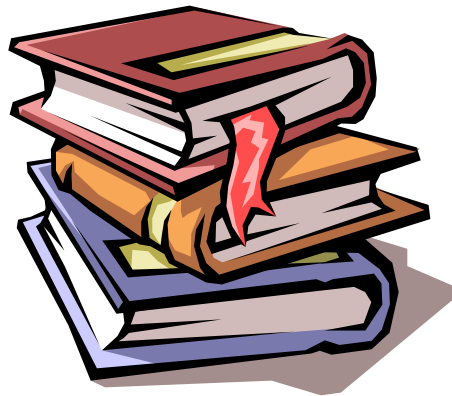


PEER SUPPORT TRAINING MANUAL



**Guideline for peer support training in the
Okanagan Health Service Area**

Introduction to the Peer Support Training Manual

The CMHA Consumer Development Project (CDP) based in Kelowna, is funded by the Interior Health Authority. The CDP is currently contracted to complete projects and provide information that will support consumers and mental health communities in the Okanagan region.

The Project began in 1992 in an effort to encourage and support consumer involvement in mental health planning and decision making throughout the Thompson, Okanagan and Kootenay area. Over the years, this Project has provided on-the-job training in mentoring and community development for staff with first-hand experience with mental illness to build a strong informed and coordinated network of consumers.

Sometimes the simplest concepts are the most profound. The CDP strives to build relationships and treat other people and their opinions with respect. It is our fundamental belief that people can and should be encouraged to speak on their own behalf. Our role is to ensure that people have opportunities and support to develop the skills to do so.

The CDP has evolved to become a leader and champion in a recovery vision of service with the idea that one of the essential roles of the mental health system is to support individuals to connect with appropriate services within the mental health system as well as build supports in other areas of their lives through personal, social, environmental and spiritual connections. We strive to bring alive the concepts of the Framework for Support, CMHA's guiding principles. A recovery vision of service is grounded in the idea that people can recover from mental illness when they play an active and empowered role in their journey.

We aim to influence policy and encourage good practice in mental health services through a coordinated program of information exchange, advocacy, training and development that focuses on recovery of the individual and that builds strength in groups and communities. Our Project strives to demystify complex issues influencing people with mental illness in communities throughout the Interior Health Authority and create and support structures such as the Consumer Facilitation Councils, Interior Health Regional Consumer Council that meaningfully involve people with mental illness in positive systemic change.

Charly Sinclair – Co-facilitator/author

My interest in peer support began in 1997 when I was a member of the advisory committee for Kelowna's peer support program, PepTalk. In 2001, the Consumer Development Project was contacted by the Mental Health Services Division to assist with the development of the Peer Support Resource Manual for peer support programs in British Columbia. I took the lead on that project and learned much about the evolution of peer support in BC. This process involved consumers from communities throughout BC who were interested and had some expertise with peer support as a best practice for consumer involvement.

In 2003, I was contacted by the Salmon Arm Peer Support program to assist with their training process. I looked for resources to assist me and found that while there were many experts throughout the province, there was an inconsistency in the training materials. As part of my role with Consumer Development, we decided to collect the best of the information available, do some additional research and package it so that future peer support volunteers and staff would have a standardized, easy to use training resource. Our goal was to create a baseline of information and allow communities to build on it as needed.

I wish to thank Maurizio Baldini from Penticton Peer Support program, Stephanie Hide, Kelowna PepTalk, Patricia Harding and Ron Nichol from Vernon Peer Support Services and Tanya Seibel from Salmon Arm Peer Support, for their expert advice and time they spent reviewing and critiquing the material and working with me to make this a valuable resource.

I am sure there are many more things that could be included in this training manual. It's meant to provide the reader with a start. We hope that you will add to it so that it fits with your community. We are always interested in hearing from you. Please let us know if you have found this document helpful.

The following resources were used to compile this manual

- ❑ Peer Support Worker Training Manual for Consumers of Mental Health Services, written by Angela Neuhausler; edited by Judith Lange; 1995
- ❑ PEPTalk, Central Okanagan Peer Support Training Manual
- ❑ Peer Support Resource Manual; BC Ministry of Health Services; July 2001
- ❑ Maurizio Baldini, Coordinator Peer Support Program Okanagan Similkameen
- ❑ Coordinators of the Vernon Peer Outreach Program
- ❑ BRIDGES course taught by consumers to consumers about mental illness and how to cope and manage recovery. (BCSS Provincial program)

Sincere thank you to everyone who has contributed information for this manual.

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Introduction – Principles of Peer Support

- ☞ Peer support includes all necessary activities and actions that help improve / enhance another consumer's / survivor's recovery of quality of life and ability to cope with daily life and set and achieve goals. Individual requirements vary but activities may include going for walks, shopping, help with completing forms, etc.
- ☞ Peer support is a helping relationship between consumers / survivors that promotes respect, trust and warmth and empowers individuals to make changes and decisions to enhance their lives.

Basic Assumptions about Peer Support

- ✓ Peer supporters are consumers/survivors
- ✓ All people with mental illness, like the general population, have diversity in skills, characteristics, talents and abilities;
- ✓ Not every consumer/survivor has the stability and ability to be a good peer supporter;
- ✓ Not every consumer/survivor wants to be a peer supporter or to be involved with peer support;
- ✓ Professional support/input needs to be available when requested; and,
- ✓ The mental health system needs to fund peer support adequately.

(Excerpt from the Peer Support Resource Manual, BC Ministry of Health Services 2001)

Fundamental elements for peer support training:

Trainers – are the person(s) who will be conducting the training sessions. This may be someone who is hired specifically for training of volunteers, or the program coordinator if there is one. Whoever does the training needs to have a good understanding of the goals, objectives and policies of the peer support program in their area, is skilled in communication and able to facilitate a group. It is suggested that there be 2 people involved in the training in order to provide support to each other, and the people being trained. Guest speakers (e.g. a pharmacist, person living with a specific mental illness) provide expertise in a specific area. This also provides an opportunity for variety in the format of the training sessions.

Class size – class size will vary according to the number of people who are available to take the training. Suggestion is that classes be kept to a minimum of 6 and a maximum of 12 participants. This is large enough to allow for breaking out into groups for exercises, but not too large so as to become overwhelming.

Facilities needed - it is important to pick a site that is accessible for everyone. This means that the location must be able to be reached by bus, or be within easy walking distance of the majority of participants. The site must also be wheelchair accessible, and in a place where people feel comfortable going.

There needs to be enough space to allow the group to break into smaller sizes for peer support exercises. If possible, it is helpful to have a couple of smaller rooms available.

Length of course and classes – the course was designed for 13 sessions. It is up to individual programs to decide whether they want to organize the sessions once, twice or three times a week. Each session has been organized to take 3 hours. It is recommended that this is the maximum time for each session, and it is up to the trainers to manage the time effectively. Each session outline has suggested time periods for each section. Individual trainers will want to consider prior to the course, and decide if they fit with their needs.

Materials Needed – instructors will need to have an easel with a pad of paper, or a blackboard with chalk and eraser. You will also need to have nametags for each of the trainers, trainees and any guests; pens and/or pencils for everyone, and pads of paper. Trainers will need to prepare certificates for everyone who finishes the training. Each group should have a list of resources available in their region for people with mental health issues.

SECTION 1:

BASICS OF

PEER SUPPORT

Session 1

(15 Minutes) Introduction: facilitators and participants

(10 minutes) Guidelines i.e. confidentiality, attendance, assignments, smoking, etc.

(10 minutes) Course outline

(50 minutes) Group Discussion: “What is Peer Support?”; hopes, concerns, goals for training

(15 minutes) Break

(45 minute) Egan’s Helping Model

(15 minutes) Break

(15 minutes) Positive Thinking

(5 minutes) Homework: Why Visit?

Session 2

(10 minutes) Discussion of homework using list of possible responses.

(20 Minutes) The Helpful Responses (Empathy) Questionnaire

(15 minutes) Perception exercise or Dot exercise

(15 minutes) Break

(45 minutes) Beliefs and values

(30 minutes) Legal Considerations; Summary of Duties;

(15 minutes) Break

(20 minutes) Confidentiality

(15 minutes) Helper role-play

(5 minutes) Homework: Self-Assessment handout

Session 3

(45 minutes) Group Discussion of Working Values in the Helping Relationship

(15 minutes) Attending Skills

(15 minute) Break

(15 minutes) Active Listening

(5 minutes) Poem *I believe...*

(10 minutes) The Skill of Paraphrasing

(15 minute) Break

(55 minutes) Active Listening Exercise

(5 minutes) Homework -The First Visit

Session 4

(5 minutes) Poem “*Listen*”

(20 minutes) Accurate Empathy
Conveyance of Ownership in empathy
Uses of empathy

(10 minutes) Non-empathetic statements

(15 minutes) Probing
Open Questions

(10 minutes) Trainers role model to the group the skills of empathy and probing.

(15 minutes) Break

(45 minutes) Accurate Empathy and Probing Exercise

(15 minutes) Break

(45 minutes) Peer Support Exercise

Session 5

(10minutes) Giving Information

(10 minutes) Self-Disclosure

(10 minutes) Role model giving information and self-disclosure

(45 minutes) Boundaries

(15 minutes) Break

(30 minutes) Peer Support Exercise

(15 minutes) Summarizing

(15 minutes) Break

(30 minutes) Peer Support Exercise

Session 6

(25 minutes) Brainstorming

(10 minutes) Goal setting

Developing strategies and action plans

(15 minutes) Break

(45 minutes) Peer support exercise

(10 minutes) Guidelines for choosing issues/problems

The brainstorming and balance sheet technique

(15 minutes) Break

(60 minutes) Peer support exercise

Session 7

(60 minutes) Recovery

(15 minutes) Break

(60 minutes) Anxiety Disorders – including panic disorders, panic attack, coping skills, phobic neuroses, OCD, Post-traumatic stress disorder and generalized anxiety disorder

(15 minutes) Break

(15 minutes) Eating Disorders

(30 minutes) Peer support exercise

Session 8

(60 minutes) Spirituality and Mental Illness

(15 minutes) Break

(60 minutes) Mood Disorder – characteristics of a depressive episode, characteristics of a manic episode, pharmacological treatment of mood disorders

(15 minutes) Break

(30 minutes) Peer support exercise

Session 9

(60 minutes) Anger Management

(15 minutes) Break

(60 minutes) Personality Disorders

(15 minutes) Break

(30 minutes) Peer Support Exercise

Session 10

(45 minutes) Stress and Stress Management

(15 minutes) Break

(90 minutes) Schizophrenia and Other Psychotic Disorders

(15 minutes) Break

(30 minutes) Peer Support Exercise

Session 11

(15 minutes) Ask group to discuss their personal attitudes towards prescription drugs and experience with addiction.

