extreme and unprecedented life experience including the harmful aftermath of exposure to such events. Events are considered morally injurious if they ‘transgress (violate) deeply held moral beliefs and expectations’ (1). The key precondition for moral injury is an act of transgression (violation or wrongdoing), which shatters moral and ethical expectations that are rooted in religious or spiritual beliefs, or culture-based, organizational, and group-based rules about fairness, the value of life, and so forth.” (Moral Injury in the Context of War, National Center for PTSD, [www.ptsd.va.gov](http://www.ptsd.va.gov), retrieved 6/15/18)

- **MYTH:** Suicide is an act of aggression, anger or revenge.
- **FACT:** Most people who kill themselves do so because they feel they do not belong or are a burden on others. They think that their death will free their loved ones of this burden. Many suicides occur in ways and in places that the person hopes will ease the shock and grief of those they left behind.
  
- **MYTH:** Nothing can stop someone once they’ve decided to take their own life.
- **FACT:** Most people who contemplate suicide are torn. They are in pain and want their suffering to end. They don’t necessarily want to die to make that happen. But they can’t conceive of another way, and too often their cries for help go unheard.

**ACTIVITY:** After you’ve read the list, ask the participants: **Did any of the myths surprise you?**



**Key Points**

- If you're concerned about someone's safety, there are actions you can take listed in your manual.

**An important step is to ask questions!**

- Have you been feeling sad or unhappy?
- Do you ever feel hopeless? Does it seem as if things will never get better?
- Do you think about dying?
- Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?
- Do you have any actual plans to kill yourself?
- If so...when do you plan to kill yourself?
- Is there anything that would help you reconsider, such as the effect on someone in our family, or a pet or your religious convictions?
- Have you ever made a suicide attempt in the past?
- Would you be willing to talk to someone or ask for help if you felt desperate? Is there a person you could talk to?

**Talking Points**



### Key Points

- Each of you has a connection to mental illness. Which family member do you represent?

---

- **ACTIVITY:** *Each leader remind audience of their loved one and role (my son has bipolar disorder so I'm a parent, etc.).*

---

- Some of us have more than one person in our lives affected by mental illness.

---

- **ACTIVITY:** *By a show of hands, how many of you are parents of someone with a mental health condition? Spouses or partners? Siblings? Adult children of a parent with a condition? Grandparents? Grandchildren? Friends? We have lots of connections to mental health!*

---

- Your eBook/manual has information about family roles, living a balanced life, setting limits and letting go

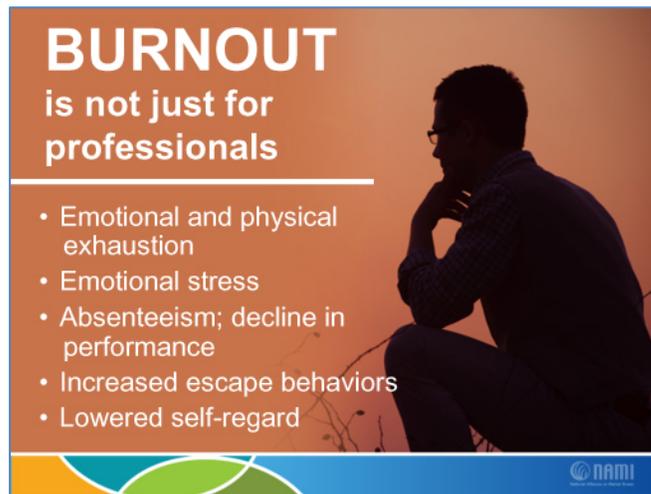
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- **Transition:** Family members and caregivers must take care of their brains too!

---

- **ACTIVITY:** *What happens if we don't take care of ourselves? Wait for someone to mention BURNOUT and move to the next slide*

### Talking Points



**Key Points**

- Sometimes it feels like we are **professional caregivers** since we gain a lot of knowledge over time about systems, services, talk therapy and medication. Being a caregiver can be stressful!

**Caregiver burnout can include:**

- Emotional exhaustion – depression, boredom, apathy, indecisiveness

---

- Physical exhaustion – headaches, muscle tension

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- Emotional stress – signs include insomnia, irritability, increased anxiety, hopelessness

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- Being absent – not participating at work, as a volunteer or even in family activities; worsening performance at duties

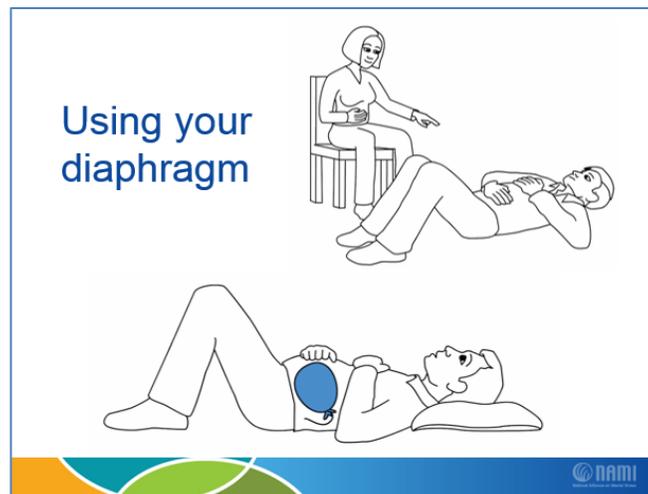
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- Increase in "escape" activities – smoking, over-eating, excessive drinking

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- Lowered self-regard – signs include self-doubt, self-blame, blaming others

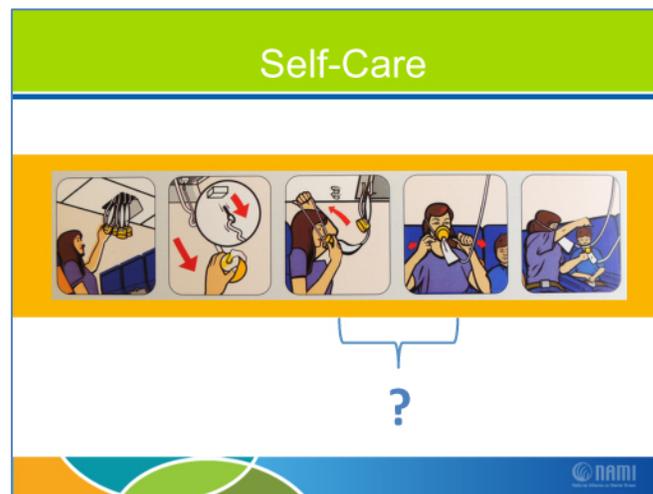
**Talking Points**



### Key Points

- One way to combat burnout and calm yourself is to breathe deeply!
- Many people are shallow breathers. If, when you breathe in deeply and let it out, you see your shoulders go up and down and your chest expand, you're a shallow breather. Shallow breathers only use the top of their lungs. The diaphragm is a large, dome-shaped muscle located below the rib cage that helps push the air in and out of the lungs. Using the diaphragm lets you use the full power of your breath.
- It is best to either sit in a chair with one hand on your upper chest and the other on your stomach. Or you can lie on the floor with your knees bent.
- Begin by taking a deep breath and watching which hand moves. Now imagine that you have a balloon in your stomach that you can inflate with your breathing. When you inhale through your nose, push your stomach out and hold your breath for just a second or two. Now exhale by pulling your stomach in and letting the air escape from your mouth. Try it again. Only the hand on your stomach should be moving. The one on your chest should remain still.
- For additional relaxation, try counting while you practice your diaphragmatic breathing. Breathe in for a count of 4, hold your breath for a count of 4 and then exhale through your mouth for a count of 8.
- Research is indicating that diaphragmatic breathing can lower the body's stress levels by releasing neurotransmitters that decrease anxiety, and, used often, may even change how the body reacts to stress.

### Talking Points



### Key Points

- What do flight attendants tell us when we prepare for take-off?
- Put your oxygen mask on **before** you help your child or neighbor!
- Why? So you don't pass out before you can assist others!
- **Transition:** A great way to take care of yourself is to attend a NAMI class, support group or presentation like this! We'd like to tell you more about what NAMI has to offer.

### Talking Points

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WAS INTENTIONALLY  
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### Key Points

- Now we'd like to share some NAMI resources with you!
- NAMI uses a **PEER** approach which means the lived experience of the volunteer leaders is the **HEART** of NAMI programs. Family members like the two of us (*point to your co-leader*) teach other families, and people with a mental health condition teach their peers while sharing their own journey toward recovery.
- **ACTIVITY:** Describe any NAMI National Education Programs offered by your affiliate using the descriptions on the opposite page. Let attendees know if you're a teacher, facilitator or presenter for any of the programs and share brochures and information about how to register/attend. If your affiliate doesn't offer one of the programs you don't need to talk about it in detail. Remind people about the resource table.

### Talking Points

**CLASSES:** NAMI classes offer information, resources and a community of support. They aim to increase understanding of mental health, improve coping skills and empower participants to advocate for themselves or their loved one.

- **NAMI Basics** is for parents, guardians and other family who provide care for youth with mental health symptoms. Available in Spanish: Bases y Fundamentos de NAMI
- **NAMI Family-to-Family** is for families, partners and friends of people who have mental health conditions. This program was designated as an evidence-based program by SAMHSA. Available in Spanish: De Familia a Familia de NAMI
- **NAMI Homefront** is for families, partners and friends who provide care for Service Members/Veterans experiencing mental health symptoms. Available in-person and online.
- **NAMI Peer-to-Peer** is for anyone who is experiencing or has experienced a mental health challenge. Available in Spanish: De Persona a Persona de NAMI
- **NAMI Provider** offers 12.5 hours of in-service training to line staff at facilities providing mental health treatment services. The course aims to expand participants' compassion for clients and their families and to promote a collaborative model of care.

**PRESENTATIONS:** NAMI presentations give audiences the opportunity to hear stories of direct experiences of mental health conditions. They aim to create awareness, reduce stigma and increase empathy.

- **NAMI Ending the Silence** is a presentation about mental health conditions in youth. Available for three audiences: students, families and school staff. All versions educate about warning signs, what to do and the importance of early intervention.
- **NAMI In Our Own Voice** is for the general public. It uses personal stories to promote awareness of mental health conditions and of the possibility of recovery. Available in Spanish: En Nuestra Propia Voz de NAMI
- **NAMI Provider Seminar** is a 4-hour presentation for staff at facilities providing mental health treatment services. It introduces audiences to NAMI and to the unique perspectives of people affected by mental illness.

**SUPPORT GROUPS:** NAMI support groups offer participants an opportunity to share their experiences and gain support from other attendees.

- **NAMI Connection Recovery Support Group** is for people with mental health conditions. Available in Spanish: NAMI Conexión Grupo de Apoyo y Recuperación
- **NAMI Family Support Group** is for family members, partners and friends of people with mental health conditions. Available in Spanish: Grupo de Apoyo para Familiares de NAMI



### Key Points

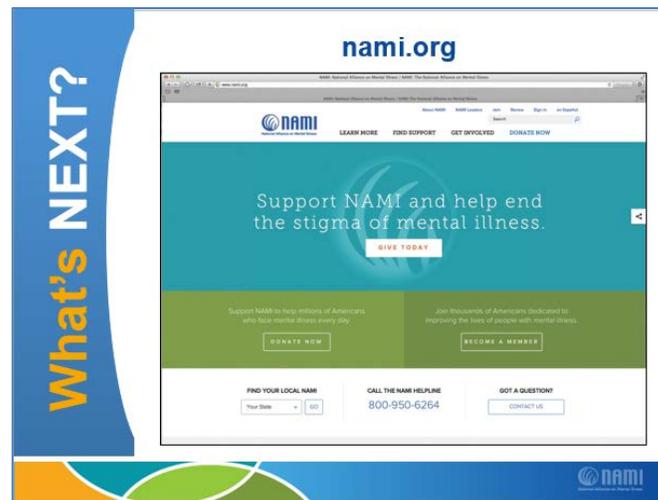
#### Remember:

- **YOU ARE NOT ALONE!**
- Mental health conditions are **MEDICAL ILLNESSES**
- It's **NOT** anyone's fault
- Learn the **WARNING SIGNS**
- **RECOVERY** is possible, there is **HOPE**
- **LANGUAGE MATTERS!** You can fight stigma by changing how you talk about mental health conditions. Instead of saying "she is bipolar," you can say "she has bipolar." As we know, a person is more than their diagnosis!

#### Next steps:

- **ACTIVITY:** *Hand out paper manuals if your affiliate provides them and encourage people to download the eBook if they haven't already.*
- Explore the resources in the eBook or manual

### Talking Points

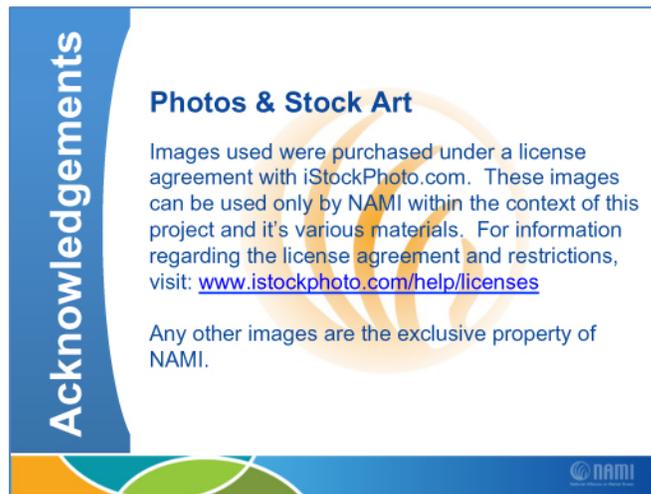


## Key Points

### Membership:

- Become a member of NAMI either online via [nami.org](http://nami.org) or take a brochure from the resource table to learn more.
- When you join NAMI, you receive national, state and local membership benefits including the quarterly NAMI Advocate magazine from headquarters and are entitled to other publications and email alerts by request.
- You'll also have access to special sections of the NAMI Website and you'll receive publications from your NAMI State Organization and local NAMI Affiliate.
- Sign up for a NAMI class, join a NAMI support group or attend a NAMI presentation!
- We appreciate your attendance and hope that you will complete the evaluation that will arrive by email. We value your feedback and want to know how we can improve the seminar.
- Thanks for coming and travel safely!

## Talking Points



**Key Points**

**Talking Points**

[INSERT]  
Participant  
Manual  
Tab





# **nami** Family & Friends

National Alliance on Mental Illness

Developed by NAMI © 2017



*“It doesn’t matter how big and how long my tunnel is . . . I can see the light at the end.  
But if I walk looking at my shoes I cannot see the light.”*

—Carlos A., De Familia a Familia de NAMI teacher trainee, 2011

## Acknowledgements

This seminar reflects the wisdom of more than 500 NAMI leaders who shared their insights and suggestions via surveys, polls, networking sessions, technical assistance webinars, Training of Trainer weekends and NAMI Conventions in San Francisco and Denver.

Special appreciation goes out to psychologist and family member Dr. Joyce Burland, the author of NAMI's flagship program NAMI Family-to-Family. I began teaching NAMI Family-to-Family in 1998 and was fortunate to be certified as a state trainer for the program by Dr. Burland in 2001.

This seminar is dedicated to the people of NAMI that astound and inspire me each day. Following a tragedy several years ago, I remember a NAMI State Director saying that he was simultaneously "always surprised by NAMI people and never surprised by NAMI people." He meant that no matter the situation, NAMI members act with compassion. They reach out to people who are isolated and offer support, education and empathy. NAMI members fight the discrimination that too often surrounds mental health conditions. Special thanks go to NAMI's extraordinary Education Team and the amazing staff at NAMI Ohio where I was honored to serve as Director of Programs for 14 years prior to coming to NAMI in 2013. I'm grateful to my parents for encouraging me to volunteer with NAMI Franklin County back in 1997.

Every day I am awed by my mother and brother who face mental illness with courage, determination and humor. So, as Carlos reminded me back in 2011, it's time for each of us to look up from our shoes and walk with purpose. Our actions change lives. Share your experiences...share NAMI...make a difference.

Suzanne Robinson, MSW  
Assistant Director of National Education Programs for NAMI  
Developer of NAMI Family & Friends

*The development of this curriculum and the launch of NAMI Family & Friends would not have been possible without the generous support of Providence St. Joseph Health.*

*Material from the following NAMI programs was incorporated into this seminar: NAMI Basics, NAMI Ending the Silence, NAMI Family-to-Family, NAMI Homefront, NAMI In Our Own Voice and NAMI Peer-to-Peer. Comprehensive references for source material can be found in the manuals for each of the programs listed, please contact NAMI for details.*

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Section I; About NAMI (National Alliance on Mental Illness).

# What is NAMI?

National Alliance on Mental Illness



**NAMI, the National Alliance on Mental Illness**, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental health. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need. NAMI offers support and education programs for families and individuals living with mental health conditions.

# What does NAMI do?

National Alliance on Mental Illness



**NAMI recognizes that the key concepts of recovery**, resiliency and support are essential to improving the wellness and quality of life of all persons affected by mental illness.

What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, we are an association of hundreds of local affiliates, state organizations and volunteers who work in your community to raise awareness and provide support and education that was not previously available to those in need.

NAMI is the foundation for NAMI State Organizations, 900+ NAMI Affiliates and thousands of leaders who volunteer in local communities across the country to raise awareness and provide essential education, advocacy and support group programs at no cost to participants. NAMI uses a **PEER** education approach which means the lived experience of the teachers, presenters and facilitators is the **HEART** of NAMI programs.

## NAMI Education Program Belief System and Principles

### We believe:

**You are the expert.** We honor the fact that you and your loved one are the best judges of what will and won't work in your situation. No one expects you to become a perfect caregiver because of this seminar. There will be no pressure to follow any of the suggestions we offer or for you to share anything you don't want to talk about. We want you to learn to trust your own instincts and take from this seminar whatever you find helpful.

**You don't need to know everything.** NAMI programs are not designed for you to learn or remember all this information. Our goal is for you to develop a critical skill: being able to find what you need. At the end of this seminar, we want you to know where to find the information you need and how to find it when you need it. We want to build a compassionate learning community where we strengthen each other.

**You can't know what no one has told you.** As you learn new facts in this seminar, you may feel that you should have already known some of this information, or that you should have found it on your own. We ask you to remember that you can't possibly know what no one has told you. None of us knew any of this information until someone told us.

**Mental health conditions are no one's fault.** Because of stigma, many families are wrongly blamed for their loved one's difficulties. Such blame is devastating. Psychiatrist Dr. Ken Terkelson has said, "The thought of having brought harm to a loved family member, intentionally or unintentionally, consciously or unconsciously, causes intolerable guilt." We address those feelings of guilt by insisting that these conditions are no one's fault.

**Mental health conditions are biological.** We recognize that the stigma surrounding these conditions and even the terms—like diagnosis, mental illness, brain condition—adds to the difficulties families face. Stigma is caused by misunderstanding—many people don't know that mental illnesses are biological conditions like any other physical illness. We recognize that this stigma makes families' experiences even more difficult. In this seminar, we refer to various mental illness diagnoses collectively as "mental health conditions."

**Mental health conditions share universal characteristics.** Rather than talking about specific diagnoses, we focus on the symptoms and challenges presented by the conditions—regardless of the diagnosis. This will be helpful for you since the diagnosis can change over time. Because many of the conditions have similar symptoms, and they all present challenges for our loved one and for us, we can learn from each other's experiences, regardless of what diagnosis our loved one may have.

## **We offer you:**

**Current information.** The material shared in NAMI programs is the most current information possible. We review the curriculum on a regular basis to reflect scientific advances in the field.

**A variety of solutions.** It's natural to look for quick solutions to the difficulties we and our loved one face. There is no magic formula that will fix everything, and no treatment approach guaranteed to work for everyone; but we know it's possible to live well with mental health conditions. This can be a lifelong journey, and challenges tend to come in cycles. Because knowledge is powerful, we believe that by helping you understand as much as possible about these conditions and their treatment, you'll be better able to find options that will work best for you and your family.

**Empathy and understanding.** When we understand how our loved one experiences their life, communicating and solving problems with them gets easier for us. NAMI programs aim to help you understand what your loved one may need in order to function better in the world, and what you can do to help. As you gain insight, you will learn what you can realistically expect from your loved one and from yourself.

**Information about resources in your community.** Throughout the seminar, we'll provide you with information about the community services in your area. We also consider each of you a valuable resource because of your experience dealing with mental health providers, service systems and other community resources.

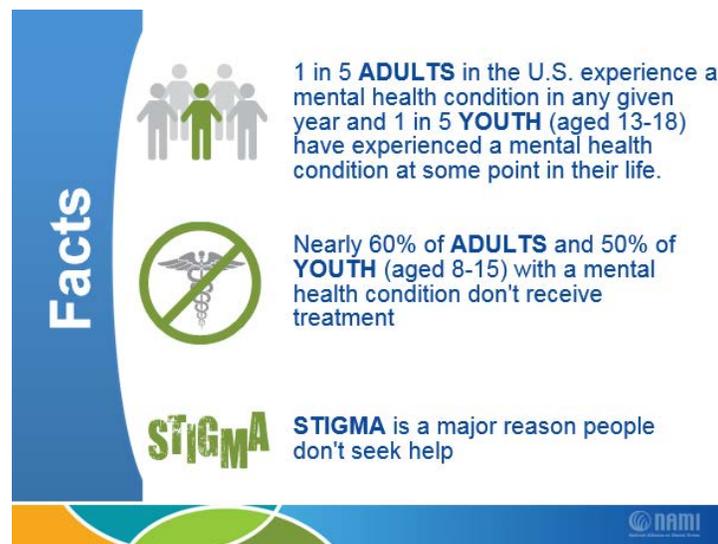
## Section II; Introduction to Mental Health.

### **Mental Health Conditions**

A mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day. Each person will have different experiences, even people with the same diagnosis.

Recovery, including meaningful roles in social life, school and work, is possible, especially when treatment starts early and the person with the condition plays a strong role in their own recovery process.

A mental health condition isn't the result of one event. Research suggests multiple, linking causes. Genetics, environment and lifestyle influence whether someone develops a mental health condition. Siddhartha Mukherjee, M.D., author of The Gene: An Intimate History, refers to it as a combination of genes, environment, triggers and chance. A stressful job or home life makes some people more susceptible, as do traumatic life events like being the victim of a crime. Biochemical processes and circuits and basic brain structure may play a role, too.



One in 5 adults experiences a mental health condition in any given year. One in 17 has a serious mental illness such as schizophrenia or bipolar disorder. In addition to the person directly experiencing challenges, family, friends and communities are also affected. (Ahrnsbrak et al, SAMHSA, 2017; Merikangas et al, Journal of American Academy of Child and Adolescent Psychiatry, 2010).

Half of mental health conditions begin by age 14, and 75% of mental health conditions develop by age 24. The typical personality and behavior changes of adolescence may mimic or mask symptoms of a mental health condition. Early engagement and support are crucial to improving outcomes and increasing the promise of recovery.

## Cultural Considerations

Mental health affects everyone regardless of race, ethnicity, gender, sexual orientation or culture. Culture is a group's beliefs, customs, values and way of thinking, behaving and communicating. Cultural background affects how someone:

- Views mental health conditions
- Describes symptoms
- Communicates with health care providers such as doctors and mental health professionals
- Receives and responds to treatment

Only about one-quarter of African Americans seek mental health care, compared to 40% of whites. Reasons include distrust and misdiagnosis sometimes attributed to prejudice and discrimination in the health care system; socio-economic factors impacting access to healthcare; lack of African American mental health professionals (only 3.7% of members of the American Psychiatric Association and 1.5% of members of the American Psychological Association are African American); some studies indicate that African Americans metabolize many medications more slowly than the general population yet are more likely to receive higher dosages resulting in a greater chance of negative side-effects and a decreased likelihood of sticking with treatment.

As a community, Latinos tend not talk about mental health issues and are less likely to seek mental health treatment. Language barriers can make communicating with doctors difficult. Many medical professionals today do speak some medical Spanish, but they may not necessarily understand cultural difference which can lead them to misdiagnose Latinos. For immigrants who arrive without documentation, the fear of deportation can prevent them from seeking help, even for their children who may be U.S. citizens. Latinos account for one-third of the uninsured. A significant percentage of the Latino population works low-wage jobs or is self-employed. Often these Latinos do not have health insurance.

LGBT (lesbian, gay, bisexual and transgender) people may confront bullying, stigma and prejudice based on their sexual orientation or gender identity while also dealing with the societal bias against mental health conditions.

The experiences of Military personnel, Veterans and their families must also be handled with sensitivity. Less than 2% of the population serves in the military, leaving military and Veteran families feeling isolated since the general population cannot relate to what it feels like to be "career military." Stigma often discourages active duty Service Members from seeking treatment, for fear of jeopardizing their military careers. In addition to combat-related injuries, invisible wounds like PTSD, TBI and other mental health conditions can have an impact on transitioning from the military into the civilian world.

# Warning Signs of Mental Health Conditions

## Know the WARNING SIGNS

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Trying to tell the difference between what expected behaviors are and what might be the signs of a mental health condition isn't always easy. There's no easy test that can let someone know if there is mental illness or if actions and thoughts might be typical behaviors of a person or the result of a physical illness.

With children and adults, it's essential for people experiencing symptoms to ask for, and get, a complete physical as part of their diagnostic work-up. The "body" signs of depressive conditions can mimic illnesses of the thyroid and adrenal glands while anxiety can feel like a heart attack so various physical disorders may need to be ruled out. Screening for traumatic brain injury, Lyme disease, dementia, cancer or other issues may also be needed to determine what your loved one is experiencing. Observations shared by family members and friends can help clinicians determine a diagnosis.

Each illness has its own symptoms, but common signs of mental health conditions in adults and adolescents can include the following:

- Excessive worrying or fear
- Feeling extremely sad or low
- Confused thinking or problems concentrating and learning
- Extreme mood changes, including uncontrollable "highs" or feelings of euphoria
- Prolonged or strong feelings of irritability or anger
- Avoiding friends and social activities
- Difficulties understanding or relating to other people
- Changes in sleeping habits or feeling tired and low energy
- Changes in eating habits such as increased hunger or lack of appetite
- Changes in sex drive

- Difficulty perceiving reality (delusions or hallucinations, in which a person experiences and senses things that don't exist in objective reality)
- Inability to perceive changes in one's own feelings, behavior or personality ("lack of insight" or anosognosia)
- Abuse of substances like alcohol or drugs
- Multiple physical ailments without obvious causes (headaches, stomach aches, vague and ongoing "aches and pains")
- Thinking about suicide
- Inability to carry out daily activities or handle typical problems and stress
- An intense fear of weight gain or concern with appearance (mostly in adolescents)
- Signs of self-harm (cutting, burning, etc.)

Mental health conditions can also begin to develop in young children. Because they're still learning how to identify and talk about thoughts and emotions, a child's most obvious symptoms are behavioral. Symptoms in children may include the following:

- Changes in school performance
- Excessive worry or anxiety, for instance fighting to avoid bed or school
- Hyperactive behavior
- Frequent nightmares
- Frequent disobedience or aggression
- Frequent temper tantrums

### **Where to Get Help**

Don't be afraid to reach out if you or someone you know needs help. Learning all you can about mental health is an important first step.

Reach out to your health insurance, primary care doctor or state/country mental health authority for more resources.

Contact the NAMI HelpLine at 1-800-950-6264 to find out what services and supports are available in your community.

If you or someone you know needs help now, you should immediately call the National Suicide Prevention Lifeline at 1-800-273-8255 or call 911.

### **Receiving a Diagnosis**

Knowing warning signs can help let you know if you need to speak to a professional. For many people, getting an accurate diagnosis is the first step in a treatment plan.

Unlike diabetes or cancer, there is no medical test that can accurately diagnose mental illness. A mental health professional will use the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, to assess symptoms and make a diagnosis. The manual lists criteria including feelings and behaviors and time limits in order to be officially classified as a mental health condition.

After diagnosis, a health care provider can help develop a treatment plan that could include medication, therapy or other lifestyle changes.

### **Finding Treatment**

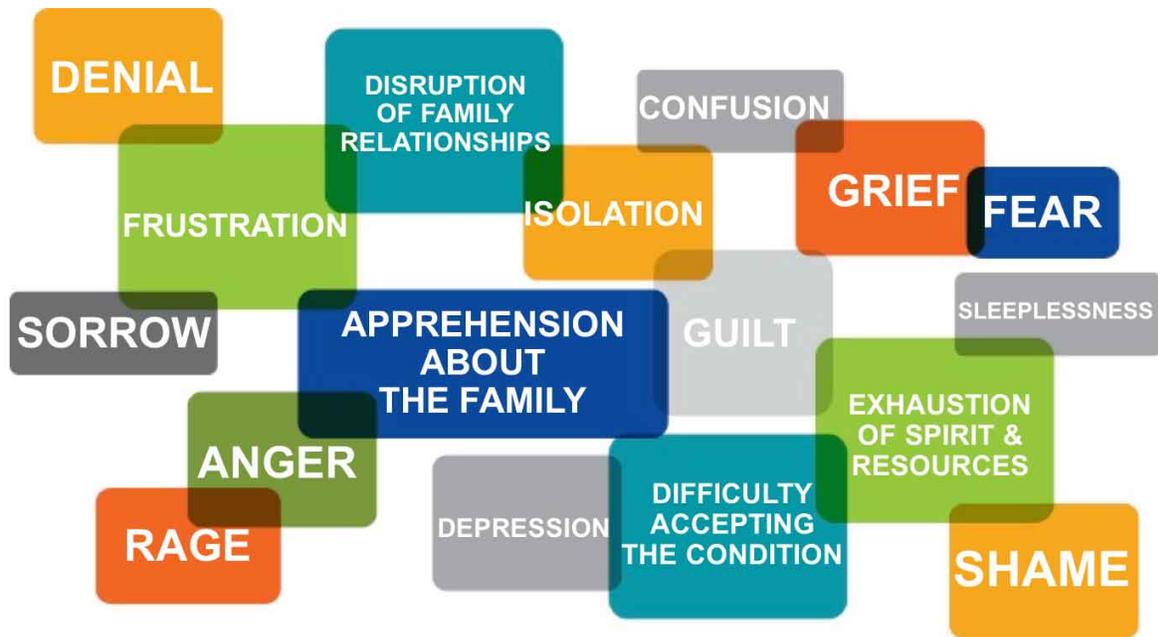
Getting a diagnosis is just the first step; knowing your own preferences and goals is also important. Treatments for mental illness vary by diagnosis and by person. There's no "one size fits all" treatment. Treatment options can include medication, counseling (therapy), social support and education.

## Understanding Symptoms of Mental Health Conditions as a Double-Edged Sword

When a person has a mental health condition, symptoms cause changes in their personality and behavior. They will gain some new behaviors and lose habits and abilities they used to have. In the (+) column, below, are positive symptoms (which are added). The (-) column describes the behaviors that are taken away or lessened. The absence of these behaviors is called the negative symptoms.

<b>Positive Symptoms (+)</b>	<b>Negative Symptoms (-)</b>
<b>Behavior changes that appear because of the illness</b>	<b>Behavior changes or losses the person experiences because of the illness</b>
Feeling constantly tense or nervous Being irritable, critical, or abusive Behaving in inappropriate and bizarre ways Being rude and hostile Being extremely stubborn (obstinate) Being afraid and intensely aware of possible threats (hypervigilant) Expressing rage or having extreme temper tantrums Over-reacting to things in an unpredictable way Speaking and responding in irrational ways Obsessing over their own activities and interests Having unreasonably grand idea of themselves (inflated self-concept) Wanting to be withdrawn and isolated Being overwhelmingly sad and crying uncontrollably Lacking interest in things (being indifferent) Being devastated by their peers' disapproval Having difficulty making decisions Easily forgetting or losing things Injuring themselves (cutting, scratching, picking)	Being able to express joy Having a sense of humor Expressing warmth and thoughtfulness in relationships Enjoying family, friends, school Feeling eager about new events and experiences Being able to be emotionally or physically intimate Being able to focus and concentrate Being able to control themselves Being able to cope with minor problems Being emotionally flexible and able to recover from being upset (resilient) Understanding what is happening to them (having insight) Having optimism, faith or belief in the future Being able to appreciate people and accept help Being able to see someone else's point of view Feeling pride about taking responsibility Taking care of their appearance and personal hygiene

## Predictable Stages of Emotional Reaction among Family Members



### I. Dealing with the catastrophic event

**Crisis/chaos/shock:** Feeling overwhelmed and dazed, not knowing what to do

**Denial:** Protecting ourselves by believing the situation is not as serious as we fear. Looking for explanations that don't involve mental health. Believing that the situation is just a phase and will pass. Resisting what is happening.