(45 minutes) Prescription Drugs

(15 minutes) Break

(45 minutes) Addiction

(15 minutes) Break

(45 minutes) Peer Support Exercise

Session 12

(60 minutes) Suicide

(15 minutes) Break

(30 minutes) Peer Support Exercise

(30 minutes) Loss and the Grieving Process

(15 minutes) Break

(45 minutes) Peer Support Exercise

Session 13

(30 minutes) Ending the helping relationship

(45 minutes) Peer support exercise

(15 minutes) Break

(30 minutes) Helpful responses questionnaire

(15 minutes) Fill out course evaluation

(45 minutes) Wrap up

SESSION 1

Introduction of facilitators and participants (15 minutes)

Purpose

- To get to know one other person in the group and pass the information on to everyone.

Method

- Divide the group into pairs. Give each person a pad of paper and pencil or pen. Each pair go to a separate area of the room and get answers to the following questions: (questions and answers may be written down)
 1. Name
 2. Where they grew up
 3. Their greatest accomplishment
 4. Their most prized possession
 5. What they like to do in their spare time
- After about 10 minutes (5 minutes for each person) call the group back together. Each pair will take turns introducing each other to the group.

Guidelines (10 minutes)

- Discuss the basic guidelines, which include:
(Group members need to agree to the guidelines)*
 - ✓ Confidentiality
 - ✓ Attendance
 - ✓ Assignments
 - ✓ Smoking
 - ✓ Breaks
 - ✓ Group behaviour
- Write guidelines on easel and post at each session.

*A possible set of guidelines is set out in Handout 1, page 17.

Course Outline (10 minutes)

Trainers will present the outline for the course, and distribute any policy and procedure manuals that have been developed for their specific geographical area. (Give all the trainees a copy of the course outline Handout 2, page 18)

Group Discussion (50 minutes)

Purpose

- To allow the members of the group to express any concerns they may have about the peer support training; develop personal and group goals for the training sessions.

Method

Three groups are formed and each group will discuss the following topics:

- ✓ hopes for the training
- ✓ fears about the training
- ✓ goals for the training, both as a group and individually

(Have the groups move to separate areas in order to have their discussions.)

- Each group chooses someone to record the ideas and present them to the class at the end of the exercise.
- After about 30 minutes the recorders are asked to share their information with the rest of the group.
- Trainers will discuss with the group the hopes, fears and goals created by the members. Everyone develops a list of group goals; trainers need to review these occasionally to make sure the group is on track with them. (Take approximately 30 minutes for this portion)

Break 15 minutes

Egan's Helping Model (45 minutes)

Purpose

- To provide trainees with an example of a helping model that can be useful for peer supporters.

Method

- Egan's Helping Model (Handout 3, page 21) containing three stages to the helping process is read and discussed; a copy may be distributed at the trainers' discretion.

Break (15 minutes)

Positive Thinking (15 minutes)

- To encourage positive thinking in the peer supporters, and evaluate their overall attitude towards other people and situations.

Method

- Handout 4 – Positive Works (page 22) is read, and trainees are asked to answer a survey – *Am I Positively Charged?*
- Each trainee adds up their scores, and the facilitators rate them according to the scale given in the handout.
- A short recap about attitudes (remainder of handout 4) is read.

Homework (5 minutes)

Purpose

- To have potential peer supporters think about how visiting with a peer will benefit them and the person they are supporting.

Method

- Trainees are instructed to answer the question “**Why visit?**” They are asked to look at this question in the role of a peer supporter, and what someone who is receiving support might answer.

Handout 1

Group Guidelines

1. Promptness – the class will start and finish on time. Please be punctual.
2. Let the group and the trainer(s) know if you can't come to a class or if you are dropping out.
3. To receive a completion certificate at the end of the program, you cannot miss more than two (2) sessions.
4. Confidentiality must be respected at all times. What is said in class stays in class.
5. Participation is welcomed. Respect everyone's airtime.
6. Breaks will be kept to 15 minutes with one break each class.
7. Please refrain from wearing strong perfumes or colognes.
8. Assigned homework must be completed before the beginning of the next class.
9. Relax, have fun and enjoy yourself!

Handout 2

Course Outline

Each session is designed to be 3 hours long, with two 15-minute breaks. The trainer may vary the time of an exercise as needed, but needs to keep the total session time to 3 hours. Each session has a mixed format, with lecture, interactive discussion, and skill exercises.

Session 1

- Introduction
- Guidelines
- Course Outline
- Group Discussion – What is Peer Support?
- Egan's Helping Model
- Positive Thinking
- Homework – Why Visit

Session 2

- Discussion about previous session's homework
- The Helpful Responses Questionnaire
- Perception exercise
- Legal Considerations; Summary of Duties
- Confidentiality
- Helper role-play
- Homework – Self-Assessment handout

Session 3

- Discussion of working values in the helping relationship
- Attending Skills
- Active Listening
- Poem – *I believe*
- The Skill of Paraphrasing
- Active Listening Exercise
- Homework – The First Visit

Session 4

- Poem – *Listen*
- Accurate empathy; owning your feelings; uses of empathy
- Probing; open ended questions
- Role model skills of empathy and probing
- Accurate empathy and probing exercise
- Peer support exercise

Session 5

- Giving information
- Self-disclosure
- Role model information giving and self-disclosure
- Boundaries
- Peer support exercise
- Summarizing
- Peer support exercise

Session 6

- Brainstorming
- Goal setting; developing strategies and action plans
- Peer Support exercise
- Guidelines for choosing issues/problems; brainstorming and balance sheet technique
- Peer support exercise

Session 7

- Recovery
- Anxiety disorders
- Eating disorders
- Peer support exercise

Session 8

- Spirituality and mental illness
- Mood disorders
- Peer support exercise

Session 9

- Anger management
- Peer support exercise
- Personality disorders
- Peer support exercise

Session 10

- Stress and stress management
- Schizophrenia and other psychotic disorders
- Peer support exercise

Session 11

- Discussion of personal attitudes towards prescription drugs and experience with addictions
- Prescription drugs
- Addiction
- Peer support exercise

Session 12

- Suicide
- Peer support exercise
- Loss and the grieving process
- Peer support exercise

Session 13

- Ending the helping relationship
- Peer support exercise
- Helpful responses questionnaire
- Course evaluation
- Wrap-up

Handout 3

Egan's Helping Model¹

According to Egan's Helping Model, there are three stages to the helping process. These stages are as follows:

Stage 1 – Exploring the Present State of Affairs

The first step of Stage 1 is for the peer supporter to help the individual look at, identify and clarify the problem areas in the peer's life.

- ◆ This step involves helping the person to focus on his/her main concerns and to talk about them in terms of real feelings, experiences, and behaviours.
- ◆ The second step of Stage 1 is helping the person to develop new perspectives on his/her problems. The skilled supporter helps the individual become more objective about his/her problem situations.

Stage 2 – Developing a Preferred Scenario

During Stage 2, the supporter helps the individual develop a vision of a better future and begin to plan actual changes that are necessary to make it happen.

- ◆ In other words, the peer supporter helps the individual set realistic goals for change and commitment for action to attain those goals.

Stage 3 – Formulating Strategies and Plans

During Stage 3, the peer supporter helps the person brainstorm a range of approaches for reaching the desired goals and then helps him/her put together solid action plans that are realistic in terms of the resources available.

¹ Neuhausler, Angela, Peer Support Worker Training Manual for Consumers of Mental Health Services; edited by Judith Lange; 1995

Handout 4

Positive Works!

(Excerpt adapted from *Positive Works*, a publication by Alberta Career Development and Employment.)

Positive attitudes make life – more exciting. No matter what we do, attitudes go a long way toward making life a joy or a pain. Friendliness, cooperation and dependability make life easier. Days pass quickly and our environment should be pleasant places to be. Positive attitudes are emotional lifts that give an optimistic outlook to life in general.

Being Positive

Being positive works! It helps us thrive. Having a positive approach can help us make lives more satisfying, and can fulfill many of our personal needs.

Being with positive people can make us feel good because their “positiveness” is infectious – for some, we could even say it’s explosive! When we are with these positive people, we often feel their energy; there’s excitement in the air. They get us charged up, feeling great and ready to tackle anything. Having a positive outlook makes us more exhilarating and dynamic to be around as well. These positive charges easily rub off on others. **You** can have that same thrilling effect on people.

Being negative, on the other hand, is an emotional drain that deflates those around us and us. Such attitudes can make us feel unhappy and unfulfilled. Since our personal outlook affects our work and our lives in so many ways, let’s **make our attitudes work for us, not against us**.

Not surprisingly, when things are difficult, it might be hard to be positive at all. Dealing with tough problems or situations can make it difficult for us to focus on any activity and often takes away our ability to be positive. By taking a closer look at our situation, we may see where and how we could become more positive. And being more positive can help us cope with and maybe even resolve those problems.

To determine if your attitudes are working for you and not against you, try the following survey, **Am I Positively Charged?** And see for yourself.

Am I Positively Charged

From *Positive Works*, a publication by Alberta Career Development and Employment.