**Hoping-against-hope:** Beginning to realize that the situation is more serious than we thought, and that we can't ignore it. Hoping that this is a temporary event and that somehow everything will go back to normal.

**Needs:** Support, comfort, empathy for confusion, help finding resources, early intervention, prognosis, empathy for pain and NAMI

### II. Learning to cope

**Anger/guilt/resentment:** Blaming the person with the mental health condition. Believing the person has control or is doing this on purpose. Insisting the person change and stop behaving abnormally. Feeling deep guilt and fear that their condition is really our fault. Blaming ourselves.

**Recognition:** Realizing that this is really happening and is our new reality. Recognizing that it will change our lives forever.

**Grief:** Deeply feeling the tragedy of what has happened to our loved one. Grieving the ideas and hopes we have about their future as we'd imagined it. This sadness does not go away.

**Needs:** Vent feelings, self-care, education, skill training, networking, cooperation from the system, let go, keep hope and NAMI

### III. Moving into advocacy

**Understanding:** Gaining a solid sense of what our loved one's experience is like and feeling empathy for them. Developing respect for the courage it takes for our loved one to cope with this illness.

**Acceptance:** Finally accepting that this has happened to our family ("bad things happen to good people") and that it's no one's fault. Recognizing that we can continue to cope and live through this sad and difficult life experience.

**Advocacy/action:** Using our anger and grief productively. Advocating for others and fighting discrimination. Joining public advocacy groups or getting involved in the cause in other ways.

**Needs:** Restoring balance in life, activism, responsiveness from system and NAMI

## Important Points about the STAGES



- None of these stages are "wrong" or "bad"
- This process is ongoing - for most of us it takes years to navigate
- Different family members are often at different places in the cycle
- This cyclical process is not about expectations
- With time, you will begin to recognize these stages and emotional reactions

## Understanding Trauma

This description of mental health conditions as “catastrophic stressors” is from the book *Helping Traumatized Families*, by Charles Figley. This is how he defines a “catastrophic stressor”:

- It’s generally an unanticipated event
- There is little time to prepare for it
- One has little previous experience and few sources of guidance
- It has a huge emotional impact
- Involves threat or danger to self or others

## Secondary Trauma for Families

### **Families assume overwhelming responsibility**

It’s not an uncommon experience for families to become the primary caregivers of their loved one. The bureaucracy of the mental health treatment system is complex and many people have trouble getting the care and services they need. Patients also have the legal right to choose not to be hospitalized or use treatments that are offered. Family members may find themselves trying to help their loved one in ways that they’re not prepared to. They may be responding to the kinds of concerns and needs that professionals are usually trained in—professionals like doctors, case managers, nurses, police officers and therapists.

### **Families feel confined**

Everyone in the home experiences challenging and sometimes frightening aspects of how mental illness affects the person they love. This can be stressful and exhausting for the individual, their family and friends. When the home is a treatment facility, everyone works a 24-hour shift, 7 days a week. In this isolated setting, behavior challenges can worsen. As in other treatment settings, families face symptoms that can be frightening and disruptive. These symptoms can include argumentativeness, bizarre actions, withdrawal, threatened or actual harm to self or others, verbal abuse, unreasonable demands, refusal to cooperate with household plans and chores, etc. Family members also experience painful grief and distress witnessing their loved one not get the help they need.



### **Families remain uninformed**

Many families have no previous knowledge of mental illness and can't recognize or understand its symptoms. To them, it looks like their relative is doing things on purpose. They may see them as immature, lazy, stubborn or weak. Depending on their religious beliefs, they may even see them as sinful. They may believe the person's symptomatic behaviors are under their control. They may believe the person is refusing to take responsibility and improve themselves. Over time, this blame can harden into the belief that people acting this way don't deserve help. The more a family believes that a person's symptomatic behaviors are under their control, the more likely they are to withdraw their support. This can be a tragic consequence in families that simply don't know about mental health conditions or understand what to do.

### **Families are emotionally exhausted**

The exhaustion and uncertainty people feel when their loved one is having a health crisis can be isolating. The addition of stigma when the crisis relates to mental health may discourage family members from seeking social support. People often feel guilt, shame and grief because of the stigma and confusion around mental health. They may feel resentment toward their loved one for the stress their condition has put on others, and then feel ashamed of that resentment, or start to disconnect from them as a way of coping. Because symptoms can affect personality traits and communication, family members may have trouble connecting to their loved one and feel a terrible loss of closeness.

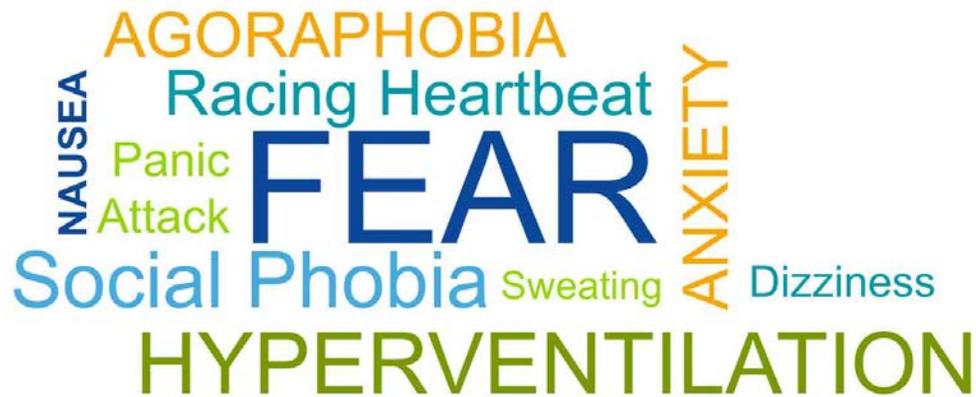
### **Families find inadequate support**

When people are overwhelmed, they may desperately hope for help that will transform the situation. When families do turn to the health care system for help, they're routinely told that providers can't discuss anything about their loved one because of confidentiality laws. When providers are unclear on what they can legally share, they may decline to listen to the family, even though that is legally allowed. This places families in an excruciating situation where seeking help and support is a source of secondary trauma.

## Section III; Mental Health Conditions & Diagnoses.

### **Anxiety Disorders**

Everyone experiences anxiety. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday things, an anxiety disorder may be the cause. Anxiety disorders are the most common mental health concern in the United States. An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder. Approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home.



### **Symptoms**

Just like with any mental health condition, people with anxiety disorders experience symptoms differently. But for most people, anxiety changes how they function day-to-day. People can experience one or more of the following symptoms:

- Emotional symptoms:
- Feelings of apprehension or dread
- Feeling tense and jumpy
- Restlessness or irritability
- Anticipating the worst and being watchful for signs of danger

Physical symptoms:

- Pounding or racing heart and shortness of breath
- Upset stomach
- Sweating, tremors and twitches
- Headaches, fatigue and insomnia
- Upset stomach, frequent urination or diarrhea

## Types of Anxiety Disorders

Different anxiety disorders have various symptoms. This also means that each type of anxiety disorder has its own treatment plan. The most common anxiety disorders include:

- **Panic Disorder.** Characterized by panic attacks—sudden feelings of terror—sometimes striking repeatedly and without warning. Often mistaken for a heart attack, a panic attack causes powerful, physical symptoms including chest pain, heart palpitations, dizziness, shortness of breath and stomach upset.
- **Phobias.** Most people with specific phobias have several triggers. To avoid panicking, someone with specific phobias will work hard to avoid their triggers. Depending on the type and number of triggers, this fear and the attempt to control it can seem to take over a person's life.
- **Generalized Anxiety Disorder (GAD).** GAD produces chronic, exaggerated worrying about everyday life. This can consume hours each day, making it hard to concentrate or finish routine daily tasks. A person with GAD may become exhausted by worry and experience headaches, tension or nausea.
- **Social Anxiety Disorder.** Unlike shyness, this disorder causes intense fear, often driven by irrational worries about social humiliation—"saying something stupid," or "not knowing what to say." Someone with social anxiety disorder may not participate in conversations, contribute to class discussions, or offer their ideas, and may become isolated. Panic attack symptoms are a common reaction.

## Causes

Scientists believe that many factors combine to cause anxiety disorders:

- **Genetics.** Research has shown that anxiety disorders run in families. This can be a factor in someone developing an anxiety disorder.
- **Stress.** A stressful or traumatic situation such as abuse, death of a loved one, violence or prolonged illness is often linked to the development of an anxiety disorder.

## Diagnosis

The physical symptoms of an anxiety disorder can be easily confused with other medical conditions like heart disease or hyperthyroidism. Therefore, a doctor will likely perform an evaluation involving a physical examination, an interview and lab tests. After

ruling out a physical illness, the doctor may recommend a person see a mental health professional to make a diagnosis.

## **Treatment**

As each anxiety disorder has a different set of symptoms, the types of treatment that a mental health professional may suggest can vary. Common types of treatment used include:

- **Psychotherapy**, including cognitive behavioral therapy (CBT)
- **Medications**, including anti-anxiety medications and antidepressants
- **Complementary health approaches**, including meditation, exercise, nutrition and equine (horse) therapy

## Depressive Disorder

Depressive disorder is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding and medical care. Left untreated, depressive disorder can be devastating for the people who have it and for their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people do get better.

Some people have only one episode in a lifetime, but for most people depressive disorder recurs. Without treatment, episodes may last a few months to several years.

An estimated 16 million American adults—almost 7% of the population—had at least one major depressive episode in the past year. People of all ages and all racial, ethnic and socioeconomic backgrounds experience depression, but it does affect some groups of people more than others. Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.



### Symptoms

Just like with any mental health condition, people with depressive disorder experience symptoms differently. But for most people, depression changes how they function day-to-day. Common symptoms of depression include:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest
- Low self-esteem

- Hopelessness
- Changes in movement
- Physical aches and pains

## Causes

Depressive disorder does not have a single cause. It can be triggered, or it may occur spontaneously without being associated with a life crisis, physical illness or other risk. Scientists believe several factors contribute to cause depression:

- **Trauma.** When a person experiences trauma at an early age, it can cause long-term changes in how their brain responds to fear and stress. These brain changes may explain why people who have a history of childhood trauma are more likely to experience depression.
- **Genetics.** Mood disorders and risk of suicide tend to run in families, but genetic inheritance is only one factor.
- **Life circumstances.** Marital status, financial standing and where a person lives influence whether a person develops depression, but it is not clear whether the life challenge or the depression came first.
- **Brain structure.** Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- **Other medical conditions.** People who have a history of sleep disturbances, physical illness, chronic pain, anxiety, and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression.
- **Drug and alcohol abuse.** Approximately 30% of people with substance abuse problems also have depression.

## Diagnosis

To be diagnosed with depressive disorder, a person must have experienced a depressive episode that has lasted longer than two weeks. The symptoms of a depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight

- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

## Treatments

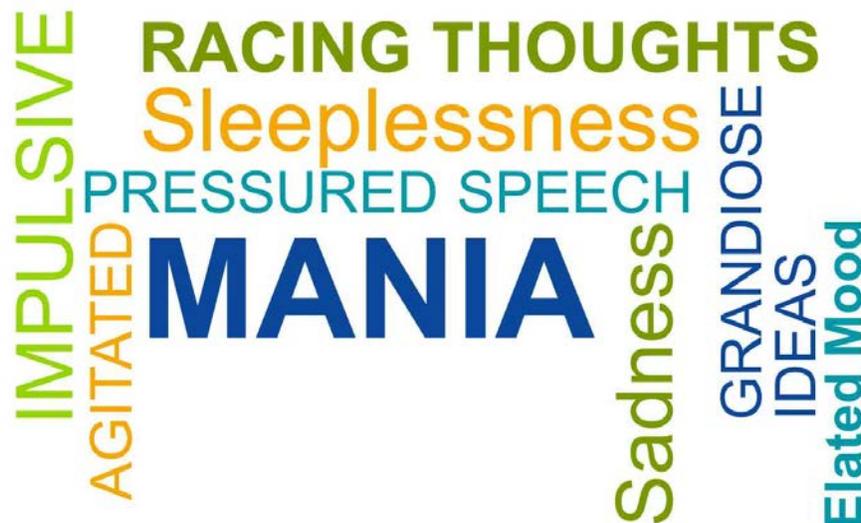
Although depressive disorder can be a devastating condition, it often responds to treatment. The key is to get a specific evaluation and a treatment plan. Treatment can include any one or combination of:

- **Medications** including antidepressants, mood stabilizers and antipsychotic medications
- **Psychotherapy** including cognitive behavioral therapy, family-focused therapy and interpersonal therapy
- **Brain stimulation therapies** including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation (rTMS)
- **Light therapy**, which uses a light box to expose a person to full spectrum light and regulate the hormone melatonin
- **Exercise**
- **Complementary health approaches**, including meditation, exercise, nutrition and equine (horse) therapy
- **Self-management strategies and education**
- **Mind/body/spirit approaches** such as meditation, faith, and prayer

## Bipolar Disorder

Bipolar disorder is a chronic mental health condition that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar disorder have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience. If left untreated, the symptoms usually get worse. However, with a strong lifestyle that includes self-management and a good treatment plan, many people live well with the condition.

Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally.



### Symptoms

A person with bipolar disorder may have distinct manic or depressed states. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood.

### Mania

To be diagnosed with bipolar disorder, a person must have experienced mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function normally in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times; others may experience them only rarely.

Although someone with bipolar may find an elevated mood very appealing, especially if it occurs after depression, the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks. Most of the time, people in manic states are unaware of the negative consequences of their actions.

### **Depression**

Depression produces a combination of physical and emotional symptoms that inhibit a person's ability to function nearly every day for a period of at least 2 weeks. The level of depression can range from severe to moderate to mild low mood, which is called dysthymia when it is chronic.

### **Causes**

Scientists have not discovered a single cause of bipolar disorder. They believe several factors may contribute:

- **Genetics.** The chances of developing bipolar disorder are increased if a person's parents or siblings have the disorder. But the role of genetics is not absolute.
- **Stress.** A stressful event such as a death in the family, an illness, a difficult relationship or financial problems can trigger the first bipolar episode. In some cases, drug abuse can trigger bipolar disorder.
- **Brain structure.** Brain scans cannot diagnose bipolar disorder in an individual. However, researchers have identified subtle differences in the average size or activation of some brain structures in people with bipolar disorder.

### **Diagnosis**

To be diagnosed with bipolar disorder, a person must have had at least one episode of mania or hypomania. The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines four types of bipolar illness:

- **Bipolar I Disorder** is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with bipolar I, a person's manic or mixed episodes must last at least seven days or be so severe that he requires hospitalization.

- **Bipolar II Disorder** is a subset of bipolar disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a full manic episode.
- **Cyclothymic Disorder or Cyclothymia**, is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.
- **Bipolar Disorder “other specified” and “unspecified”** is diagnosed when a person does not meet the criteria for bipolar I, II or cyclothymia but has had periods of clinically significant abnormal mood elevation.

## Treatment

Bipolar disorder is a chronic illness, so treatment must be ongoing. If left untreated, the symptoms of bipolar disorder may get worse, so diagnosing it and beginning treatment in the early stages is important. There are several well-established types of treatment for bipolar disorder:

- **Medications** such as mood stabilizers, antipsychotic medications and antidepressants
- **Psychotherapy** such as cognitive behavioral therapy and family-focused therapy
- **Electroconvulsive therapy (ECT)**
- **Self-management strategies and education**
- **Complementary health approaches** such as meditation, exercise and nutrition

## Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them.