Here's an opportunity for you to evaluate your attitude toward others and the situations you may find yourself in. This survey may help you to assess how positive or negative you tend to be overall, and determine if any areas need some attention. Beside each question, write the number that most closely represents your answer most of the time. **Go with your first reaction!**

3 – Mostly Yes

2 - Sometimes

1 – Mostly No

1. ____ Am I friendly?
2. ____ Do I refrain from being a complainer?
3. ____ Can I be optimistic when others are depressed?
4. ____ Do I have a sense of duty and responsibility?
5. ____ Do I control my temper?
6. ____ Do I speak well of my employer?
7. ____ Do I feel well most of the time?
8. ____ Do I follow directions willingly, asking questions when necessary?
9. ____ Do I keep promises?
10. ____ Do I organize my work and keep up with it?
11. ____ Do I readily admit my mistakes?
12. ____ Is it easy for me to like nearly everyone?
13. ____ Can I stick to a tiresome task without being prodded?
14. ____ Do I realize my weaknesses and attempt to correct them?
15. ____ Can I take being teased?
16. ____ Do I avoid feeling sorry for myself?
17. ____ Am I courteous to others?
18. ____ Am I neat in my personal appearance and work habits?
19. ____ Do I respect the opinions of others?
20. ____ Can I adapt to new and unexpected situations readily?
21. ____ Am I tolerant of other people's beliefs?
22. ____ Do I refrain from sulking when things go differently than I'd like?
23. ____ Am I a good listener?
24. ____ Am I the kind of friend I would like others to be?
25. ____ Can I disagree without being disagreeable?
26. ____ Am I normally punctual?
27. ____ Do I consider myself a courteous driver?
28. ____ Do I generally speak well of others?
29. ____ Can I take criticism without being resentful or feeling hurt?
30. ____ Do I generally look at the bright side of things?
31. ____ Can I work with someone I dislike?
32. ____ Am I pleasant to others even when I feel displeased about something?
33. ____ Am I enthusiastic about the interests of others?
34. ____ Do I tend to be enthusiastic about whatever I do?
35. ____ Am I honest and sincere with others?
- ____ Total

Scoring: There are 35 questions; the maximum score would be 105. Total your score and rate yourself according the following scale:

95 – 105 your positives are terrific! 75 – 94 your positives are definitely admirable!

45 – 74 your positives need more polish in certain areas.

Below 45 Your positives have almost fizzled out. Take a close look at your attitude. You may need to pay particular attention to those questions you answered with a 1. Can you see any room for improvement there?

SESSION 2

Discussion of Homework (10 minutes)

Method

- The trainees will be asked to read their answers to the homework question – “Why Visit?”
- One of the trainers will write the answers down on an easel pad.
- The group will compare their answers with the answers supplied in Handout 5, page 29.

The Helpful Responses Questionnaire (20 minutes)

Purpose

- To provide a base line of the capabilities trainees have prior to the training. A comparison will be made at the end of the training course.

Method

- The Helpful Responses Questionnaire (Handout 6, page 30) is distributed.
- Trainees are asked to give short responses to the scenarios given in the questionnaire. Questionnaires need to have the trainee’s name and date written on them.
- After approximately 20 minutes the facilitators will gather the questionnaires, and save them for comparison with a questionnaire completed at the last class.

Perception Exercise (15 minutes)

Purpose

- To show how people see the same things differently according to their own perceptions.

Method

- Each participant is given the perception handouts provided in Handout 7, page 32
- Everyone is asked to work alone on this exercise, and record their view of the two diagrams they are given.
- After a few minutes, the trainers ask people what they saw on each image.

- The trainers lead a discussion on how important it is for peer supporters to understand that people see things differently. It is necessary for peer supporters to be able to see situations from the other person's perspective.

OR

Dot Exercise (15 minutes)

Purpose

- To experience how fixed beliefs and values can interfere with creative thinking.

Method

- Divide participants into 3 groups (size will depend on the number of participants)
- Inform the groups that their task is to solve a riddle.
- Give each group a copy of the Dot Exercise handout. (Handout 8, page 34)
- Ask anyone who is familiar with the exercise to refrain from giving the solution, and act as an observer.
- Instruct each group that the task is to connect all nine dots with only four straight and connected lines.
- After ten minutes, give each group a copy of the solution. (Handout 8, page 35)
- Discuss with the trainees how sometimes people need help in looking at their problems from a different perspective in order to see different options.

Break – 15 minutes

Beliefs and Values (45 minutes)

Purpose

- To encourage participants to be aware of how the beliefs and values that people have influence the decisions they make.

Method

- Read Handout 9, page 36 – Beliefs and Values
- Provide trainees with an opportunity to discuss the information they have just heard.
- Trainers encourage the group to express their opinions about the material on beliefs and values.

Legal Considerations and Summary of Duties (30 minutes)

Purpose

- To give the trainees an understanding of the legal obligations as peer supporters.
- To provide an opportunity for trainees to discuss and understand the roles of a peer supporter.

Method

- Read Handout 10 (page 38) – Legal Considerations.
- Read Handout 11 (page 39) – Summary of Duties and discuss with the group.

Break (15 minutes)

Confidentiality (20 minutes)

Purpose

- To discuss the importance of confidentiality in the peer support relationship

Method

- Write the following on the flip chart as a starting point for the following discussion.

CONFIDENTIALITY IS THE CORNERSTONE OF TRUST

- Read the following scenario, and ask the group to discuss if and how confidentiality was breached.

Jane is a peer supporter meeting with her peer at Tim Horton's when Sally a friend of hers comes up and starts talking to her.

"Hi Jane, whatcha up to?"

"Hey Sally, I'm just hanging out, doing my peer support stuff. This is Paula, my peer. We're having a meeting right now, so I'll call you later."

- Lead a discussion with the group about how important it is to maintain confidentiality, and what this means. This is especially important in smaller communities, where people are more likely to know more of the people.

Watch for: (ask for examples where possible)

- Using a person's name where someone can hear it and draw conclusions
- Talking with other people about the individual
- When/if confidentiality can and should be broken
- Giving information that would let people recognize a person

Helper Role Play (15 minutes)

Purpose

- To demonstrate the impact of “good” vs. “bad” listening skills in the helping relationship.

Method

- Divide group into pairs. Take one member of each pair to a separate area and give each person a set of the following instructions. Explain that the idea is for the person to exaggerate the “bad” listening role to provide a clear picture of what makes for a poor listener. Have people rejoin their partners.
- Each pair goes to a private area of the room to complete the exercise.
- ◆ For the first five minutes you will start the role-playing by being a peer supporter and your partner will be the peer. You will be a peer supporter who does the following: (“bad” listener)
 - ✓ Makes little eye-contact with your partner, looks around the room or anywhere but at them
 - ✓ Moves about nervously in your chair like rocking back and forth or swinging a leg
 - ✓ After approximately 3 minutes you move closer to your partner (to within 3 feet) and stare at them.
 - ✓ Gives any verbal responses that you feel are appropriate.
- ◆ After about 5 minutes, you will get a signal to switch roles and become a peer supporter who does the following: (“good” listener)
 - ✓ Makes good eye contact with your partner.
 - ✓ Sits in an open posture, avoid crossing arms or legs.
 - ✓ Leans slightly forward towards the other person at some points during conversation; does not get too close.
 - ✓ Gives responses that paraphrase what your partner is telling you. (Repeats what they have just told you in your own words)
- After about five minutes, signal the individuals to stop and return to the group.
- Talk with the trainees to see how they felt with each of their roles.

Homework (5 minutes)

Purpose

- To give trainees the chance to review some of their strengths and weaknesses and look at what peer support means to them.

Method

- Distribute “Self-Assessment for Outreach Volunteers” (Handout 12, page 40)
- The handout is to be filled out for homework, and volunteers may keep their answers private.

Handout 5

Why Visit?

Benefits to the participant:	Benefits to you:
▪ Exposure to illness management skills that work for others	▪ Experience of training as well as visiting
▪ Friendship	▪ Learn to co-operate better
▪ Neutral/real person to talk to (doesn't view you as a file number)	▪ Sense of pride and accomplishment with friends and family
▪ Sense of worth	▪ Self-esteem builder
▪ Social skills	▪ Provides a true sense of worth
▪ Confidence builder	▪ Honorariums
▪ Comfort	▪ Work-type experience
▪ Compassion	▪ Learn about yourself
▪ HOPE	▪ Teaching others
▪ SUPPORT	▪ Character builder
▪ Sense of humor	▪ Friendship
▪ Better understanding of what help is available	▪ Putting back into the community
▪ Someone who can relate	▪ Helping yourself to stay well and mentally stable
▪ Exposed to a different perspective of the illness	▪ Sharing your experiences and knowledge with others who might benefit from it.

"It is one of the beautiful compensations of this life that no one can sincerely try to help another without helping himself"

- ____ Charles Dudley Warner

Handout 6

The Helpful Responses (empathy) Questionnaire

Pre and Post Training Feedback

Instruction: The following six paragraphs are things that a person might say to you. For each paragraph imagine that someone you know is talking to you and explaining a problem that he or she is having. You want to help by saying the right thing. Think about each paragraph as if you were really in the situation, with that person talking to you. In each case write the next thing that you would say if you wanted to be helpful. Write only one or two sentences for each situation. Please print or write clearly.

1. A 41-year-old woman says to you: "Last night Joe got really drunk and he came home late and we had a big fight. He yelled at me and I yelled back and then he hit me really hard! He broke a window and the TV set too! It was like he was crazy. I just don't know what to do!"

Your response: _____

2. A 36-year-old man tells you: "My neighbour is really a pain. He's always over here bothering us or borrowing things that he never returns. Sometimes he calls us late at night after we've gone to bed and I really feel like telling him to get lost."

Your response: _____

3. A 15-year-old girl tells you: "I'm really mixed up. A lot of my friends, they stay out real late and do things their parents don't know about. They always want me to come along and I don't want them to think I'm weird or something, but I don't know what would happen if I went along either."

Your response: _____

4. A 35-year-old parent says: "My Maria is a good girl. She's never been in trouble, but I worry about her. Lately she wants to stay out later and later and sometimes I don't know where she is. She just had her ears pierced without asking me! And some of the friends she brings home.... Well, I've told her again and again to stay away from that kind. They're no good for her, but she won't listen."

Your response: _____

5. A 43-year-old man says: "I really feel awful. Last night I got drunk again and I don't even remember what I did. This morning I found out that the screen of the television is busted and I think I probably did it, but my wife isn't talking to me. I don't think I'm an alcoholic, you know, because I can go for weeks without drinking. But this has got to change."

Your response: _____

6. A 59-year-old unemployed teacher tells you: "My life just doesn't seem worth living anymore. I'm a lousy father. I can't get a job. Nothing good ever happens to me. Everything I try to do turns rotten. Sometimes I wonder whether it's worth it."