Symptoms typically begin during childhood, the teenage years or young adulthood, although males often develop them at a younger age than females. More than 2% of the U.S. population (nearly 1 out of 40 people) will be diagnosed with OCD during their lives. If a parent or sibling has an obsessive-compulsive disorder, there's close to a 25% chance that another immediate family member will have it.

Compulsions  
**Obsessions**  
GERM PHOBIA  
REPETITIVE ACTS  
FEAR  
Intrusive Thoughts  
Or Impulses  
CHECKING

### Symptoms

Just like with any mental illness, people with obsessive compulsive disorder experience symptoms differently. Most people have occasional obsessive thoughts or compulsive behaviors.

In OCD, however, these symptoms generally last more than an hour each day and interfere with daily life. Obsessions are intrusive, irrational thoughts or impulses that repeatedly occur.

Compulsions are repetitive acts that temporarily relieve the stress brought on by an obsession. Like obsessions, people may try not to perform compulsive acts but feel forced to do so to relieve anxiety.

#### Obsessions may include:

- Thoughts about harming or having harmed someone.
- Doubts about having done something right such as turning off the stove or locking a door.

- Unpleasant sexual images.
- Fears of saying or shouting inappropriate things in public.

#### **Compulsions may include:**

- Hand washing due to a fear of germs.
- Counting and recounting money because a person can't be sure they added correctly.
- Checking to see if a door is locked or the stove is off.
- "Mental checking" that goes with intrusive thoughts is also a form of compulsion.

### **Causes**

The exact cause of obsessive-compulsive disorder is unknown, but researchers believe that activity in several portions of the brain is responsible. More specifically, these areas of the brain may not respond normally to serotonin, a chemical that some nerve cells use to communicate with each other. Genetics are thought to contribute to the likelihood of developing OCD.

### **Diagnosis**

The sudden appearance of symptoms in children or older people merits a thorough medical evaluation to ensure that another illness is not causing these symptoms. To be diagnosed with OCD, a person must have:

- Obsession, compulsion or both.
- Obsessions or compulsions that are upsetting and cause difficulty with work, relationships, other parts of life and typically last for at least an hour each day.

### **Treatment**

For many, a combination of medicine and therapy is superior to either approach alone. While medicine may work directly on the brain, the therapies are believed to help retrain the brain to recognize the "false threats."

- **Medication:** the most common type of medications used to treat OCD are antidepressants. However, it may require a larger dose and take longer for antidepressants to impact the symptoms of OCD than those of depression.
- **Psychotherapy:** There are two types of psychotherapies that are helpful for treating OCD:
  - **Exposure and response therapy (ERT):** ERT exposes a person to the cause of their anxiety. For example, a person with a fear of germs may be asked by a doctor or therapist to put their hand on something considered

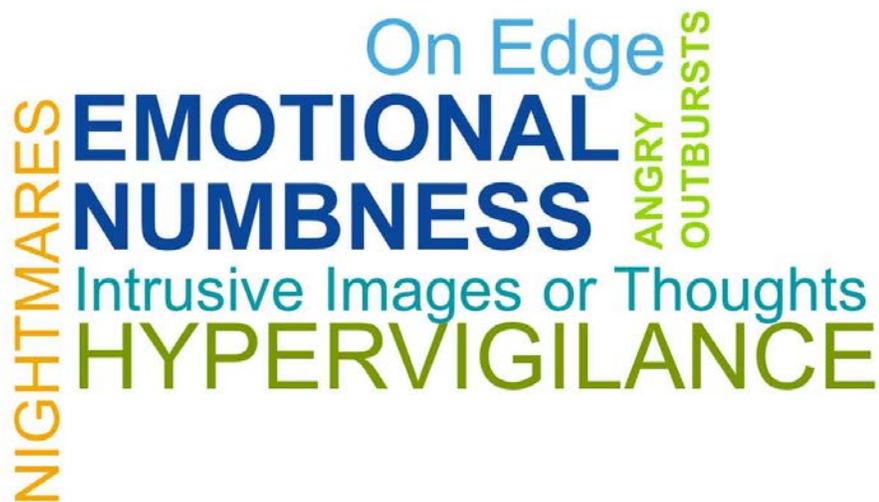
dirty, such as a doorknob. Afterwards, they will refrain from immediately washing their hands. The length of time between touching the doorknob and washing hands becomes longer and longer.

- **Cognitive behavioral therapy (CBT):** CBT focuses on the thoughts that are causing distress, and changing the negative thinking and behavior associated with them. For obsessive-compulsive disorder, the goal of this therapy is to recognize negative thoughts and, with practice, gradually lessen their intensity to the point of harmlessness.
- **Complementary Health Approaches:** aerobic exercise is a key complementary intervention that can work to improve the quality of life for people with OCD. Exercise may reduce the baseline level of anxiety a person experiences.

## Post-traumatic Stress Disorder (PTSD)

Traumatic events, such as military combat, assault, an accident or a natural disaster, can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms because they are not integrated into consciousness.

Post-traumatic stress disorder (PTSD) affects 3.5% of the U.S. adult population-about 7.7 million Americans with women more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is in a person's early 20s.



### Symptoms

The symptoms of PTSD fall into the following categories:

- **Intrusive Memories**, which can include flashbacks of reliving the moment of trauma, bad dreams and scary thoughts.
- **Avoidance**, which can include staying away from certain places or objects that are reminders of the traumatic event. A person may also feel numb, guilty, worried or depressed or having trouble remembering the traumatic event.
- **Dissociation**, which can include out-of-body experiences or feeling that the world is "not real" (derealization).
- **Hypervigilance**, which can include being startled very easily, feeling tense, trouble sleeping or outbursts of anger.

Recent research has found that children 1-6 years of age can develop PTSD and the symptoms are quite different from those of adults. Symptoms in young children can include:

- Acting out scary events during playtime.
- Losing the ability to talk.
- Being excessively clingy with adults.
- Extreme temper tantrums, as well as overly aggressive behavior.

## Diagnosis

Symptoms of PTSD usually begin within 3 months after a traumatic event, but occasionally emerge years afterward. Symptoms must last more than a month to be considered PTSD. PTSD is often accompanied by depression, substance abuse or another anxiety disorder. Because young children have emerging abstract cognitive and limited verbal expression, research indicates that diagnostic criteria must be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children.

## Treatment

- **Medications:** There is no one medication that will treat all cases of PTSD. The effective combination of psychotherapy and medication should be used together to reduce its symptoms. Given the common co-occurrence of depression, related anxiety disorders, aggression and impulsivity, selecting medications that address these related problems is recommended. Common categories of medications include antidepressants, antipsychotics and mood stabilizers.
- **Psychotherapy:** People with PTSD respond better to select, structured interventions than to unstructured, supportive psychotherapy. In addition to the following therapies, research is being conducted on dream revision therapy, also known as Imagery Rehearsal Therapy (IRT).
  - **Cognitive behavioral therapy (CBT)** helps change the negative thinking and behavior associated with depression. The goal of this therapy is to recognize negative thoughts and replace them with positive thoughts, which leads to more effective behavior.
  - **Eye Movement Desensitization and Reprocessing (EMDR)** is an eclectic psychotherapy intervention designed for trauma that employs exposure to traumatic memories with alternating stimuli (eye movements are one of several options) in structured sessions with an individual certified to perform EMDR.

- **Exposure therapy** helps people safely face what they find frightening so that they can learn to cope with it effectively. For example, virtual reality programs allow a person to experience the situation in which he or she experienced trauma.
- **Other forms of therapy** include the use of service dogs and support groups.
- **Complementary and Alternative Methods**, Recently, many health care professionals have begun to include complementary approaches in their regimens. Some methods that have been used for PTSD include:
  - Yoga
  - Aqua therapy, such as floatation chambers and surfing
  - Acupuncture
  - Mindfulness and meditation

# Schizophrenia

Schizophrenia is a serious mental health condition that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is a complex, long-term medical illness, affecting about 1% of Americans. Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early twenties for men, and the late twenties to early thirties for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.



## Symptoms

Just like with any mental health condition, people with schizophrenia experience symptoms differently. Symptoms include:

- **Hallucinations**, which can include a person hearing voices, seeing things, or smelling things others can't perceive.
- **Delusions**, which are false beliefs that don't change even when the person who holds them is presented with new ideas or facts.
- **Disorganized thinking**, such as struggling to remember things, organize thoughts or complete tasks.
- **Anosognosia**, which means they lack insight and are unaware that they have an illness.
- **Negative symptoms**, such as being emotionally flat or speaking in a dull, disconnected way.

## Causes

Research suggests that schizophrenia may have several possible causes:

- **Genetics:** Schizophrenia isn't caused by just one genetic variation, but a complex interplay of genetics and environmental influences. While schizophrenia occurs in 1% of the general population, having a history of family psychosis greatly increases the risk. Schizophrenia occurs at roughly 10% of people who have a first-degree relative with the disorder, such as a parent or sibling.
- **Environment:** Exposure to viruses or malnutrition before birth, particularly in the first and second trimesters has been shown to increase the risk of schizophrenia. Inflammation or autoimmune diseases can also lead to a compromised immune system.
- **Brain chemistry:** Problems with certain brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neurotransmitters allow brain cells to communicate with each other. Networks of neurons are likely involved as well.
- **Drug use:** Some studies have suggested that taking mind-altering drugs during teen years and young adulthood can increase the risk of schizophrenia. A growing body of evidence indicates that smoking marijuana increases the risk of psychotic incidents and the risk of ongoing psychotic experiences. The younger the user and more frequent the use, the greater the risk. Another study has found that smoking marijuana led to earlier onset of schizophrenia and often preceded the manifestation of the illness.

## Diagnosis

Diagnosing schizophrenia is not easy. The difficulty is compounded by the fact that many people who are diagnosed do not believe they have it. Lack of awareness is a common symptom of people diagnosed with schizophrenia and greatly complicates treatment. To be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

## Treatment

With medication, psychosocial rehabilitation and family support, the symptoms of schizophrenia can be reduced. People with schizophrenia should get treatment as soon as the condition starts showing, because early intervention can reduce the severity of their symptoms. Treatment options include:

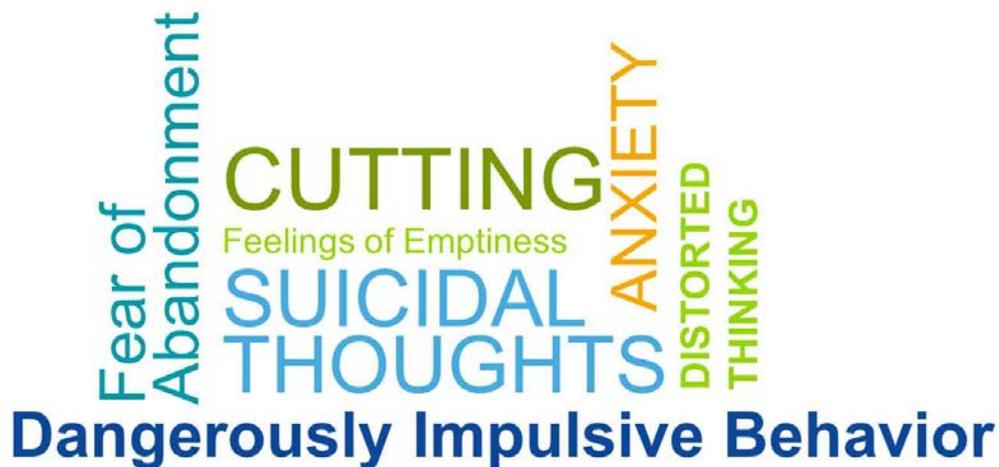
- **Antipsychotic medications:** Typically, a health care provider will prescribe antipsychotics to relieve symptoms of psychosis, such as delusions and hallucinations. Due to lack of awareness of having an illness and the serious side effects of medication, people often hesitate to take antipsychotics.
- **Psychotherapy:** such as cognitive behavioral therapy (CBT) or cognitive enhancement therapy (CET).
- **Psychosocial Treatments:** People who engage in therapeutic interventions often see improvement, and experience greater mental stability. Psychosocial treatments enable people to compensate for or eliminate the barriers caused by their schizophrenia and learn to live successfully. If a person participates in psychosocial rehabilitation, they are more likely to continue taking their medication and less likely to relapse. Some of the more common psychosocial treatments include assertive community treatment (ACT).

## Borderline Personality Disorder (BPD)

Borderline personality disorder (BPD) is a condition characterized by difficulties in regulating emotion. This difficulty leads to severe mood swings, impulsivity and instability, poor self-image and stormy personal relationships.

People may make repeated attempts to avoid real or imagined situations of abandonment. BPD is ultimately characterized by the emotional turmoil it causes. People who have BPD feel emotions intensely and for long periods of time, and it is harder for them to return to a stable baseline after an emotionally intense event. Suicide threats and attempts are very common for people with BPD. Self-harming acts, such as cutting and burning, are also common.

It's estimated that 1.6% of the adult U.S. population has BPD but it may be as high as 5.9%. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. In the past, men with BPD were often misdiagnosed with PTSD or depression.



### Symptoms

People with BPD experience wide mood swings and can display a great sense of instability and insecurity. Signs and symptoms may include:

- Frantic efforts to avoid being abandoned by friends and family.
- Unstable personal relationships that alternate between idealization and devaluation. This is also sometimes known as "splitting."

- Distorted and unstable self-image, which affects moods, values, opinions, goals and relationships.
- Impulsive behaviors that can have dangerous outcomes.
- Suicidal and self-harming behavior.
- Periods of intense depressed mood, irritability or anxiety lasting a few hours to a few days.
- Chronic feelings of boredom or emptiness.
- Inappropriate, intense or uncontrollable anger—often followed by shame and guilt.
- Dissociative feelings (disconnecting from your thoughts or sense of identity, or “out of body” type of feelings) and stress-related paranoid thoughts. Severe cases of stress can also lead to brief psychotic episodes.

## Causes

The causes of borderline personality disorder are not fully understood, but scientists agree that it is the result of a combination of factors:

- **Genetics.** While no specific gene has been shown to directly cause BPD, studies in twins suggest this condition has strong hereditary links. BPD is about five times more common among people who have a first-degree relative with the disorder.
- **Environmental factors.** People who experience traumatic life events, such as physical or sexual abuse during childhood or neglect and separation from parents, are at increased risk of developing BPD.
- **Brain function.** The way the brain works is often different in people with BPD, suggesting that there is a neurological basis for some of the symptoms. Specifically, the portions of the brain that control emotions, decision making and judgment may not communicate well with one another.

## Diagnosis

There is no single medical test to diagnose BPD, and a diagnosis is not based on one sign or symptom. BPD is diagnosed by a mental health professional following a comprehensive psychiatric interview that may include talking with previous clinicians, medical evaluations and, when appropriate, interviews with friends and family. To be diagnosed with BPD, a person must have at least 5 of the 9 BPD symptoms listed above.

## Treatment

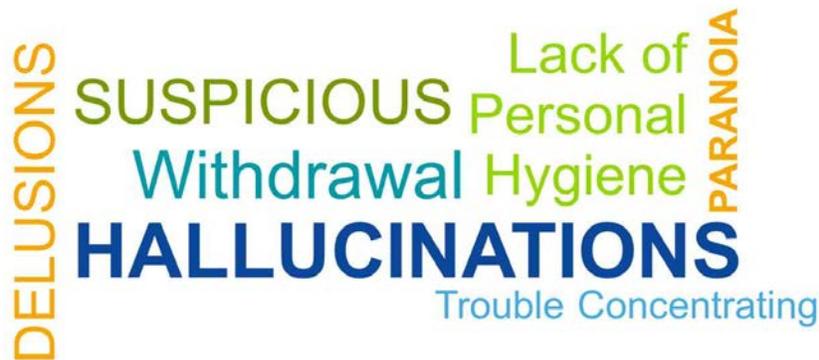
People with BPD are often treated with a combination of psychotherapy, peer and family support and medications to address co-occurring symptoms.