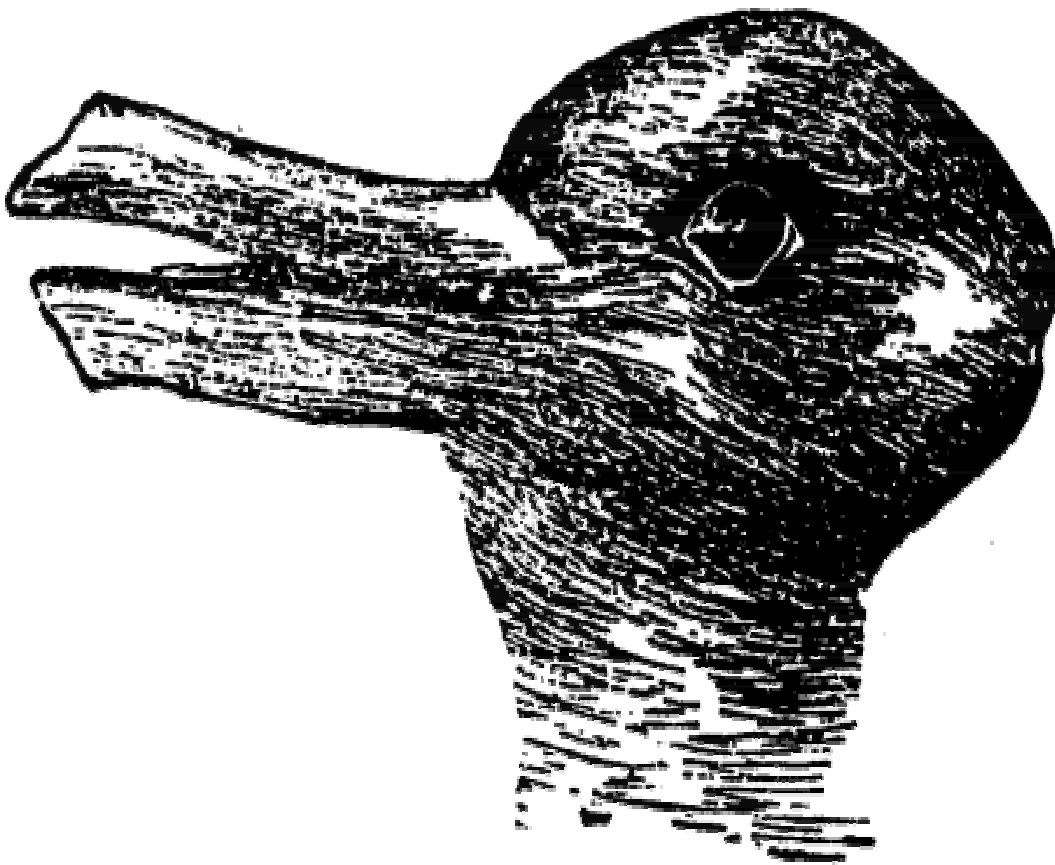
Your response: _____

Name _____ Date _____

Handout 7



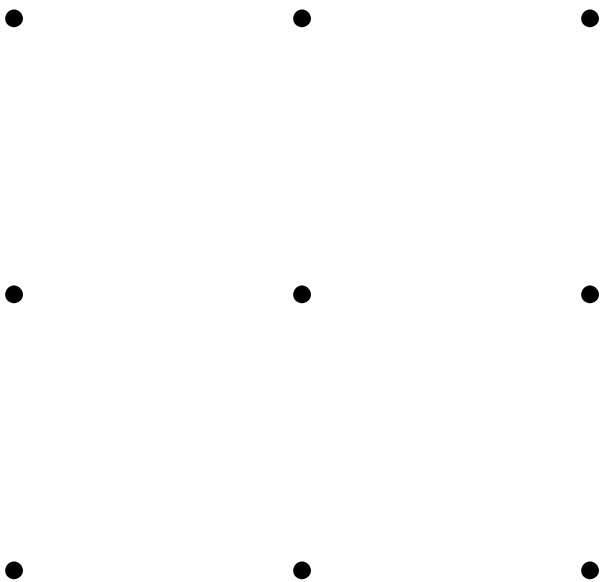
Handout 7 (continued)



Handout 8

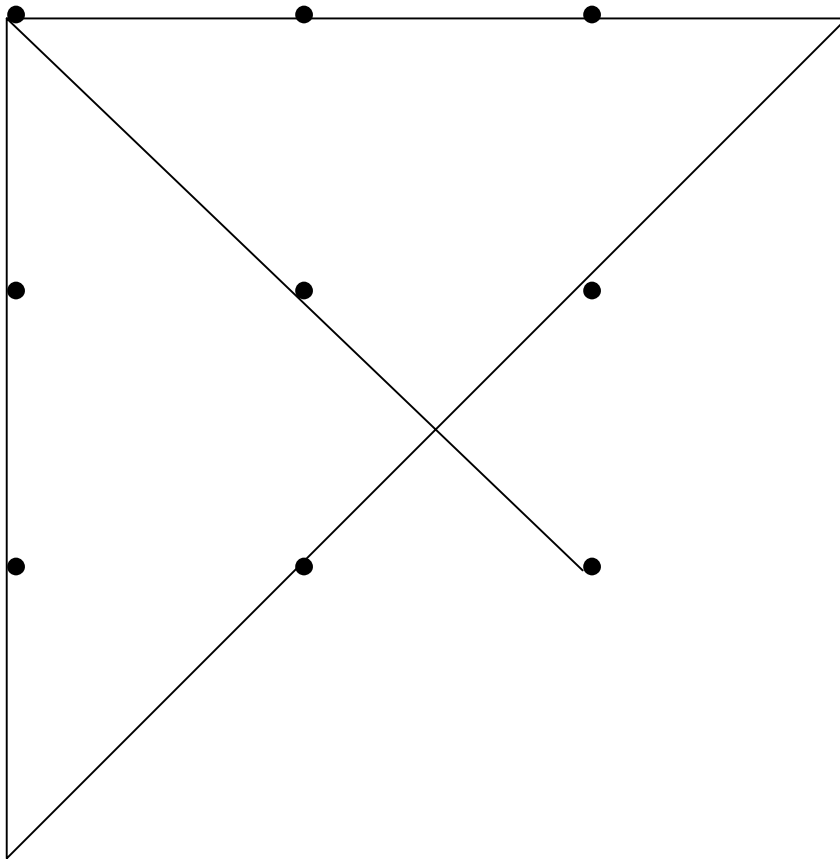
Dot Exercise

GOAL: To work together to find a way to connect all nine dots with only four, straight connected continuous lines.



Handout 8 continued

Dot Exercise Solution



Handout 9

Beliefs and Values

- Beliefs and values strongly influence the choices individuals make and their resulting behaviour. **For example**, someone who does not believe in abortion will not consider that as an option for an unwanted pregnancy and would most likely choose to keep the baby or give it up for adoption. Another example would be a person who believes in having “lucky days” and as a result gambles away large sums of money.
- Individuals are not always aware of the beliefs and values that are affecting their behaviour. **For example**, a person might constantly sabotage his/her chances for success because deep down inside s/he feels unworthy. Another example would be a person who believes that s/he is not racist but every time s/he encounters a black male on the street, s/he unconsciously holds her purse tighter. Such a person’s behaviour is being affected by racist stereotypes that s/he is not necessarily aware of at the conscious level.
- Beliefs and values are sometimes taken as undisputed “truths” that are not questioned by an individual or a culture as a whole. **For example**, some individuals believe that the bible is the word of God and represents an undisputable “truth”. Another example would be a culture that believes that women are the “weaker sex” and as a result, have little power in that society.
- Cultures and individuals frequently profess to hold certain beliefs and values but end up behaving in an opposite manner. **For example**, even though the Charter of Rights gives equal status to gays and lesbians, the law still discriminates against them. Likewise, a father might profess to be non-racist but reacts when his daughter informs him that she is marrying a black man.
- The development of beliefs and values is strongly influenced by the person’s social environment. In early years, parents play a major role. During adolescence, parental values are often rejected for those of peers. As adults, individuals may revert to parent’s beliefs and values. Also, cultural factors such as religion, the media, and laws also influence the beliefs and values that an individual adopts during the course of their life.
- Most beliefs and values are formed in response to some basic needs. **For example**, a young child adopts parental beliefs and values out of a need to be loved and approved of by the parents. Similarly, a teenager might drastically change his/her beliefs in response to the need for a sense of belonging and approval from peers. An adult might embrace a new religion to fulfill the need for spiritual meaning to what otherwise seems a chaotic, senseless and cruel world.

- Effective peer supporters will ideally exhibit an attitude of tolerance towards other people's beliefs and values and constantly question whether they are judging someone through their own personal biases. Thus it is important for peer supporters to continually examine their own beliefs, values and attitudes.

Handout 10

LEGAL CONSIDERATIONS

Exercise Caution in your Work

Being careful means exactly that – don't do anything rash that could have harmful consequences for you or your peer. Follow the guidelines laid down by the peer support program's manual. Perform the duties and services described in your job description; if you wish to perform other services or tasks for your match, discuss them first with the coordinator or alternate if there is no coordinator. Always observe the rules and regulations of the institution where your peer lives, or any instructions from their doctor. Whenever you are in doubt about what you should do, discuss the matter with the coordinator or alternate.

When you are doing support in the hospital on the psychiatry unit, follow the guidelines set out by the program.

Confidentiality

In the course of your regular visits, a peer may reveal intimate details of his or her life, family relationships, or various problems. What is told to you in confidence must remain just that – confidential. To ensure this confidentiality, it will be required that all volunteers read, understand and sign an Oath of Confidentiality once they have been accepted as peer supporters.

Handout 11

SUMMARY OF DUTIES

1. Attend training sessions and notify coordinator of areas where additional training would be helpful. Maintain regular contact with coordinator (or alternate) and report any concerns as soon as possible.
2. Participate in a trial period of visits to test the compatibility of the one-to-one match.
3. Develop a relationship through regular visits. Be clear on the guidelines the peer support program has regarding the support relationship.
4. Establish a flexible schedule. Make appointments in advance. If changes are necessary notify coordinator (or alternate) if necessary.
5. Maintain strict confidentiality about personal information.
6. Keep records of visits and expenses as required by the program guidelines.
7. Develop and maintain a supportive relationship with fellow volunteers.

*When you respond to me I feel special,
It will make up for all those who, during the day,
Have passed me up without seeing me.*

- Leo Buscaglia, PhD

Handout 12

SELF-ASSESSMENT FOR OUTREACH VOLUNTEERS

NAME: _____

DATE: _____

My strengths are:

I would like to learn/improve:

I dislike people who:

I get nervous when:

I am at my best with people when:

Self-Assessment cont'd.

When people disagree with me I:

As a volunteer I like to be rewarded by:

I feel intimidated by/when:

I feel good about myself when:

My personal support systems include:

I like people who:

Some things/activities that make me feel good:

When my illness challenges me I:

I get bored when people:

“Peer Support” for me, means:

Meeting new people is:

I handle disappointment by:

Being a team player means:

Other:

SECTION 2

COMMUNICATION

SKILLS

SESSION 3

Group Discussion – Working Values in the Helping Relationship (45 minutes)

Purpose

- To look at trainees' experiences with therapy or counselling.
- To relate personal experiences to values which are helpful for a peer support relationship.

Method

- Divide the group into two.
- Ask the group to choose a group leader and give the person pen and paper.
- Have groups go to separate areas of the space in order to work independently.
- Instruct the groups to discuss the qualities of a therapist or counselor that they found helpful or interfered with the helping relationship.
- Give the groups approximately 45 minutes to discuss and then call the group back together.
- Group leaders can share with the class their responses.
- Trainers summarize and link the main attitudes, values and beliefs that are important to a good working partnership in the helping relationship.
- Discuss Handout 13 – Egan's Working Values page 47 (Egan is the author of a book: *Skilled Helper*).

Attending Skills (15 minutes)

Purpose

- To emphasize the importance of developing and using attending skills in order to improve communication.

Method

- Remind trainees of the Helper Role Play done in the last class and how it felt in the respective roles of peer supporter and the person being supported.
- Use the easel and write out the 'Attending Acronym' (see handout 14 page 48):

<p>S – square stance O – open posture L – lean toward E – eye contact R – relaxed stance</p>
--

- Elaborate on each item, giving a detailed description as outlined in Handout 14, [age 48 – the Attending Acronym.

Active Listening (20 minutes)

Purpose

- Learn the principles and practice the skill of active listening.

Method

- Read Lecturette – Active Listening – Handout 15, page 50
- Read and discuss poem – *I believe* Handout 16, page 52

The Skill of Paraphrasing (10 minutes)

Purpose

- To learn and practice the skill of paraphrasing.

Method

Discuss with the trainees the following information:

Paraphrasing is giving responses that reflect back to a person what s/he is saying. A good paraphrase has the following components:

- ◆ Gives the same meaning but uses your own words, avoids parroting.
- ◆ Brief, clear, concise, captures the spirit of the message and leaves out unnecessary details, helps clarify, not confuse.
- ◆ Worded as a question to leave room for the person to correct you.

Following are some examples of how to start a paraphrase to make it sound questioning:

- ◆ “Sounds like you are...”
- ◆ “Let me see if I got it right...”
- ◆ “So I hear you say...”
- ◆ “...Is that correct?”

Break 15 minutes

Accurate Empathy Exercise (60 minutes)

Purpose

- To develop and practice the skill of active listening.
- To develop and practice the skill of giving constructive feedback.
- To develop and practice observation skills.

Method

- Divide group into groups of 3
- Each person in the group will take turns role-playing a peer supporter, a person receiving support and an observer. Each turn takes 15 minutes.
- Instruct the groups that when they are role-playing a person who is receiving support that they are to discuss a problem they feel comfortable sharing, or they may ask for a scenario to use.
- Instruct peer supporters to use the skill of accurate empathy as much as possible. They may ask questions when necessary to keep the conversation going.
- Instruct the observers to record their observations on the sheet provided (Appendix 1, page 173). Observers give feedback to the peer supporters before the group switches roles.
- Trainers circulate through the groups to observe and give feedback.
- After each trainee has a turn in each role, they return to the main group for discussion.

Homework – First Visit (5 minutes)

- Handout the sheets titled “First Visit” (Handout 17, page 53) and “What if I were a peer?” (Handout 18, page 54) to help the trainees think about what their peer might want from seeing a peer supporter.
- Ask group members to answer the questions, and think of other possible conversation starters.

Handout 13

Egan's Working Values²

◆ Pragmatism:

- Do whatever is useful and ethical
- Stay flexible in the methods you use
- Maintain a real life focus
- Develop a bias towards action
- Do only what is necessary

◆ Competence:

- Work at becoming proficient in the helping process
- Have an attitude of ongoing learning

◆ Respect

- Have an attitude of prizing people simply because they are human beings
- Value diversity and individuality
- Keep peer's agenda in focus
- Be available for the peer
- Assume the peer's goodwill
- Be warm within reason

◆ Genuineness:

- Be yourself in the helper's role
- Do not pretend to be someone you are not
- Be spontaneous and open
- Avoid defensiveness

◆ Peer Self-Responsibility:

- Help people help themselves
- Peer is ultimately responsible for choices
- Facilitate people's discovery and use of their own resources

² Egan, Gerard, *The Skilled Helper*, 2002; pg. 43 - 61

Handout 14

Attending Acronym

Listening is the basis of communication, and this is one example of a method that can be used to improve your listening skills.

Egan uses the acronym S-O-L-E-R to outline basic physical attending skills.

S – SQUARE STANCE

O – OPEN POSTURE

L – LEAN TOWARD

E – EYE CONTACT

R – RELAXED STANCE

S – Square stance – face the person you are talking with squarely. Physical distance between you is important as well. In North American culture, 1 to 1.5 metres distance is usually appropriate. Some people will want more or less distance between you and them.

O – Open posture – you need to say through your posture that you are willing to be involved and accessible. Crossed arms and legs can be seen as defensiveness or withdrawal.

L – Lean toward the other person – as understanding increases, people tend to draw closer together physically, leaning toward the other person.

E – Eye contact – keep eye contact, this is a strong sign of involvement and can directly influence trust. Maintaining eye contact does not mean that you stare fixedly at the person, this is often uncomfortable for people. (Research has shown that when we like people, our eye contact is more intense and longer; we are likely to feel more positive about people who use a lot of eye contact; people are apt to see us as less trustworthy when we avoid eye contact.)

R – take up a relaxed position. Stay still and avoid fidgeting that might make it seem that you are preoccupied, nervous or uncomfortable with the discussion. If you are relaxed you show that you are not embarrassed and that you are able and willing to listen. If a person feels that you are judgmental or overwhelmed, they may stop the conversation or change to a subject they feel you would be more comfortable with.

*Remember that these are guidelines. Different cultures and individuals may react in different ways.

There are some other simple courtesies that can be used to show someone that you are willing to listen to what they have to say and it is important:

- Be on time for meetings
- Keep interruptions from happening
- Remember key details and information (it may be helpful to keep short notes for yourself as reminders)
- Use verbal and non-verbal gestures to show interest (encouraging questions, head nods)
- Manage feelings and attitudes so that your commitment to your peer is genuine and not faked.

Remember to be flexible when you apply these principles – cultural and individual needs may require a different approach. For example, some people are very uncomfortable with even a short amount of eye contact.

Handout 15

Active Listening

Active listening involves paying careful attention to what the peer is saying so that you can gain an understanding of his/her point of view. However, understanding their perspective does not mean that you have to agree with it. Peers sometimes have perceptions of themselves and others that are distorted. Therefore, active listening also involves careful attention to discrepancies and gaps in the peer's story, which might have to be challenged at appropriate times. Before you challenge the discrepancies, however, it is essential that you first convey your understanding to the person.

For example, you might be supporting someone who perceives herself as being fat even though appearing to be of normal weight. Before you challenge her on her distorted perception of herself, it is important that she first gets the sense that you understand and empathize with her distressed feelings regarding her weight. The most useful method to convey your understanding and empathy is through Active Listening.

Obstacles to active listening include: becoming distracted with your own thoughts, interrupting unnecessarily, personal cultural, familial and personal biases, labeling and becoming too emotionally involved.

- Avoid becoming distracted with your own thoughts since it will prevent you from fully listening to the peer. This is especially a problem for peer supporters who become so preoccupied with their next response that they stop paying attention to the peer. It is better to fully pay attention and then allow yourself some time to respond.
- Avoid interrupting the peer when it is not necessary. However, under some circumstances it is appropriate to gently interrupt the person.

For example, if your peer has been talking non-stop and you are having a hard time following him, it is quite appropriate to interrupt by saying something like: "Before you go on, let me check with you whether I've been following you correctly". Then paraphrase, briefly, what you have heard.

- Another obstacle in active listening is when your own cultural, familial or personal biases get in the way of understanding the peer.

(Ask for examples from the trainees for when this may have happened with them.)

- Labels that we use to categorize people might also distort listening.

For example, you are supporting a peer who has been diagnosed with schizophrenia. He tells you he has been hearing noises at night. It would be wrong to assume that the noises are in the person's imagination or are hallucinations.

- Listening can also be compromised when you allow yourself to get too emotionally involved with the peer. In other words, if you feel too much sympathy for the person, you may accept their perspective without question, and be unable to be objective.
- Nonverbal communication – although we are not always aware of it, much communication takes place through our body language. Non-verbal cues such as body posture, facial expression and tone of voice send out messages that confirm or deny what is being said verbally. Nonverbal behaviour also adds emotional intensity to the words being said and sometimes, nonverbal cues speak louder than words.

For example, a peer might express with words that she is not upset but a worried look on her face and a flat tone of voice might be telling you otherwise. Under such circumstances, it would be appropriate to point out the discrepancy to the peer with a statement such as “Even though you are telling me that you are not feeling upset, your expression looks worried.”

- Effective peer supporters learn to read nonverbal cues such as bodily behaviour, facial expressions, voice related behaviour, autonomic physiological responses, physical characteristics and overall appearance of the peer. Peer supporters must also learn to pay attention to their own body reactions while interacting with peers.

Handout 16

I believe
the greatest gift
I can conceive of having
from anyone
is
to be seen by them,
heard by them,
to be understood
and
touched by them.
The greatest gift
I can give
is
to see, hear, understand
and to touch
another person.
When this is done
I feel
contact has been made.

- Virginia Satir

Handout 17

The First Visit

Introduce yourself with your name and that you are from the peer support program.

Ask where they would like to go to sit and visit or, if they would like to walk.

They will be as nervous as you are!!!

Most people enjoy talking about themselves. As you listen you can comment on their feelings, the content of what they are saying, ask questions and let them know you understand and accept them.