- **Medications** are not specifically made to treat the core symptoms of emptiness, abandonment and identity disturbance, but can be useful in treating other symptoms associated with BPD, such as anger, depression and anxiety. Medications may include mood stabilizers, antipsychotics, antidepressants and anti-anxiety drugs.
- **Psychotherapy** is a cornerstone for treating a person with BPD. In addition to dialectical behavioral therapy (DBT), which was created specifically for the treatment of BPD, there are several types of psychotherapy that are effective. These treatments include cognitive behavioral therapy (CBT) and metallization-based therapy (MBT).

# Psychosis

An episode of psychosis is when a person has a break from reality and often involves seeing, hearing and believing things that aren't real. Approximately 3 in 100 people will experience an episode of psychosis during their lives. Young adults are placed at an increased risk to experience an episode of psychosis because of hormonal changes in the brain that occur during puberty, but a psychotic episode can occur at any age.

Psychosis is not an illness, but a symptom. A psychotic episode can be the result of a mental or physical illness, substance use, trauma or extreme stress.



## Symptoms

Symptoms of a psychotic episode can include incoherent speech and disorganized behavior, such as unpredictable anger, but psychosis typically involves one of two major experiences:

- **Hallucinations** are seeing, hearing or physically feeling things that aren't actually there.
- **Delusions** are strong beliefs that are unlikely to be true and may seem irrational to others.

## Early Warning Signs

Most people think of psychosis as a sudden break from reality, but there are often warning signs that precede an episode of psychosis. Knowing what to look for provides the best opportunity for early intervention. Some indications are:

- A worrisome drop in grades or job performance.
- Trouble thinking clearly or concentrating.
- Suspiciousness or uneasiness with others.

- A decline in self-care or personal hygiene.
- Spending a lot more time alone than usual.
- Strong, inappropriate emotions or having no feelings at all.

## Causes

Several factors can contribute to psychosis:

- **Genetics.** Many genes are associated with the development of psychosis, but just because a person has a gene doesn't mean they will experience psychosis.
- **Trauma.** A traumatic event such as a death, war or sexual assault can trigger a psychotic episode.
- **Substance use.** The use of marijuana, opioids, heroin and other substances can increase the risk of psychosis in people who are already vulnerable.
- **Physical illness or injury.** Traumatic brain injuries, brain tumors, strokes, HIV and some brain diseases such as Parkinson's, Alzheimer's and dementia can sometimes cause psychosis.

## Diagnosis

A diagnosis identifies an illness, and symptoms are components of an illness. Psychosis is a symptom, not an illness.

Health care providers draw on information from medical and family history along with a physical examination to make a diagnosis. If causes such as a brain tumor, infection or epilepsy are ruled out, a mental health condition might be the cause of psychosis.

## Treatment

Identifying and treatment psychosis as early as possible leads to the best outcomes. Early intervention is always the best approach to treatment a mental health condition, because there is a chance of preventing the condition from progressing.

There are many specialized centers that focus exclusively on psychosis and crisis treatment in youth. The American Psychiatric Association (APA), your state chapter of the APA, primary care doctor, insurance carrier and the state or county mental health authority are other resources that can help you.

Treatments for psychosis can include a combination of psychotherapy, medication, complementary health approaches or even hospitalization. It's important to work with a mental health care professional to determine the right treatment plan.

## Dual Diagnosis

Dual diagnosis is a term for when someone experiences a mental illness and a substance abuse problem simultaneously. Dual diagnosis, also referred to as co-occurring diagnosis, is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when they abuse heroin during periods of mania.

Either substance abuse or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms they experience. Research shows though that drugs and alcohol only make the symptoms of mental health conditions worse. Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.



### How Common is a Dual Diagnosis?

About a third people experiencing mental health conditions and about half of people living with the most severe forms of the conditions also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of alcohol abusers and more than half of drug abusers report experiencing a mental health condition.

Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with other medical illnesses.

## Symptoms

The defining characteristic of dual diagnosis is that both a mental health and substance abuse disorder occur simultaneously. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance abuse may include:

- Withdrawal from friends and family.
- Sudden changes in behavior.
- Using substances under dangerous conditions.
- Engaging in risky behaviors when drunk or high.
- Loss of control over use of substances.
- Doing things you wouldn't normally do to maintain your habit.
- Developing tolerance and withdrawal symptoms.
- Feeling like you need the drug to be able to function.

The symptoms of a mental health condition also can vary greatly. Knowing the warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide, can help identify if there is a reason to seek help.

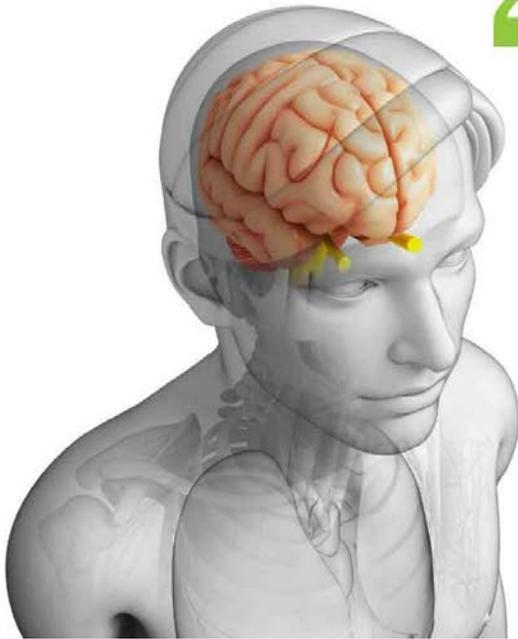
## Treatment

The most common method of treatment for dual diagnosis today is integrated intervention, where a person receives care for both a specific mental health condition and substance abuse. Because there are many ways in which a dual diagnosis may occur treatment will not be the same for everyone.

- **Detoxification:** The first major challenge that people with dual diagnosis must endure is detoxification. During inpatient detoxification, a person is monitored 24/7 by trained medical staff for up to 7 days. Inpatient detoxification is generally more effective than outpatient for initial sobriety. This is because inpatient treatment provides a consistent environment and removes the person battling addiction from exposure to people and places associated with using.
- **Inpatient Rehabilitation:** A person experiencing a serious mental health condition and dangerous or dependent patterns of abuse may benefit most from an inpatient rehabilitation center where concentrated medical and mental health care is offered 24/7. These treatment centers provide therapy, support, medication and health services with the goal of treating addiction and its underlying causes. Supportive housing, like group homes or sober houses, is another type of residential treatment center that is most helpful for people who are newly sober or trying to avoid relapse.

- **Medications:** Medications are a useful tool for treating a variety of mental health conditions. Depending on the mental health symptoms a person is experiencing, different medications may play an important role in recovery. Certain medications are also helpful for people experiencing substance abuse. These medications are used to ease withdrawal symptoms or promote recovery. Medications to ease withdrawal are used during the detoxification process.
- **Psychotherapy:** Psychotherapy is almost always a large part of an effective dual diagnosis treatment plan. Education on a person's illness and how beliefs and behaviors influence thoughts has been shown in countless studies to improve the symptoms of both mental health conditions and substance abuse. Cognitive behavioral therapy (CBT) in particular is effective in helping people with dual diagnosis learn how to cope and to change ineffective patterns of thinking.
- **Self-help and Support Groups:** Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, successes, referrals for specialists, where to find the best community resources and tips on what works best when trying to recover. Members also form friendships and find sponsors that can help them stay sober.

## The Biology of Mental Health Conditions



“ What we have to get across, is how it is that people get mental illness. Nobody is to blame. This is not a mental weakness. These are diseases just like any other neurobiological disorders. They just happen to affect complex behaviors. ”

Dr. Steven Hyman, former Director of the National Institute of Mental Health (NIMH)

## Section IV; Communication Strategies.

### Offering Empathy



- **Support instead of criticizing.** People experiencing a mental health crisis are very vulnerable. When we criticize them, or make negative remarks, we take advantage of their vulnerability. This contrasts with our goal to help meet their immediate needs and support them on their way to recovery. As part of our efforts, it's critical that we respect and protect their self-esteem. Frame any recommendations in terms of what benefit we believe they may bring, rather than what we think the person is doing "wrong."
- **Encouragement instead of punishing.** The most effective way to help people start a beneficial behavior is to respond empathetically to their experience, validate their perspective, find a shared goal, listen to their ideas, and suggest our own. When we follow this process and genuinely share ideas and concerns, we will build trust with our loved one. This is the most effective way to encourage long-term change. Influencing people through intimidation or punishment is coercive and leads to more conflict and worse outcomes. Family members have direct experience with this. Joe Talbot, a parent quoted in Patricia Backlar's book, *The Family Face of Schizophrenia*, said:

*"With this disease there is no fighting. You may not fight. You just have to take it and take it calmly. And remember to keep your voice down. . . [Also] punishment doesn't work with this disease. Now that I have lived with a person with schizophrenia, it makes me very upset when I see mental health workers try to correct their clients' adverse behavior by punishment, because I know it doesn't work."*

- **Reward positive behavior and ignore negative behavior.** Studies have shown that people will want to behave in ways that bring them recognition and approval. Research has demonstrated that criticism, conflict and emotional pressure are highly correlated to relapse. It's better to simply wait and ignore negative behavior, if it is not actively dangerous, than to react to it or focus on it.
- **Recognize and accept all the person's symptoms.** It can be tempting to try to "fix" someone's symptoms because they may resemble intentional behaviors. It's critical that we remember that lack of motivation in a depressed person is a symptom of their condition and not something we can counteract or make go away, except for, possibly, through an effective treatment plan. We can't argue with someone's psychotic delusions or deflate someone's grandiose self-image when they're having a manic episode. These aren't social behaviors—they are medical symptoms that can be addressed through a variety of treatments. Instead, offering support and empathy can relieve the person's guilt and anxiety and make treatment more possible.
- **Patiently encourage independent behavior.** To encourage our loved one to take independent steps in their recovery process, ask them what they feel they're ready to do. Make short-term plans and goals and be prepared for changes and pauses. Progress in mental illness requires flexibility. It may require family members and providers to let go of the standards by which they measure progress and listen more to how the person with the mental health condition measures progress. Patience and waiting can be healing. Be aware that someone with a mental health condition may be anxious that when they show signs of improvement, their support system will withdraw and they'll be in greater risk. Reassure your loved one that your concern and support will be present even when there isn't in a crisis.
- **Maintain basic expectations.** Like with anyone else, we can expect reasonable, basic behaviors from people with mental illness. Everyone has a better chance of co-existing well when expectations for behavior and cooperation are clear, so we must be sure to express ours.
- **Validate the emotional content of what our loved ones express.** Being empathetic often involves listening and responding to the emotional truth of what someone is expressing. We may not agree with the details or ideas they're sharing, but we must recognize and express the validity of their emotional response to their experience. For example, if someone says, "Everyone in this house thinks I'm a

failure,” we can validate the difficulty of what they’re feeling without agreeing with the idea. We can say something like, “It must be upsetting to think we’re disappointed with you. That would be painful.” This shows we’ve listened carefully, gives them a chance to clarify any misunderstanding, and demonstrates that they can trust us with how they really feel. Once we build trust like this, we can start to clarify how we see the situation and find things we agree on as we move forward.

- **Have empathy for ourselves.** We aren’t superheroes, and many things are outside of our control. A loved one may not have the outcomes we’d like, or they may seem stuck in a difficult stage for a long time. It’s admirable to do our best to help improve the well-being of our loved one, but we can’t guarantee what exactly that will look like. We must be compassionate toward ourselves and our limits.

### **Learn more**

For an articulate and engaging illustration of empathy, see Brené Brown’s animated video on empathy vs. sympathy: <https://www.youtube.com/watch?v=1Evwqu369Jw>

## Basic Communication Guidelines



- Use short, clear, direct sentences. Long, complicated explanations can be difficult for people experiencing mental health symptoms to follow. They may stop listening.
- Keep the content of what you say simple. Discuss only one topic at a time and give only one direction at a time. Be as concrete as possible.
- Keep the level of stimulation as low as possible so your loved one will be able to listen and understand you. Keep your voice low and calm, keep your body language calm and still, and speak respectfully and carefully rather than accusing or criticizing.
- Be pleasant and firm. Saying things that contradict each other, or saying one thing and doing something that contradicts it, makes it hard for your loved one to understand and trust you. When you communicate clearly and well, you show your loved one that you have healthy boundaries and that they must respect them.
- Assume that the person may not be able to absorb a lot of what you say to them. You will often have to repeat instructions and directions. Be patient.
- If your relative seems withdrawn and reluctant to talk, pause the conversation and give them space for a while. Don't try to force a conversation. You'll have a better chance of getting the response you want when your loved one is more capable of interacting with you.

## **I-Statements**

- I-statements focus on the facts, without blaming anyone. They allow you to express your own personal feelings about what your loved one has chosen to do and say.
- Using I-statements regularly can change the atmosphere in your home. If one person changes their communication style, it will absolutely have an effect on how the rest of the family communicates, too.
- When you get used to using I-statements, don't make the mistake of undoing their impact by expressing doubt or by adding something that reverses the point you just made. Say what you mean, and mean what you say, period.
- Remember, our loved one's thinking is often distracted, disorganized and scared. It helps them when we are clear, calm and concise. I-statements can also help you request something of your loved one and give them positive feedback, like praise.

### **Sample I-statements:**

- I feel frustrated there are dirty dishes around the house.
- I worry when you stay up late. I know how difficult it is for me to get up in the morning when I stay up late.
- I feel frightened when you stop talking to me—I worry that something might be wrong.
- I feel sad when there is fighting in the house.

## Reflective Responses

### Basic steps for making a reflective response:

1. Acknowledge the reality of your loved one's lived experience—that is, what is real and true to them (rather than to you).
2. Focus your response on what someone having this experience must be feeling (rather than what you are feeling).
3. Communicate that you understand what your loved one believes and how they feel.

A central part of reflective responses is staying with the emotional content of what your loved one says, instead of arguing with them about how they see the situation. Don't try to convince your loved one that what you think is true. Instead acknowledge what is real to them. Here's an example. Imagine how you would usually react if your loved one said, "Everyone at school hates me." You might think, "That's not true—everyone doesn't hate them," and try to change their mind. But we're asking you to try something different. It may not be true that everyone hates them, but your loved one's feelings of being hated are real. Their emotions are really happening.

Acknowledge what they are feeling. If your loved one says, "I hate school and I'm never going back," you can say "It sounds like you really don't like going there." If your loved one says, "I hate you and I hate living in this house!" you can say, "It must feel terrible to be so unhappy with us."

That's reflecting. You focus on the feelings that your loved one has communicated. You listen closely for the emotional content of what you're hearing, instead of getting upset about the words they're using or whether you agree or disagree with how they see the situation. You tell them what you observe about how they feel. In this way, you reflect back the essential part of what your loved one is communicating to you. This helps your loved one feel validated and heard. Feeling understood can help your loved one trust you and make more communication possible.

### Examples of reflective responses:

- It must be frightening to think someone's trying to hurt you.
- You seem sad today.
- I know this is frustrating for you.
- Not being included in a group is hard.
- You sound very discouraged about school.

## Section V; Treatment & Recovery

### **Bio-Psycho-Social Dimensions of Mental Health Conditions**

The three dimensions of mental health conditions, bio-psycho-social, are interdependent.

- No one dimension can ignore the knowledge base of the other two
- Focusing on one dimension alone is not sufficient for recovery

<b>Biological/Physical Medical Dimension: Science- based knowledge</b>	<b>Psychological/Emotional Personal Dimension: Psychology-based knowledge</b>	<b>Social/Occupational Rehabilitation Dimension: Services-based knowledge</b>
<b><i>Focus: Medical aspects of the condition</i></b>	<b><i>Focus: Emotions and feelings</i></b>	<b><i>Focus: Re-establishing connection</i></b>
Symptoms; Diagnosis	The inner experience of mental health conditions	Definition and testimonials of recovery
Future course of illness (prognosis)	Normative family responses to the stresses of mental illness	Principles of rehabilitation
Acute care in critical periods	Telling our stories; validating family strengths	Vocational challenges (acquiring skills via training or school)
Medications and side effects	Coping strategies used to protect self-esteem in mental health conditions	Sources of system/community support
Adherence to treatment	Empathetic listening and responding skills	Restoration of social ties
Scientific advances in medications	Challenges of different relative roles in the family	Rebuilding after transitions (hospitalization, incarceration, relocation, deployment, separating from the military)
Early warning signs of relapse	Handling anger, frustration, and feelings of confinement	Long-term care
Impact of mental health on overall health	Coming to terms with “shattered dreams”	Increased self-determination
Insight into clinical realities of brain disorders	Self-care skills; keeping our lives going	Maximum personal fulfillment and quality of life
Best medical strategies to maximize recovery	Value of peer understanding and support	Problem solving skills
Current research on brain disorders		Communication skills
		Advocacy for better services and fair policies
		Celebrating our progress

## Health Insurance Portability and Accountability Act (HIPAA)



### What is HIPAA and Why is it Important?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a national standard for the protection of certain types of health care information. The U.S. Department of Health and Human Services then issued a “Privacy Rule” to implement the requirements of HIPAA. The Privacy Rule limits the circumstances in which individually identifiable health information can be used and disclosed by health care insurers, providers, and clearinghouses. The Privacy Rule refers to this type of information as “protected health information” (PHI).