Conversation Starters

- How long have you lived here?
Where do you live now?
- Where were you born? Do you have any brothers or sisters?
- What kinds of things do you like to do as hobbies?
or
What games/sports do you like to play?

Handout 18

What if I were a peer? (This can be used to develop empathy and give you a chance to “put yourself in the other person’s shoes”).

1. Picture yourself as a peer. Think of some of the problems you have had to grapple with or are struggling with now. Jot down words, phrases, or simple sentences in response.

- a. What would I want to get out of seeing a peer supporter?

- b. What would I want the peer supporter to be like?

- c. How would I want to be treated?

SESSION 4

5 minutes

- Open class with a discussion of the homework exercise.
- Read poem “*Listen*” (Handout 19, page 57) to provide inspiration to the group members and remind them that one of the most important roles of a peer supporter is listening.

Accurate Empathy (35 minutes)

Purpose

- Explain the difference between sympathy, empathy and identification.
- Provide examples of empathic statements.
- Discuss the need for ownership in empathic responses
- Discuss the role of accurate empathy in the helping process
- Discuss common inappropriate responses by peer supporter.

Method

- Read – Accurate Empathy (Handout 20, page 58)
- Read – Conveyance of Ownership in Empathy (Handout 21, page 59)

Write on the easel the following statements and ask for someone to give an “I” message.

1. An individual is insisting anyone who does not share his particular religious beliefs is stupid and trying to make you agree with him.
2. You have been talking for a long time and the individual you are talking with won’t focus on the main problem.
3. An individual is using abusive language and this is distracting you.
4. An individual insists on asking you your marital status.
5. An individual is talking in circles and this is confusing you.

- Read – The Uses of Empathy (Handout 22, page 60)
- Read – Non-Empathic Statements (Handout 23, page 61)

Probing (20 minutes)

Purpose

- Introduce and discuss the skill of probing
- Practice peer support skills of empathic listening and probing

Method

- Read – Probing (Handout 24, page 62)
- Read – Open Questions (Handout 25, page 63)
- Trainers role model Empathy and Probing – trainers need to decide before hand on a topic they will talk about; it is helpful to use personal situations to make clear the skills of empathy and probing.

Break 15 minutes

Accurate Empathy and Probing Exercise (45 minutes)

- Group is divided into sets of 3 (class can decide if they wish to stay with the same group as last class or if they wish to change group members.)
- Use the same method as last week's exercise.

Break 15 minutes

Advanced Accurate Empathy

- Read – Advanced Accurate Empathy. (Handout 26, page 65)
- Practice skills using same method as last week.

Handout 19

LISTEN

When I ask you to listen to me and you start giving
advice you have not done what I asked.

When I ask you to listen to me and you begin to tell me why
I shouldn't feel that way, you are trampling on my feelings.

When I ask you to listen to me, and you feel you have to do something
to solve my problems you have failed me, strange as that may seem.

Listen! All I ask is that you listen, not talk or do – just hear me.
Advice is cheap: 60 cents will get you both Dear Abby and Billy Graham
in the same newspaper. And I can do for myself: I'm not helpless; maybe
discouraged and faltering, but not helpless.

When you do something for me that I can and need to do for myself,
you contribute to my fear and weakness.

But, when you accept as a simple fact that I do feel, no matter how irrational,
then I can quit trying to convince you and get about the business of
understanding what's behind the irrational feeling.

And when that's clear the answers are obvious and I don't need
advice. Irrational feelings make sense when you understand
what's behind them.

Perhaps that's why prayer works, sometimes, for some people,
because God is mute, and doesn't give advice or try to fix things.
God just listens and lets you work it out for yourself.

So, please listen and just hear me. And if you want to talk,
wait a minute for your turn, and then I'll listen to you.



- Anonymous

Handout 20

Accurate Empathy

Accurate empathy is a response by the peer supporter, which shows their understanding of the peer's problem situation. The most powerful empathic responses are those that reflect the peer's feelings and emotions and link it to the corresponding experiences or behaviours.

- ◆ **For example:** "It's been a terrible week, my stepdaughter and I have been fighting non-stop. The worst thing about it is that my husband seems to take her side and is constantly undermining me in front of her...He makes me so angry!"
Empathic response: "You are angry at your husband because he fails to support your authority with your stepdaughter".
Non-empathic response: "My husband is such a jerk, too. He really makes me mad."

Peer supporters may also respond selectively as to highlight feelings, behaviours or experiences. **For example:**

Response emphasizing experience:

"Sounds like you've had a lousy week with your family."

Response emphasizing behaviour:

"You have been fighting with your stepdaughter and getting angry with your husband".

Response emphasizing feelings:

"You are feeling really angry".

An effective peer supporter develops the skill to assess what is emphasized in an empathic response.

- ◆ **For example,** a peer who shows resistance in talking about feelings might feel threatened by empathic responses, which emphasize affect. This peer might initially benefit more from empathic responses that emphasize experiences and behaviours until enough trust has been established to talk about feelings.

Handout 21

Conveyance of Ownership in Empathy

Peer supporters need to be careful in wording their empathic statements so as not to imply that others are responsible for the peer's feelings. Empathic statements always give a feeling of honouring the peer's ownership of his/her feelings.

♦ **For example:**

a) Do not respond:

"Your brother makes you feel angry because he puts you down. He especially causes you to feel hurt when he does it in front of your friends."

b) Respond instead:

"You feel angry at your brother because he frequently puts you down. It is especially hurtful when he does it in front of your friends".

The first response suggests the brother is responsible for the peer's angry and hurtful feelings. It might also give the impression to the peer that s/he is a victim at the mercy of the brother with no power to change circumstances. S/he might not see there may be another choice for how he reacts to the brother's behaviour.

A useful communication skill which can be taught to peers is the use of "**I**" statements to increase their sense of ownership over their feelings.

♦ **For example:** You can suggest your peer respond:

"I feel hurt because you ignored me at the party"; instead of "You have caused me so much pain by ignoring me". Another advantage of using "I" statements is that they tend to make a person less defensive and more sensitive to the other person's feelings.

Handout 22

The Uses of Empathy

The skill of empathy can serve several functions in the helping relationship. As suggested by Egan (1994) empathy works because it:

- a) Helps build the relationship. Peer feels understood, supported, and taken seriously.
- b) Helps the peer explore their feelings in a non-judgmental manner.
- c) Is a tool that the peer supporter can use to focus the attention of the peer in the direction that may help lead to deeper understanding.
- d) Is a perception-checking tool. Allows the peer to set the record straight.
- e) Paces the helping process. Keeps the peer supporter from asking too many questions.

Handout 23

Non-empathic Statements

Sometimes peer supporters fail to give empathic responses when they are reasonable and instead respond with an out of place statement, which may get in the way of the helping relationship. Following are examples of common types of non-empathic responses, which are to be avoided:

- ◆ Example: “I think that my agoraphobia is acting up again. The last few times I went to the mall, my heart started racing and I just wanted to run out of there.”
- a) Responding with a question: “When did the agoraphobic attacks start again?”
- b) Responding with a cliché: “This is not unusual, many people have small relapses.”
- c) Responding with an interpretation: “I think your relapse was triggered by the breakup of your marriage”
- d) Responding with advice: “I think you should increase your medication.”
- e) Responding with an overly sympathetic response: “Oh, you poor thing, that is so awful!”
- f) Responding with a “rescuing statement”: “Oh, don’t worry about it, it’s just a little relapse. I am sure you’ll get over it”.

These statements are not helpful because they do not recognize the peer’s feelings.

- ◆ Instead an appropriate empathic response could be: “Sounds like you are afraid of being unable to cope in public places again.”

Note that some of the above non-empathic responses might be appropriate at some points in the helping relationship. For example, after an empathic response, it might be appropriate to ask the question “When did the agoraphobic attacks start again?”

Handout 24

Probing

Probes are verbal statements that help explain relevant issues. Good probes help define problems in terms of real and specific experiences, behaviours, and/or feelings.

- ◆ **For example:** “That’s it, I am ready to walk out of this relationship. My husband’s attitude just sucks and I don’t think he’s going to change.... It’s hopeless!”

In this situation, the helper could use an empathic response followed by a probing statement:

- ◆ “You feel pessimistic about your relationship ever getting on the right track again. Maybe you can describe to me what your husband does that you find so difficult to accept”.

Or an empathic response followed by a probing question:

- ◆ “You are feeling pretty bad about your marriage and don’t see any hope. What specifically does he do that you find objectionable?”

A probe does not have to be a full question or statement. It can simply be a word or phrase.

- ◆ **For example:** “Hopeless?”

Handout 25

Open Ended Questions

The following are examples of open-ended questions. What makes these unique is that they cannot be answered with a yes or no. Try to use as many different ones as you can.

What does that feel like?
Can you tell me more about...?
How are you feeling right now?
Would you like to talk about...?
Where would you like to begin?
How is that (use specific example) for you?
How do you feel now about...?
Can you tell me what that means to you?
How would you like things to be?
What do you imagine...?
What have you thought of?
What would it be like?
How do you see things changing?
What would you like to do about...?
I'm wondering...?
What's that like?
What can you think of?
What's more important for you now?
Does it sound reasonable to you?
Could this be what's going on, you...?
From where I stand, you...?
This is what I think you are saying...?
You appear to be feeling...
Perhaps you're feeling...
I somehow sense that maybe you feel...
Is there any chance that you...?
Let me see if I understand; you...?
Let me see if I'm with you...?

Open vs. Closed Questions

CLOSED	OPEN
Restrictive	Broad
Limit responder's answer to "yes", "no", "maybe", or "I don't know"	Responder has an opportunity to figure out their own response; opens door to further discussion
Help to focus on a specific piece of information or clarify a point	Encourage the responder to expand on and describe their experience
May encourage defensiveness, imply a 'right' answer or push someone into a position	Invite exploration
Examples: "Don't you think that's unreasonable?" "Are you planning to go then?" "Do you have enough information to make that decision?" "Aren't you going to try?"	Examples: "What does 'fair' mean to you?" "What did I do that gave you the impression I don't care?" "How did his response affect you?" "What will you do now?"

Closed questions sound like statements, but they are not as clear. Often they sound aggressive.

Below are some closed questions that have been changed to form open questions.

CLOSED	OPEN
Do you understand what I mean?	What do you think of what I just said?
Do you agree that the contract is clear?	What do you think about the clarity of the contract?
Have you noticed low morale with your staff?	How would you describe the morale of your other staff?
Don't you think this is basically a financial problem?	What do you feel is the root of the problem?

*Notice the difference in tone.

5 W-H QUESTIONS (Asking Fact-finding Questions)

WHO
WHAT
WHERE
WHEN
HOW

Open – encourages discussion
Closed – discourages discussion

Handout 26

Advanced Accurate Empathy

Advanced accurate empathy is an empathic response which reflects deeper meanings that the peer is only half saying or implying in his/her statements. It is considered a difficult skill because it brings to light what the peer is frequently not fully conscious of, and this new awareness might challenge the peer's worldview in some way.

- ◆ **For example:** "This job here sounds like something I would enjoy doing But I don't even feel like trying anymore. I have become really discouraged with this job-hunting. With so many unemployed people, I don't stand a chance to even make it on the short list".

Basic empathic response: "You feel discouraged in finding a job because of a competitive job market."

Advanced empathic response: "It's been painful being turned down so many times before and now you hesitate in taking a chance. I wonder whether your reluctance has something to do with fearing rejection".

In the last example, the peer is tentatively, challenged on his world view (i.e. looking for a job is a waste of time because of the economic situation) by focusing him on the possibility that he might have become immobilized because of fear of rejection.

Advanced accurate empathy can also be used to make peers aware of themes or patterns in their feelings, behaviours and/or experiences.

- ◆ **For example:** "I can't believe it, it started as an argument over a quiz question and then he starts calling me ignorant ... and next thing I knew, I lost control and started fist-fighting with this guy".

Advanced empathic response: "Seems like you were feeling hurt because he called you ignorant. I recall a similar incidence with your brother where you reacted with a physical confrontation when he called you a weakling."

The above statement tentatively challenges the peer to look at his pattern of reacting violently when he feels hurt.

It is important to word advanced empathic statements tentatively because they involve a lot of guesswork on the part of the peer supporter. By being tentative, the peer will feel more comfortable in disagreeing with the peer supporter's statement. Also, non-verbal responses by the peer to the advanced empathic statements will give useful cues as to their accuracy. Advanced accurate empathy is not to be used too soon. It is most useful when rapport and trust have already been established in the peer support relationship.

SESSION 5

Giving Information, Self Disclosure (45 minutes)

Purpose

- To introduce and practice the skills of information giving and self-disclosure

Method

- Read – Giving Information (Handout 27, page 68) and Self-disclosure (Handout 28, page 69)
- Role model information giving and self-disclosure

Boundaries (45 minutes)

Purpose

- To discuss what boundaries are and the types boundaries that exist.
- To discuss how to set limits.

Method

- Ask group members to discuss types of boundaries. Use easel to list answers from participants. Add to list if needed.
- Read Handout 29 (page 70) – Boundaries and Setting Limits.
- Read Handout 30 (page 72)– Setting Limits with Gentle Refusal.
- Break group into pairs and using the model for gentle refusal role-play the situations outlined in Handout 31, page 73. Instruct pairs to alternate roles – making the request and refusing the request. (For the purpose of this exercise, act as if you do not want to do what the other person is asking of you.)

Break 15 minutes

Peer Support Exercise (30 minutes)

Practice skill of giving information and self-disclosure.

Summarizing (15 minutes)

Purpose

- To introduce and practice the skill of summarizing

Method

- Read – Summarizing (Handout 32, page 74)

Break 15 minutes

- Practice peer support skills using same method as last session. (30 minutes)

Handout 27

Giving Information

- ◆ Lack of accurate information can keep peers from looking at problems objectively and seeing all the options that are available to them. **For example**, a recently immigrated woman in a battering relationship might feel staying with her abusive husband is her only option because she lacks the awareness of services such as transition houses and income assistance. An effective peer supporter is familiar with the various resources in the community and makes that information available as appropriate.
- ◆ Information giving is considered a challenging skill because it can bring to awareness uncomfortable facts that are not easy to take. **For example**, a peer who smokes marijuana might not like hearing all the negative side effects this drug has.
- ◆ When giving information, Egan (1994) suggests the following pointers:
 1. Make sure the information you are giving is true. If you are not certain of the facts, it is better not to say anything.
 2. Only give information that is relevant to the problem. Do not overwhelm the person with information not directly related to the problem.
 3. Be tactful when giving challenging information. Be prepared to provide emotional support and help in dealing with the new information.
 4. Avoid giving advice disguised as information. **For example**, a peer supporter who discusses only abortion resources with a pregnant peer is really giving their opinion of the only choice.

Handout 28

Self-Disclosure

- The skill of self-disclosure involves the sharing of important personal information by the peer supporter. The most helpful self-disclosures are those related to similar past issues that the peer supporter has successfully resolved but with which the peer is still struggling. Therefore, this skill is also a form of modeling since it provides peers with an option for conflict resolution and challenges them to take similar action.

For example:

A person with a mental illness might be bothered about his weight but feels discouraged after several attempts of crash dieting. Professionals have told him that his diet contains too much fat. A peer supporter with a similar past weight problem might use the following self-disclosure:

- ◆ “Ten years ago I was feeling self-conscious about my weight but didn’t seem to have enough will power to stop eating all that junk food. I used food as a way of soothing myself. But one day I decided to do something about it and joined a weight loss support group. I received the emotional support to change my eating habits and slowly I began to lose weight for a total of 50 pounds. I also learned to accept the fact that I was never going to be a size 5 if I wanted to eat balanced meals without starving myself.”
- When using self-disclosure, Egan suggests that the following points be kept in mind:
 1. Only self-disclose material that is relevant to the peer. Avoid extravagant and rambling stories about yourself.
 2. Do not use self-disclosure as a means of unburdening your own unresolved issues on to the peer. This may result in the peer feeling as though they are supporting the peer supporter.
 3. Be sure you don’t use self-disclosure too early or too often.

Handout 29

Boundaries and Setting Limits

Boundaries

Definition: a boundary is a limit or an edge that defines you as separate from others.

This limit can be violated and, depending on the nature of the violation, can cause a person to suffer. Our body is our most obvious boundary, but we also have an invisible boundary that extends beyond our skin. We know this boundary has been violated when someone feels too close. Sometimes we will say, “that person has invaded my space”.

Each of us have the right to state what our boundaries are and we have a responsibility to respect others' boundaries regardless of whether or not we agree or understand.

When we have grown up in environments that lacked healthy boundaries, then we are deprived of developing our own limits and how to protect ourselves. We learn about boundaries from our early life experiences.

Boundaries need to be clear and maintained. If we cannot define them for people, then we are at risk of being hurt or of hurting others. If we do not reinforce or maintain them, we are in danger of being victimized.

Boundaries can be rigid or flexible.

Boundaries can be too close, both physically and other wise. If you have to be physically nose-to-nose with someone, if you have to have answers to all your questions, or if you feel you must reveal your thoughts and feelings to everyone, then your boundaries are too close. We all have a right to privacy. You need not feel what all your peers or friends feel, you need not comfort them, and you need not burden them with your own difficulties.

A boundary becomes too wide when people feel disconnected from you, when you feel neglected or abandoned. This may be due to an underlying emotional problem but it needs to be checked out if it is a boundary issue. People who have been hurt may keep wide boundaries because it protects them from harm; but if you are working with people you must ask why the boundary is so wide.

A person with rigid boundaries may be frightened and has these boundaries because they do not want to be hurt. A consequence of rigid boundaries is narrow vision and a limited experience of the world.

A person whose boundaries are too wide often feels overwhelmed by the world and has difficulty coping.

Boundaries are extremely important in doing peer support. Your ability to define your own boundaries will impact on how you identify yourself in your role and how respectful you will be of peers' boundaries. As a peer supporter you will be in a more powerful position and you must take on the responsibility of making the relationship between yourself and the person you are supporting a safe one. This can only be done if you have established appropriate boundaries for yourself and the person you are supporting.

Setting Limits

The capacity to set limits is essential to feeling good about yourself. Many consumer/survivors have not known how to define their own time, to protect their bodies, to put themselves first, or to say no.

Learning to say no is a difficult challenge; it is a relief to be able to stop doing what you don't want to. By setting limits, you protect yourself and give yourself freedom at the same time. Watch for situations in your life in which you want to say no. Start with what's easiest and build up to the harder ones. If you have never or hardly ever said no, your first attempts may feel awkward or even rude. Saying no does not have to be loud or hostile. As you become more at ease with setting limits a simple "no I don't want to", "no thanks" or "no, I would rather not" will become easier. People that know you will notice your boundaries are not as wide as they were and may try to convince you that you should go back to the way you were, or they may feel hurt or that you don't like them anymore. But stay with your changed boundaries and people will soon realize and appreciate the new you.

In conclusion, boundaries are the foundation of a strong and safe relationship whether that relationship is with friends, peers, supervisors, doctors, etc. If you do not feel safe within a relationship, or a person you are supporting does not feel safe in the relationship, then little will be accomplished and more harm than good may result. Remember that boundary violations, regardless of how small, can cause harm. As a peer supporter, you must be aware of boundary issues and the potential for violations.

Handout 30

Setting limits with “Gentle Refusal”

Have you ever been in a situation where you’ve been asked to do something you really didn’t want to do, but didn’t know how to say “No”? Can you think of recent times where you wanted to help out – but not to the extent that you did become involved?

If during a conversation, you find that you have to set limits, one effective way is to set limits with gentle refusal. This skill provides you with a way to say “no” as gently and caringly as possible, while inviting the other person to continue to explore with you on a more constructive level.

Do not let people place conditions on your helping them. You will find it helpful to use gentle refusal when:

- ✓ A person makes unrealistic demands on you
- ✓ A person wants guarantees
- ✓ A person demands advice
- ✓ A person asks personal questions and you feel uncomfortable
- ✓ A person is verbally abusive
- ✓ A person seems continually to say, “Yes, but...” to many of your reflections or opinions
- ✓ You just want to end the conversation

The Model for Gentle Refusal

Example: Your friend asks to borrow money

1. **Reflection** – Let the person know that you hear behind the question or demand. This will demonstrate that you understand what is happening.

“It sounds like you are really desperate for money right now”.

2. **The refusal: setting your limits or saying “no”** – Say as clearly as you can what your limits are (and if you choose – your reason.)

“I can’t lend you money right now, (because...)” or
“I’m not willing to lend you money.”

3. **Offering the invitation** – Say clearly what you can, and/or are, willing to do.