The Privacy Rule limits the use and disclosure of PHI by “covered entities.” It does not affect other organizations or individuals. Covered entities can use and disclose PHI with no restriction only for treatment, payment, and health care operations. All other uses and disclosures must be authorized by the individual or be authorized under a section of the Privacy Rule.

- Don't be intimidated when someone mentions HIPAA
- Family members need to understand what kind of information they can get regarding their relative's diagnosis, treatment plan, medications, etc.
- Getting a signed release from your loved one is one way to access this information
- HIPAA does NOT prohibit you from sharing information, observations and concerns with your loved one's treatment providers

An overview of the Privacy Rule:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

## Collaborative Care



## Therapeutic Intervention Techniques



The most effective treatment usually involves a combination of:



**Psychotherapy** - to address the psychological



**Medication** - to address the biological

## Treatment settings

### Treatment settings:

- **Outpatient** mental health services are provided while the individual continues to live at home and continues their regular routines with work, school and family life. For this reason, outpatient services are considered the least restrictive form of treatment.
- **Inpatient** means that the individual is admitted to a treatment environment that requires staying overnight. It may be a hospital, a residential treatment center, or a crisis unit of some sort, but the treatment is provided while the individual is on site at the treatment facility 24 hours a day.
- There are also “mixed” types of treatment settings called **day treatment**, or **partial hospitalization** programs. In these programs, the individual goes home at night, but spends much of the day at a treatment facility participating in structured therapeutic activities.

Regardless of whether treatment services are provided in an outpatient, partial hospitalization, day treatment or inpatient setting, there are a variety of different therapeutic techniques that can be used.

## Psychotherapeutic Interventions

Intervention	Description
Behavior Therapy	Helps the individual change negative behaviors and improve behaviors through a reward and consequences system. In behavior therapy, goals are set and small predetermined rewards are earned to reinforce positive behavior.
Cognitive Behavioral Therapy (CBT)	Teaches individual how to notice, take account of, and ultimately change the thinking and behaviors that impact their feelings. In CBT, the individual examines and interrupts automatic negative thoughts that make them draw negative and inappropriate conclusions about themselves and others. CBT helps the person learn that thoughts cause feelings, which often influence behavior.
Cognitive Enhancement Therapy (CET)	Cognitive rehabilitation training program for adults with schizophrenia or schizoaffective disorder who are stabilized and maintained on antipsychotic medication and not abusing substances. CET is designed to provide cognitive training to help improve impairments related to neurocognition (including poor memory and problem-solving abilities), cognitive style (including impoverished, disorganized, or rigid cognitive style), social cognition (including lack of perspective taking, foresight, and social context appraisal), and social adjustment (including social, vocational, and family functioning), which characterize these mental disorders and limit functional recovery and adjustment to community living. Participants learn to shift their thinking from rigid serial processing to a more generalized processing of the core essence or gist of a social situation and a spontaneous abstraction of social themes.
Dialectical Behavior Therapy (DBT)	CBT approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatically emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Exposure Therapy	Educates and teaches individuals about how to manage fears and worries to reduce their distress. The individual is gradually exposed to threatening situations, thoughts or memories that make him/her excessively anxious or worried.
Eye Movement Desensitization and Reprocessing (EMDR)	A nontraditional type of psychotherapy. It's growing in popularity, particularly for treating post-traumatic stress disorder (PTSD). PTSD often occurs after experiences such as military combat, physical assault, emotional or sexual abuse, natural disasters or car accidents. EMDR doesn't rely on talk therapy or medications. Instead, EMDR uses the individual's own rapid, rhythmic eye movements. These eye movements dampen the power of emotionally charged memories of past traumatic events. The premise is that EMDR weakens the effect of negative emotions and that disturbing memories will become less disabling.
Family Education and Support	Evidence-based practice in adult mental health. Designed to achieve improved outcomes for people living with mental illnesses by building partnerships among individuals, families, providers and others supporting the individual and family. May be led by clinicians or by other family members (NAMI programs are in this category).
Interpersonal Therapy (IPT)	Designed for treatment of symptoms of depression. Examines relationships and transitions, and how they affect a person's thinking and feeling. Focuses on the individual and helps them manage major changes in their lives, such as divorce and significant loss, including the death of a loved one.
Psycho-educational Multifamily Groups (PMFG)	Treatment modality designed to help individuals with mental illness attain as rich and full participation in the usual life of the community as possible. The intervention focuses on informing families and support people about the illness, developing coping skills, solving problems, creating social supports, and developing an alliance between consumers, practitioners, and their families or other support people. Practitioners invite five to six individuals and their families to participate in a psycho-education group that typically meets every other week for at least 6 months. "Family" is defined as anyone committed to the care and support of the person with mental illness. People in recovery often ask a close friend or neighbor to be their support person in the group. Group meetings are structured to help people develop the skills needed to handle problems posed by mental health conditions.

## Intensive Home and Community-Based Interventions

Intervention	Description	Average Length of Treatment
Multisystemic therapy (MST)	Short-term and intensive home-based therapy. MST therapists have small caseloads, designed to meet the immediate needs of families. The MST team is available 24 hours a day, seven days a week to work with families.	4 months with approximately 60 hours of contact with the MST Team
Mental Health Intensive Case Manager (referred to as MHICM, mental illness case management in the VA)	Generally, relies on a single case manager who is assigned to work closely with the family and other professionals to develop an individualized comprehensive service plan for the individual and family.	Long term (no limit)
Wrap Around Services	A philosophy of care that includes a definable planning process involving the individual and family that results in a unique set of community services and natural supports individualized for that individual and family to achieve a positive set of outcomes.	Long term (no limit)

## Complementary Health Approaches

Traditional medical and therapeutic methods have improved over the years, but often they do not completely lessen or eliminate symptoms of mental health conditions. As a result, many people use complementary and alternative methods to help with recovery. These nontraditional treatments can be helpful but it's important to remember that, unlike prescription medications, the U.S. Food and Drug Administration (FDA) does not review or approve most of them.

The National Center for Complementary and Alternative Medicine (NCCAM) favors the term "Complementary health approaches," which encompasses three areas of unconventional treatment:

- Complementary methods where non-traditional treatments are given in addition to standard medical procedures
- Alternative methods of treatment used instead of established treatment
- Integrative methods that combine traditional and non-traditional as part of a treatment plan

Data is still lacking on the effectiveness and safety of many complementary practices, but there are studies supporting that some of these strategies seem to have minimal, if any, adverse effects.

### Natural Products and Activities

Some people find that taking supplemental vitamins and minerals lessens the symptoms of their mental health conditions. There are several ways these substances may help.

- **Omega-3 fatty acids** are groups of chemicals found in several different foods, including certain fish, nuts and seeds. Studies have found that certain types of omega-3 fatty acids are useful in the management of both medical and mental illnesses. Research shows that for young people experiencing an episode of psychosis for the first time, treatment with omega-3 fatty acids may help decrease their risk of developing a more chronic and serious form of schizophrenia.
- **Folate** is a vitamin required for the human body to perform many essential processes on a day-to-day basis. Also called folic acid or vitamin B9, folate is a compound that the human body is unable to make on its own. Some people with mental health conditions have been shown to have low folate levels and may benefit from treatment with additional folate supplementation. At the current time,

the FDA has approved only one form of folate—l-methylfolate (Deplin)—for use in the treatment of depression and schizophrenia. L-methylfolate has not been approved as a primary treatment, but rather as an additional form of treatment.

- **Medical foods** are another type of product containing natural ingredients. These are foods made with or without specific nutrients to help treat a health condition. For example, gluten-free foods are designed to give people with celiac disease the nutrients they need but without the gluten which makes them sick. Like supplements, medical foods are not as closely monitored by the FDA as prescription medicines.
- **Mind and Body Treatments:** Many people find that physical activity is beneficial to their well-being. Some types of mind and body treatments are:
  - Yoga
  - Exercise (aerobic and anaerobic)
  - Meditation
  - Tai chi

Some of these, such as meditation, are mental exercises, while others are mostly concerned with muscle movement. However, all mind and body treatments can improve mood, anxiety and other symptoms of mental health conditions. In addition, physical activity can help reduce weight gain, fatigue, and other side effects of many conventional medicines used to treat mental health conditions.

- **Equine Therapy** or equine-assisted psychotherapy (EAP), is a form of animal-assisted therapy that teaches individuals how to groom, care for and ride horses. The goal of horse therapy is to use experience with horses to improve emotional and behavioral outcomes.

Small studies and anecdotal evidence have shown equine therapy can help reduce symptoms of anxiety, depression and impulsiveness common to many mental health conditions. However, more data is needed to test its effectiveness.

***IMPORTANT! Make Sure to Check with Your Doctor.*** Even simple vitamins can interact with medication. While something may be safe to use with one prescription medicine, it can make others less effective or toxic. Also, any new exercise or outdoor activity should be discussed with a doctor. People taking certain medicines for depression, schizophrenia or other conditions should make sure to stay cool and drink enough water to avoid heat stroke. Other medicines can lower body temperature, so special preparation may be needed for cold weather.

## Medications & How They Work

# MEDICATIONS & How They Work

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## Common Emotional Experiences that Affect Treatment Decisions



### **Lacking insight into the condition: “I’m not ill”**

Lack of insight is a phenomenon where someone with a mental health condition doesn’t perceive that something concerning is happening with their health. This happens when a person is genuinely disconnected from the perceptions and beliefs shared by a wider community. A person lacking insight is unable to see the validity of other points of view. Because they don’t sense that anything is unusual, they don’t think there’s a reason to consider treatment.

This is a common phenomenon called “anosognosia.” It’s especially common in schizophrenia and in episodes of mania. It’s so common that it’s considered one reliable sign of these conditions when making a diagnosis. People with depression also may not recognize when their condition is serious.

When people lack insight into their condition, they may continue to believe nothing is wrong, even if their symptoms improve with treatment. Many of the people who go voluntarily to the hospital go because someone has urged them to, but do not believe they need to.

### **Using denial as a protective coping strategy: “I don’t need treatment”**

When a person is overwhelmed or unequipped to address what’s happening, they may deny that the problem exists or ignore it, hoping it will go away. They may recognize that something is wrong but find it too painful to acknowledge to themselves or to others. As we’ve reiterated, people use denial to cope with many upsetting events and medical crises, not just mental health conditions. Being in denial temporarily protects the person. When someone is in denial, choosing treatment would be admitting that something is medically wrong. If they are in denial and do take medication anyway, they may be unlikely to tolerate side effects when they don’t see the benefits.

### **Missing the thrill of mania: would rather feel pain than be numb or bored**

Some mental health treatments reduce the intensity of your emotions. Some people report not having emotions at all when taking certain medications. When a person's emotional baseline changes, they must develop a new sense of what is normal, which can be frustrating and demoralizing. A person may prefer to tolerate the ups and downs of their condition rather than give up feelings they're used to having or not feeling at all. When that's the case, it's understandable that someone might experiment with stopping and starting medication.

### **Wishing to be seen as a person, not an illness; not wanting to be seen as broken**

People who choose to seek treatment and experience it as beneficial may decide not to continue long-term, even if they're receiving benefits from it. Many people don't like the idea of having a chronic condition that involves going to therapy or taking a medication indefinitely. People often say they feel they're seen or treated as "just" their diagnosis, rather than as a full person with a variety of traits, needs and hopes.

This experience is true of people with many health conditions, not only mental health ones. Being involved in treatment or taking medications long-term can seem like admitting you'll never return to how you used to be. That can be extremely difficult to accept. When people start improving, they may stop treatment or stop taking medication because it seems, and they hope, that their need for treatment has gone away.

### **Being reluctant to accept things as they are, or partial acceptance**

When a person is unable to accept a situation or condition, it's often because their experience feels too painful to tolerate. It may seem easier to disregard the problem even if there are negative consequences in the future.

## Section VI; Crisis Planning.

### **Supporting Your Loved One During Treatment**



- If your loved one with the mental health condition is willing to discuss treatment, help them to understand how medications and talk therapy work and how they can help
- You need to have a workable plan for monitoring medications (for treatment and safety)
- All medication issues need to be discussed openly
- Sometimes adherence increases by avoiding the “mental illness” connotation of these medications (addressing the impact of the treatment on the symptoms that are causing distress rather than the diagnosis itself)
- It’s helpful to keep written records of the medications your loved one has taken, the dosages and the side effects that have been troublesome
- Confidentiality will not be a barrier to communication with a treatment provider if your relative gives permission. If permission isn’t granted you may speak to the provider but the provider cannot give you information in return.
- If your relative refuses treatment, then you must prepare yourself for another period of crisis

*“Don’t rely only on medication and don’t refuse to try it.”*

-Peter Jensen taken from NAMI Basics

## Universal Warning Signs of Relapse

Noticeable changes in these behaviors or emotions:

Feeling more tense or nervous	Enjoying things less
Having more trouble sleeping	Feeling more aggressive or pushy
Feeling that people are talking about me	Feeling too excited or overactive
Change in level of activity	Eating less
Having more trouble concentrating	Having trouble relating to family
Having more nightmares or bad dreams	Having more religious ideas
Hearing voices or seeing things	Having frequent aches and pains
Feeling more depressed	Preoccupied with one or two ideas
Feeling that someone else was controlling me	Drinking more alcohol
Stopped caring how I looked	Having trouble making sense when talking
Feeling badly for no apparent reason	Using/abusing more drugs (marijuana, opioids, heroin, inhalants)
Losing interest in things I like doing	Feeling like I was forgetting things more
Feeling angrier over little things	Feeling worthless
Seeing friends less	Thinking about hurting someone else
Thinking about hurting myself	Feeling like I was going crazy

*Source: McFarlane, W., Terkelson, K.. "New Approaches to Families Living with Schizophrenia. Institute," 62<sup>nd</sup> Annual Ortho-Psychiatric Meeting, NY.*

## Crisis Planning



- Nowhere is it more important to maintain an empathetic mindset toward our loved ones than when they're experiencing an increase in symptoms that creates a crisis situation. It's rare that people suddenly lose total control of thoughts, feelings and behavior.
- Family members or close friends will see signs like sleeplessness, ritualistic preoccupation with certain activities, suspiciousness/paranoia, unpredictable outbursts, and so on.
- Separate the disorder from the person you love, and view their behaviors, even the scary ones, objectively; that is, from the perspective of protecting the person living with the condition as well as the rest of the family.
- The goal during a crisis is to prevent things from getting worse and to provide immediate protection and support to the person experiencing the crisis.
- Addressing early warning signs can often prevent a full-blown crisis.
- Trust your intuition. If you're feeling frightened or panicked, the situation calls for immediate action. Remember, your primary task is to help your loved one regain control, to keep everyone safe and to not escalate the situation.
- Remain calm. If you're alone, contact someone to join you until professional help arrives.

## Calling 911 and Talking with Police

If a situation escalates into a crisis, you may have to call the police. There are a few things you can do to keep the situation as calm as possible.

### On the Phone

Share all the information you can with the 911 dispatcher. Tell the dispatcher that your loved one is having a mental health crisis and explain his/her mental health history and diagnosis. If the police who arrive aren't aware that a mental health crisis is occurring, they cannot handle the situation appropriately. Many communities have crisis intervention team (CIT) programs that train police officers to handle and respond safely to psychiatric crisis calls. Not every police officer is trained in a CIT program, but you should request that a CIT be sent if possible.

### During a Crisis

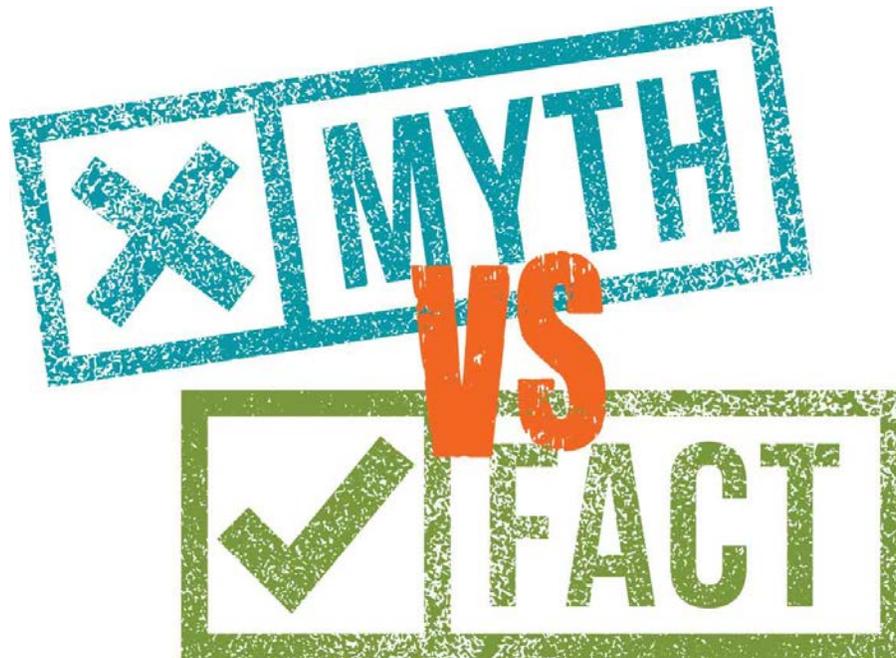
Police are trained to maintain control and keep the community safe. If you are worried about a police officer overreacting, the best way to ensure a safe outcome is to stay calm. When an officer arrives at your home, say "this is a mental health crisis." Mention you can share any helpful information, then step out of the way. Yelling or getting too close is likely to make the officer feel the situation is escalating.

Be aware that your loved one may be placed in handcuffs and transported in the back of a police car. This can be extremely upsetting to witness, so be prepared.

### What Can the Police Do?

- **Transport a person who wants to go to the hospital.** A well-trained CIT officer can often talk to a person who is upset, calm him down and convince him to go to the hospital voluntarily.
- **Take a person to a hospital for an involuntary evaluation.** In certain circumstances, police can force a person in crisis to go to the hospital involuntarily for a mental health evaluation. The laws vary from state to state.
- **Check on the welfare of your loved one if you are worried and can't reach him or her.** Call the non-emergency number for the police department in your community and explain why you are concerned. Ask them to conduct a welfare check.

## Mental Health Myths & Facts



- **Fact:** Those with schizophrenia and mania who take medication regularly and who do not abuse alcohol or other drugs are no more violent than the rest of the population
- **Fact:** The combination of major mental health conditions and substance abuse is a significant predictor of aggressive behavior
- **Fact:** The likelihood of violence is greatest among males in their late teens or early 20's
- **Fact:** The best prediction of future behavior is past behavior
- **Fact:** Your loved one is probably terrified by the experience of losing control over their thoughts and feelings
- **Fact:** If your loved one is experiencing auditory hallucinations—such as voices—they may be hearing life-threatening commands; messages may be coming from the television; the room may be filled with poisonous fumes; snipers may be lurking in public places; random authority figures may be seen as the enemy

**Fact:** You have no way of knowing what your loved one is experiencing, but be assured that it is real to them

## Suicide Myths & Facts

**Myth:** People who talk about suicide never attempt it.

**Fact:** Most of the time, people who attempt suicide have provided clues to their intentions.

**Myth:** Talking about suicide with someone may give them ideas.

**Fact:** Talking about suicide with a loved one gives them an opportunity to express thoughts and feelings about something they may have been keeping secret. Discussion brings it into the open and provides an opportunity for intervention.

**Myth:** Only certain “types” of people die by suicide.

**Fact:** There is no specific type. While some demographic factors contribute to higher risk for suicide, it is important to remember that suicide does not discriminate. People of all genders, races, ethnicities, ages, upbringings and socio-economic statuses kill themselves. Pay attention to what the person says and does – not what he/she looks like or how you believe that person should think, feel or act.

**Myth:** Suicidal people overreact to life events.

**Fact:** Problems that may not seem like a big deal to one person, may be causing a great deal of distress for someone else. For example, a teen may have a strong reaction to an issue that an adult considers minor; a family member may not realize the impact “invisible wounds” like PTSD, TBI or moral injury have on a Veteran. We must remember the perceived crises are just as concerning and predictive of suicidal behavior as actual crises.

**Myth:** Suicide is an act of aggression, anger, revenge or selfishness.

**Fact:** Most people who die by suicide do so because they feel they do not belong or are a burden on others. They think that their death will free their loved ones of this burden. Many suicides occur in ways and in places that the person hopes will ease the shock and grief of those they left behind.

**Myth:** Nothing can stop someone once he or she has decided to take his or her own life.

**Fact:** Most people who contemplate suicide are torn. They are in pain and want their suffering to end. They don't necessarily want to die to make that happen. But they can't conceive of another way, and too often their cries for help go unheard.

*Source: American Association of Suicidology*

## **Warning Signs That Your Loved One May Be Thinking about Suicide**

The presence of any, or all, of these symptoms does not mean that your loved one is going to attempt suicide, or that they are even thinking about it. What these signs do mean is that your loved one is having difficulty and that it's time to act.

You need to intervene immediately if they are talking about:

- Killing themselves
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Other possible warning signs, like those listed below, can be more subtle. The potential for suicide risk is greater if a behavior is new or has increased, especially if it's related to a painful event, loss, or change. Pay attention to these behaviors and don't be afraid to ask questions.

- Increased use of alcohol or drugs
- Looking for a way to kill themselves, such as searching online for materials or means
- Acting recklessly
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

*Source: American Foundation for the Prevention of Suicide*

# Preventing Suicide through Communication

## A Checklist for Parents and Families of People Living with Mental Illness to Assist in Communicating with Treatment Providers \*\*

*Created by the Oregon Council of Child and Adolescent Psychiatry, used with permission by NAMI*

**Purpose:** Statistics from the Centers for Disease Control and Prevention (CDC) indicate that more than 44,000 people died by suicide in 2015 (the most recent year for which full data are available) making suicide the 10th leading cause of death in the U.S. The highest rates of suicide occur among people ages 45 – 54 years and second highest among people aged 55 – 64. While unintentional injury is the leading cause of death among young people ages 10-14 years, suicide was the second leading cause of death among youth ages 15-19 years and those ages 20-34 years. In 2015, 49.8% of deaths by suicide involved a firearm, 26.8% were by suffocation and nearly 15.4% were by poisoning (CDC website).

According to the American Foundation for Suicide Prevention (AFSP), no complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm. 494,169 people visited a hospital for injuries due to self-harm. This number suggests that approximately 12 people harm themselves for every reported death by suicide. However, because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. Many suicide attempts, however, go unreported or untreated. Surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm. Females attempt suicide 3 times more often than males. As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide 3 times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly (AFSP website).

Communication between family members of persons seeking treatment for mental illness and primary care providers and/or mental health practitioners improves the quality of care provided to these persons, reduces the risk of suicide and self-harm behaviors, and encourages the use of community resources to improve overall outcomes for these persons. While confidentiality is a fundamental component of a therapeutic relationship, it is not an absolute, and the safety of the patient overrides the duty of confidentiality. Misunderstandings by clinicians about the limitations created by HIPAA, FERPA, and state laws for preserving confidentiality of patients has caused unnecessary concern regarding disclosure of relevant clinical information. Communication between family members or identified significant others and providers needs to be recognized as a clinical best practice and deviations from this should occur only in rare and special circumstances.

To address a perceived deficit of communication, the Oregon Council of Child and Adolescent Psychiatry published a checklist for health providers in 2012. This companion checklist is designed to help family members access information that might be essential to preserving the life of their loved one.

### **Definitions**

**Person involved in treatment:** A person receiving care for a mental illness, which may include a child, sibling, parent, or other person whom you wish to support in treatment services, herein abbreviated to “person.”

**Treatment Services:** May include outpatient therapy, medication management, support groups, or other treatment supports, partial hospitalization, hospitalization, or therapeutic residential treatment programs.

**Provider:** May include primary care providers, emergency room physicians, psychiatrists, nurse practitioners, licensed clinical social workers, licensed professional counselors, or other qualified mental health professionals.

**Family:** May include first-degree biological relatives, adoptive family, foster parent(s), spouse, or other individuals who occupy a similar position in the life of the person involved in treatment.

*\*\* NOTE: If patient is a minor, parents may consult state statutes to determine when the provider may or must disclose patient's information to parents.*

### **For all persons with mental health issues, families should request the following:**

- Has the provider requested that the person sign an authorization to speak with the family? If not, why not? If yes and the person refused, did the provider explain the therapeutic value of speaking with the family?
- Has a comprehensive risk assessment including personal interview with the person, record review, and solicitation of information from the family been completed by the provider or another qualified professional?
- Has the provider or any other professional concluded that the person is at elevated risk of suicide?
- Has the provider reviewed the records of previous mental health providers, and communicated with all others who are involved with the persons' treatment and care (e.g., therapist, family physician, case manager, et al.)?

- You should offer to provide additional history to the provider and tell the provider what you already know about the family member's illness and need for treatment, especially any episode that suggests the potential for self-harm.

**Where an elevated risk of suicide is identified in persons involved in treatment, families have a compelling interest to learn the following:**

- What are the diagnoses and treatment recommendations? How can the family best support the provider's recommendations? Where can one learn more about the illness which has been diagnosed?
- What is the provider's evaluation of suicide risk in this case? What are the particular warning signs (not the same as risk factors) for suicide in this person's situation? What steps should the family take if they see these factors occurring, such as taking the person to the hospital for reassessment? You may wish to ask the provider to help create a plan to monitor and support the family member. What protective factors exist, and how can these be expanded or enhanced for this person?
- What community resources are available to help the family and the person involved in treatment, including resources for case management, peer and family support groups, and improving mental health at home?
- What type of ongoing care is required? Who should provide that care? How can the family access that care?
- What can the family do to best help the person involved in treatment? What should the family not do?
- When the person transitions from one level of care to another or from one provider to another, how will provision of care be coordinated? You may wish to request that the provider assures that follow up is in place with a specific timely appointment, that the accepting provider has full knowledge of history and risk issues/records, and that the original provider confirms that family member has attended the follow up appointment.

**Where the person is at university or similar setting, the family may wish to ask the Dean of Students:**

- What systems are in place to support students living with mental illness and avoid self-harm? Is peer counseling available for the student with mental illness? Are the health service and/or counseling services on call 24/7? If not, what are their hours? Is there a 24-hour number to call in case of emergency?

- Is there an office to intercede with instructors for the student who feels overwhelmed or highly stressed? Will use of these resources imperil any scholarships the student might have?

## Take Warning Signs of Suicide Seriously



### Ask questions:

- Have you been feeling sad or unhappy?
- Do you ever feel hopeless? Does it seem as if things will never get better?
- Do you think about dying?
- Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?
- Do you have any actual plans to kill yourself?
- [If so...] When do you plan to kill yourself?
- Is there anything that would hold you back, such as the effect on someone in our family, a pet or your religious convictions?
- Have you ever made a suicide attempt in the past?
- Would you be willing to talk to someone or ask for help if you felt desperate? Is there a particular person you would you talk to?

**Don't leave them alone**

**Call a suicide crisis line**

**Got to an emergency room or call 911**

**Don't keep suicide warning signs a secret**

### Crisis numbers:

- National Suicide Lifeline at 800-273-TALK (8255)
- Veterans Crisis Line 800-273-8255 press 1

## Guidelines to Help De-Escalate a Crisis



- **Don't threaten.** This may be interpreted as a power play and increase fear or lead to violence.
- **Don't shout.** If the person with the symptoms of a mental health condition seems not to be listening, it isn't because he or she is hard of hearing. Other "voices," thoughts, anxieties or paranoia may be interfering or dominating.
- **Don't criticize.** It will only make matters worse; it can't possibly make things better
- **Don't squabble with other family members** over "best strategies" or who is to blame. This is no time to prove a point.
- **Don't aggravate or provoke your loved** into acting out threats; the consequences could be tragic
- **Don't stand over your loved one** if he or she is seated since this may be experienced as threatening. Instead, seat yourself. However, if a person with a mental health condition is getting increasingly upset and stands up, consider standing up so that if you feel threatened or unsafe, you can quickly leave the room.
- **Avoid direct, continuous eye contact or touching your loved one.** Comply with requests that are reasonable and safe. This provides the person in crisis with an opportunity to feel somewhat "in control."
- **Don't block the doorway.** Don't try to keep your relative in the room if they want to leave. If possible, stay calm. Research suggests that strong expressions of negative emotion may further destabilize individuals with a mental health condition.

*Assistance with this section was provided by Al Horey, Western State Hospital, and Dr. Anand Pandya, MD, NAMI member*

## **Crisis Plan**

### **A Crisis Plan Should Include:**

- Multiple Emergency Contacts – Phone, Cell phone and email
- Physician – Phone
- Psychiatrist – Phone
- Therapist or Counselor – Phone, Cell phone and email
- Case Manager – Phone, Cell phone and email
- Peer Support Specialist – Phone, Cell phone and email
- Current Medications & Dosages
- Allergies (medications, foods, etc.)
- Formal steps to be followed if a crisis reaches a point where outside help must be called
- Plans should include how the other family members will be taken care of, especially if there are children, people requiring 24-hour physical care or frail elderly involved

## **Relapse Plan**

### **A Relapse Plan Should Include:**

#### **Collaboration:**

- The person with the mental illness and the family/support system create and agree on the plan together

#### **Answers to specific questions:**

- How will we know you're going into crisis?
- List signs and symptoms of relapse, mild to severe

#### **What will we do if you go into crisis?**

- When mild symptom appears, we will:
- When more serious symptoms appear, we will:
- When severe/potentially dangerous symptoms appear, we will...

#### **At what point will hospitalization be considered?**

- What action or symptoms would prompt a trip to the ER?
- Which hospital is preferred?

#### **At what point might emergency services or law enforcement be contacted?**

- What action or symptoms would prompt the call?

Section VII; Support for Family Members & Friends.

**Self-Care for Family Members**



## **Life Challenges for Family Members and Caregivers**

### **Life Challenges for the Primary Caregiver** (usually spouses/ partners and parents):

- Getting through crises with your loved one while trying to meet the needs of other family members; coping with inevitable family conflict due to different perspectives, stages of acceptance and coping styles
- Learning how to deal with residual symptoms—social withdrawal, silence, suicidality and/or aggressiveness, apathy, irritability, resistance—on a “permanent” basis
- Trying to stay alert to signs of relapse and taking appropriate action; dealing with police, crisis teams, involuntary commitment; trying to get information and help from mental health professionals; finding services, taking on the primary “case-manager” role on a permanent basis
- Dealing with anxiety about relapse, alcoholism, drugs, the whereabouts of a missing loved one, treatment options, physical safety, pregnancy, nutrition, smoking, etc.
- Finding a way to balance responsibilities of work with responsibilities of care; trying to make life decisions in the face of an uncertain future
- Dealing with the impact that your loved one’s symptoms have upon your own relationship or marriage; loss of intimacy and carefree time together; worry that this primary source of support will be jeopardized or lost
- Dealing with financial worries and plans for future care

### **Life Challenges for the Sibling or Adult Child:**

- Coping with disproportionate attention being given to the sibling or parent who has a mental health condition; growing up in an atmosphere of secrecy, confusion, silence, shame; witnessing terrifying psychotic breaks and personality changes
- Being threatened, frightened or hurt by someone who is supposed to be a caring, protective family member; experiencing the sibling or parent as “bad” rather than as someone who is experiencing symptoms of a mental health condition
- Bearing the social stigma of having a loved one who is viewed as “strange” or “scary”

- Handling the emotional needs of the caretaking parents or the neglected spouse/partner
- Having more chores and responsibility; having to “grow up fast”; pressure to be a “perfect” child to make up for the parent or sibling who has a mental health condition
- Worrying that you caused the disorder, or that you will get the condition, or that you will make the parent or sibling worse
- Worrying about how much you should do for the loved one; worrying about the time when the parent, or parents, die and caretaking will be your responsibility

### **Some Life Challenges for the Spouse/Partner:**

All the primary caregiver challenges plus:

- Coping with loss of an intimate confidant, with the loss of a partner in the household, and often with the loss of a wage earner that the family needs; coping with an undermined sense of partnership in marriage and commitment
- Dealing with the “emotional silence” and sexual distance that occurs when a spouse/partner has a mental health condition; dealing with changed feelings toward the spouse/partner; dealing with ambivalence about divorce, about being frustrated, about being “selfish,” about wanting to have a different, better life
- Taking on the dual role of single-parent and primary caregiver; worries about money, how the mental health condition in the house is affecting the children; coping with all these demands single-handedly, without much recognition or thanks
- Deciding whether to start or expand the family after serious injury or a diagnosis of a mental health condition
- Being the target for lots of anger from your spouse/partner (who doesn’t want to be “treated like a child”) and from your children (who may believe you have the power to “solve” the family dilemma); dealing with lack of feedback that you’re an important and valuable person
- Coping with stigma, social isolation, lack of a peer group of “couples” friends; dealing with pressure or opposition from in-laws

## Principles of Living a Balanced Life

Try taking these positive actions to make life better when a family member has a mental health condition:

- Do as much as you can financially and physically to improve the situation, but don't feel guilty about all you won't be able to do. If it isn't possible to maintain a degree of peace, dignity and wellbeing within the family while the person with a mental health condition lives at home, other arrangements may need to be made. If it's necessary, don't be embarrassed by seeking public support through available social services such as community clinics and state hospitals. You have every right to ask for information and help from the facilities of your state Department of Mental Health. Tax dollars are meant to help those in need of social services.
- Strive for good physical health. Both your loved one and your other family members will benefit from a healthy diet, regular exercise, and a safe living environment.
- Watch your stress level. Don't let yourself burn out. When you feel yourself getting anxious, slow down and take a deep breath. Doing something that stops or changes the direction of your thoughts can be helpful.
- Remember that no life is without stress. Learning how to cope with stress is the key to maintaining balance in life. Look for what gives you peace of mind and enjoy it: a walk on the beach or in the woods, a movie, a play, a good book, a painting, a funny TV show, a conversation with a dear friend, a prayer. The point is to let yourself go, to relax, to let your body and mind renew themselves, thus recharging your energy.
- An effort to maintain social contacts is critical. If a loved one develops a debilitating physical condition—heart disease or cancer, for instance—neighbors, friends and co-workers tend to be very supportive. If the condition is mental, the family involved may feel isolated. The family unit often withdraws, shielding themselves from stigma in society. It's better if they continue to circulate in their community in as normal a way as possible. Families are in a unique position to fight prejudice and fear that surround mental health conditions. If communication exists between families affected by mental health conditions and their neighbors, there is often a great deal of compassion and understanding expressed.

- Seek out and join a support group formed by families of people with mental health conditions. There's much comfort and knowledge shared in such groups. If a group hasn't been formed in your community, you might start one.
- Continue pursuing your own interests. Burying your hopes and desires to focus only on your loved one with a mental health condition will add to the challenges, not diminish them. If you're an artist, continue to draw and paint. If you enjoy woodworking, if you jog, if you're an active club member, continue to do those things that give you pleasure and make your life fulfilling. You will be better able to cope with challenges because you'll still be your own person. Don't let resentment build up in you because you've given up interests and dreams to meet the needs of your loved one. It will do neither one of you any good. Be kind to yourself as well as others.
- Do something for someone else. Our own problems seem less defeating when we're involved in giving support to others.

## Diaphragmatic Breathing

One way to combat burnout and calm yourself is to breathe deeply using your diaphragm!



## Setting Limits

- You are not alone
- Ask for help from family, friends or authorities
- Create and honor healthy boundaries when it comes to psychotic symptoms or behaviors
- Set limits on psychotic behavior and have a plan for what you will and won't tolerate
- Trust your instincts
- Don't ignore concerns about violence and suicide
- Even if you are terrified or angry, approach your loved one with respect
- Acting to protect our loved ones with mental health conditions is the highest form of caring for them
- Acting to keep ourselves clear of danger is the highest form of self-care

## Letting Go



Letting go...

- Is not to cut myself off, but to realize I can't control another person
- Is not to stop caring, but to realize I can't do it for someone else
- Is to allow someone to learn from natural consequences
- Is to recognize when the outcome is not in my hands
- Is not to care for, but to care about
- Is not to fix, but to support
- Is not to judge, but to allow another to be a human being
- Is not to criticize or regulate anybody, but to try to become what I dream I can be
- Is not to expect miracles, but to take each day as it comes, and cherish myself in it
- Is not to regret the past, but to grow and live for the future; to let go is to fear less and love more

## Self-Care

What do flight attendants tell us when we prepare for departure?

- Put on your oxygen mask before you help your child or neighbor!
- Why? So you don't pass out before you can assist others!



A great way to take care of yourself is to attend a NAMI class, support group or presentation!

## Section VIII; NAMI Resources

### **NAMI Programs**

For information about NAMI's education programs, support groups and presentations, please go to [www.nami.org/programs](http://www.nami.org/programs)

### **NAMI Support Groups**



“ I don't know where I'd be without NAMI Connection; it literally saved my life. I'm so grateful for my group and now I just want to share this program with everyone living with a mental illness. ”

**NAMI Connection** is a recovery support group program open to any adult (18+) with a mental health condition. It is designed to connect, encourage, and support participants using a structured support group model in a relaxed setting. Groups are confidential and free to participants, meeting weekly or bi-weekly for 90 minutes. Participants are welcome to attend on a walk-in basis, and no formal diagnosis is required. The support group is offered in Spanish as NAMI Conexión, Grupo de Apoyo y Recuperación in a limited number of states.

**NAMI Connection** groups are:

- Facilitated by trained people with mental health conditions themselves



“ Family Support Group training is essential to the success of our support groups. Without the training.... support groups would become nothing more than “cry” sessions or “gripe” sessions. ”

**NAMI Family Support Group** is a peer-led support group for family members, caregivers and loved ones of individuals with mental illness. This group provides support in a confidential environment and offers insight into the challenges and successes of others. The Spanish-language version of this program, Grupo de Apoyo para Familiares de NAMI, is available in a limited number of states.

**NAMI Family Support Groups** are:

- Facilitated by trained family members with loved ones who have mental health conditions

## NAMI Presentations



Thank you for coming to my school and sharing our story. You have changed my life forever. The things you explained about your depression relate to how I feel. When I got home, I immediately talked to my parents and hopefully I will get some help.

I have had many thoughts of suicide...



**NAMI Ending the Silence (ETS)** is a 50-minute prevention and early intervention program that engages youth in a discussion about mental health. ETS dispels myths, instills a message of hope and recovery and encourages teens to reduce stigma. Teens learn to recognize the early warning signs of mental health conditions and what to do if they or someone they know is showing these signs. ETS presentations for school staff and for families are also available addressing the importance of early intervention and prevention; warning signs and how to address them; communication; strategies to support learning in school and at home.

**NAMI Ending the Silence** is:

- Presented by a 2-person team, one of which is a young adult with a mental health condition



# **nami** In Our Own Voice

National Alliance on Mental Illness

“ After seeing an In Our Own Voice presentation, several of the mental health staff stated that they saw recovery as a real option for the first time ever. ”

**NAMI In Our Own Voice** is an interactive presentation that provides insight into what it's like to live with mental illness. The presentation includes video and discussion. The Spanish-language version of this program, En Nuestra Propia Voz de NAMI, is available in a limited number of states.

**NAMI In Our Own Voice** is:

- Led by two adults with mental health conditions

## NAMI Classes



“ This course has given me a sense of who I am. I understand what is going on with me and I am able to cope. I have gained employment and committed to my recovery. ”

**NAMI Peer-to-Peer** is a free, 8-week recovery course for adults (18+) with a mental health condition. It offers information, skills, resources and a community of support. Participants learn in an environment of respect, understanding, encouragement and hope. Those interested in attending must register. No formal diagnosis is required. Topics covered include the brain and body; diagnoses; communication; relationships; treatment options; working with providers; stress reductions; goal setting and self-awareness. The course is offered in Spanish as De Persona a Persona de NAMI in a limited number of states.

**NAMI Peer-to-Peer** is:

- Led by trained people with mental health conditions themselves



“ I have been working at the hospital for 20 years, and this is one of the best programs I have been through for staff. We have worked hard over the years to create a more humanistic and compassionate culture. This program will definitely help us in that direction. ”

**NAMI Provider** is available as a 5-session course or a 4-hour introductory seminar for healthcare staff. The program offers a fresh understanding of and empathy for the lived experience of the client and the family—especially during treatment. Promotes collaboration between the person with the mental health condition, the family and the health care provider to achieve the best level of recovery possible.

**NAMI Provider** is:

- Led by teaching team that includes a person with a mental health condition who is in recovery, a family member of someone with a mental health condition and a healthcare professional who also has a mental health condition or is a family member



“ This is such a great step by step program that walks parents every step of the way.  
It is as if you are holding their hand through it all. ”

**NAMI Basics** is a 6-session course for parents/caregivers of people younger than 22 years of age experiencing mental health challenges. The program offers practical up-to-date information about mental health conditions and information necessary for effective advocacy with the child’s school and mental health provider. NAMI Basics also teaches problem solving and communication skills. The course is offered in Spanish as Bases y Fundamentos de NAMI in a limited number of states.

**NAMI Basics** is:

- Led by trained family members whose children experience mental health challenges



“ Learning as a family member will allow me to deal with my Dad’s suicide and helping my family cope. Learning as a Service Member and with a mental illness, hopefully I will be able to help my wife and family deal with what goes on with me. The training was so helpful! I appreciate the time and effort that went into this class. It was well worth the time. ”

**NAMI Homefront** is a 6-session course for families, partners and friends of military Service Members and Veterans. The course consists of 2-hour classes designed to help military/Veteran families understand mental health conditions and improve their ability to support their Service Member. Some of the topics covered are mental health diagnoses including PTSD and TBI, treatment options, crisis management, communication skills, the impact of combat stress and moral injury, the stigma associated with seeking mental health treatment while serving in the military and services available to both active duty personnel and Veterans. NAMI Homefront is also available online, taught live in a virtual classroom. The online classes have removed some of the barriers presented by geography, caregiving responsibilities (for families with wounded warriors and/or children) and opened the course to active duty military families concerned that attending a traditional class might jeopardize the career of a Service Member.

**NAMI Homefront** is:

- Led by trained military/Veteran family members with loved ones who have mental health conditions

“ The course should be on every psychiatrist prescription pad for families for their loved ones. A lot of heartache would be spared. ”

**NAMI Family-to-Family** is a 12-session course for families, partners and friends of people with mental health conditions. The course is designed to help participants gain a better understanding of mental health conditions, improve communication techniques, enhance coping skills and become effective advocates for their loved one. It was designated as an evidence-based program by SAMHSA (the Substance Abuse and Mental Health Services Administration) in 2013. The course is offered in Spanish as De Familia a Familia de NAMI in a limited number of states.

**NAMI Family-to-Family** is:

- Led by trained family members with loved ones who have mental health conditions

## IMPACT of NAMI Programs



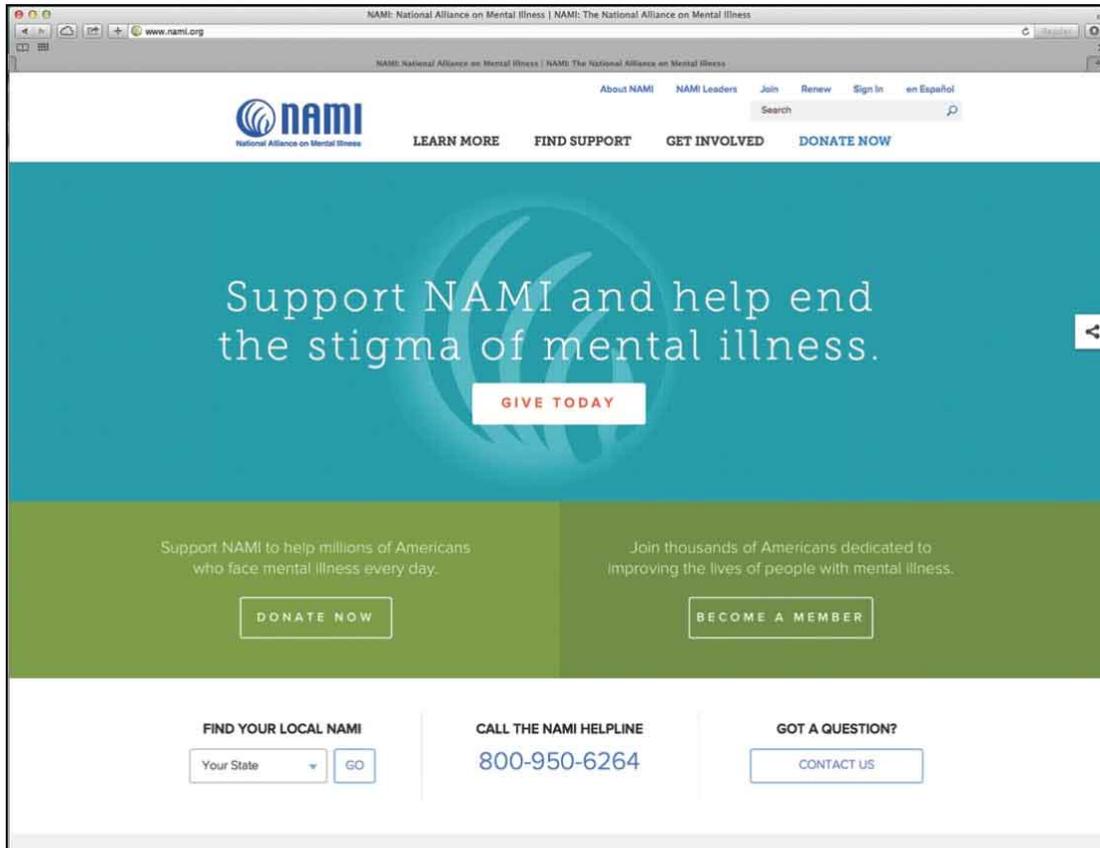
## Never Lose Hope!



Remember:

- **YOU ARE NOT ALONE!**
- Mental health conditions are **MEDICAL CONDITIONS**
- It's **NOT** anyone's fault
- Know the **WARNING SIGNS**
- **RECOVERY** is possible, there is **HOPE**
- **LANGUAGE MATTERS!** You can fight stigma by changing how you talk about mental health conditions. Instead of saying "she is bipolar," you can say "she has bipolar." As we know, a person is more than their diagnosis!

# www.nami.org



<http://www.nami.org/>

## References

Material from the following NAMI programs was incorporated into this seminar: NAMI Basics, NAMI Ending the Silence, NAMI Family-to-Family, NAMI Homefront, NAMI In Our Own Voice and NAMI Peer-to-Peer. Complete references for source material can be found in the manuals for each of the programs listed please contact NAMI for details.

Material from the following websites was referenced in this seminar:

- NAMI (National Alliance on Mental Illness) [www.nami.org](http://www.nami.org)
- SAMHSA (Substance Abuse and Mental Health Services Administration) [www.samhsa.gov](http://www.samhsa.gov)
- NIMH (National Institute of Mental Health) [www.nimh.nih.gov](http://www.nimh.nih.gov)
- VA (U.S. Department of Veterans Affairs) [www.va.gov](http://www.va.gov)