“However, maybe we can look at other resources you might tap into.”

This invitation shows that even though you can’t meet the specific request, you are still concerned and want to keep your focus on that friend and her or his feelings.

Handout 31

Gentle Refusal Exercise

With a partner, go through the following role-plays alternating roles. In one situation you will be the person making the request, in the next situation you will be refusing the request.

In making your refusal, follow the model for gentle refusal:

1. reflect back the feelings or need behind the request
2. refuse: set your limit or say no
3. offer an invitation (what you are willing to do)

Situation #1: Your peer wants to take you to her favourite hang out “Doc’s Burgers and Fries”. You have been there before and found it so loud from the music they play and the large number of young people who hang out there, that you could not hear a thing and left with a major headache. You dread going back there.

Situation #2: The peer outreach coordinator phones you at the last minute and asks if you will go to the ward right away. Other volunteers have cancelled and there are two people who have requested to see someone from peer outreach. The coordinator is really in a bind and doesn’t want to let these people down. You are feeling overwhelmed and have been reluctant to be a peer supporter on the ward and are at this point feeling scared.

Situation #3: Another peer outreach volunteer phones you at night and says he needs to talk as he has had an awful day. You really like this person and he has been supportive to you, but you also had an awful day today and don’t feel like you can be much support. The idea of listening to anyone right now seems beyond you.

Situation #4: A peer asks if he can borrow five dollars for cigarettes and says he will pay you back when you get together. He is unusually short of money this month as his car broke down and he had to pay \$150.00 in repairs. He has never asked for money before, but you are uncomfortable lending any.

Handout 32

Summarizing

Summarizing refers to the ability of capturing the main points that have been covered during a single or several sessions. This skill can be helpful in focusing both the peer supporter and peer on the main issues. **For example:**

- ◆ “Maybe I could summarize what we have covered in the last session. We explored some of your reservations in applying for the nursing program this fall. You’re afraid you will not have enough knowledge of the sciences because you’ve been out of school for 15 years. You’re worried the added stress might trigger another episode of depression. However, you’ve been thinking about going into psychiatric nursing for a long time and feel you have something valuable to contribute. Let’s look at ways you can prepare yourself if you do get sick during school.”

Summarizing can also function as a challenging skill that prompts the peer to shift perspective. By bringing isolated pieces of information together, the person might gain a new perspective and insight into possible goals and courses of action. **For example:**

- ◆ Peer Supporter: “You have told me that your husband drinks, gambles, verbally abuses you and the children, has hit you several times, does not allow you to have friends or see your family, controls your money, tells you how you should dress, has jealous fits of rage, and most of the time, you feel controlled and unsafe around him. That seems like a heavy burden to carry.”
- ◆ Peer: “It is a heavy cross to bear. I just feel so tired and depressed all the time...Sometimes I wonder what it would be like to be on my own again, with just me and the kids.”

Summaries are particularly useful at the beginning of a session since they decrease the chances of peers repeating themselves, and challenge them to move forward. A summary can also be used to help focus a session that is going nowhere. It is particularly useful at this time to challenge clients to do the summarizing. **For example:**

- ◆ “It might be useful at this point to pull together the main concerns you have talked about during our sessions. Would you like to try giving me a summary of what you feel are the main issues you want to tackle?”
- The challenge to this person is to become more focused on the problem areas she wants to work on.

To conclude, summaries by the peer supporter act as a link of relevant information in a concise manner so that potentially, the peer can gain more awareness of problem areas and move forward towards setting goals and action plans for change.

SESSION 6

Brainstorming and Balance Sheet Technique (90 minutes)

Purpose

- To introduce brainstorming and the balance sheet technique as methods for problem solving.

Method

- Read - Brainstorming. (Handout 33, page 78).
- Read – The Balance Sheet Technique. (Handout 34, page 79)
- Take approximately 30 minutes; ask someone in the group to provide a problem they are working on. Using the easel, have the group brainstorm solutions.
- Using another 30 minutes, have the group use the balance sheet technique to select possible solutions.

Break 15 minutes

Goal Setting and Developing Strategies and Action Plans (60 minutes)

Purpose

- To discuss the role of the peer supporter in helping set goals.
- To develop skills in setting goals.
- To discuss ways of developing strategies and action plans to achieve goals.

Method

- Read handout 35, page 80 – Goal Setting
- Read handout 36, page 82 – Developing Strategies and Action Plans
- Using the peer support exercise format break into groups of 3 and practice these skills.

Guidelines for choosing issues / problems

Purpose

- Provide basic guidelines for peer supporters to assist people in choosing which issue or problem to discuss.

Method

- Read – Guidelines for Choosing Issues/Problems (Handout 37, page 84)
- Using the peer support exercise format break into groups of 3 and practice these skills.

Handout 33

Brainstorming Technique

The technique of brainstorming can be used to tap into the creative resources of a person. It encourages the peer to come up with as many ideas as possible about a particular situation.

For example, in the early stages of the helping process, the peer supporter might suggest: “Let’s brainstorm and make a list of as many issues you can think of that you might want to work on”. At later stages of the helping process, brainstorming might be used as a tool for helping a peer come up with goals and strategic action plans to accomplish desired change.

As suggested by Egan, keep in mind the following points while helping someone to brainstorm:

1. **There is no such thing as a bad idea.** The practicality of the possibilities generated during brainstorming can be discussed at a later stage.
2. Help the person use ideas already generated as a takeoff point to come up with additional ideas. This can involve expanding on one idea or combining several ideas to form new possibilities.
3. Help the person clarify their brainstorming ideas using open-ended questions. This process may generate further possibilities.

If a peer is having difficulty coming up with ideas, the peer supporter may offer some “wild” possibilities to encourage the client to do the same. Wild possibilities may contain the seeds of useful ideas that can be uncovered with further probing.

Handout 34

Balance Sheet Technique

After the peer has been encouraged to brainstorm and come up with as many ideas as possible, the next step is to help him/her look at each possibility critically. To help in this process, the peer supporter now needs to focus possible consequences, positive and negative, of each alternative generated. As suggested by Egan, one way of doing this is to use a balance sheet where the pros and cons are examined from three different vantage points:

- a) consequences to the peer
- b) consequences to significant others
- c) consequences to the peer's environment

The above decision making process can help a peer move out of his/her uncomfortable situation without making impulsive or rash decisions which might be regretted later.

Handout 35

Goal Setting

Helping a peer set realistic goals is an important part of the helping process. Goals provide a sense of direction for action that encourages the peer to think of strategies for realizing them.

The goal setting process always involves an assessment of whether the peer's goals are well matched with his/her values. Sometimes it is necessary to backtrack and help the peer re-assess his/her values before defining desired goals. **For example**, a peer might want to end her marriage but feels conflicted because her religious values do not support that option. If this peer ends her marriage without first resolving her conflict in values (i.e., Valuing freedom from an unhealthy marriage vs. valuing her religious belief that marriage is a life-long commitment), her decision might result in feelings of guilt that can affect her future emotional well-being.

Egan (1994) gives some excellent examples of open-ended questions that can help peers generate future scenarios out of which desirable goals might be generated. These include:

- “What would this problem situation look like if you were managing it better?”
- “What patterns of behaviour would be eliminated?”
- “What new patterns of behaviour would help to overcome this problem?”
- “What would this opportunity look like if you developed it?”
- “What do you need to accomplish to get the changes you want?”

It is most important that the peer supporter does not force his/her own agenda or goals on his peers, no matter how worthwhile and sensible these goals might seem. As Egan points out, choosing goals for peers only gives them an opportunity to blame others if they fail to attain them. **For example**:

- A peer supporter might think a useful goal would be to lose weight because the peer's obesity is affecting her self-esteem. However, if the peer does not see her obesity as an issue the peer supporter has to respect that and follow the peer's agenda.

The helping process suggested here is one in which peers take ownership and responsibility for their choices.

It is also important that you assist peers to set goals which can be stated in specific and concrete terms as opposed to encouraging vague or lofty goals. **For example**, the goal of wanting to be a more spiritual person is too vague. The peer supporter can help the peer state this goal in more specific goals by asking a question like “What in particular can you do that will give you the sense of being a more spiritual person?” With such probing, the peer might come up with very concrete goals such as making a commitment to do volunteer work or joining a church.

In some instances, it is also helpful to break down a long-term goal into smaller more immediate goals that are steps towards realizing the larger goal. **For example**, a peer who failed to graduate from high school might decide as a long-term goal to get a university degree in Psychology. To realize this long-term goal, the peer could first set the more immediate goal of attending night school to get the courses necessary for a high school diploma.

As a peer supporter, it is important that you help peers assess whether their desired goals are realistic considering the inner and outer resources available. **For example**, it would be unrealistic to encourage someone to set the goal of becoming a doctor if s/he has serious learning disabilities (inner resources). Conversely, it would not be helpful to encourage a peer to set a short-term goal of becoming a professional sailboat racer if s/he presently lacks the financial resources necessary for such an expensive sport (i.e. Lacks the external resources). Encouraging unrealistic goals may set peers up for failure that can potentially damage their self-esteem and discourage them from trying again. Instead, small successes build confidence, which can motivate people to move forward towards challenging long-term goals.

Handout 36

Developing Strategies and Action Plans

Once a person has decided what goals to pursue, the next step in the helping relationship involves facilitating the development of action plans and strategies to attain desired change.

Frequently people know exactly what they want but have no clear idea on how to get there. The brainstorming technique can be a useful starting point in assisting people to develop strategies/action plans which best fit their situation and resources. **For example**, a peer who has decided to make a commitment to lose weight might use the brainstorming technique to generate a list of possible strategies to achieve this goal. The options generated might look like:

- a. Stop eating junk food.
- b. Join Weight-Watchers
- c. Have an operation done to reduce the size of his/her stomach
- d. Help of a friend
- e. Retreat to a health farm
- f. Stop eating at restaurants
- g. Start exercising at a gym
- h. Exercise at home with the aid of a videotape
- i. Go on a fast
- j. Have his/her mouth wired shut and only consume a liquid diet
- k. Join a self-help group
- l. Join an exercise class
- m. Consult a dietician
- n. Go for daily walks

If the peer has difficulty coming up with strategies during the brainstorming phase, the helper might give tentative suggestions. **For example**, the peer supporter could say:

“Here are some strategies that have worked for other people with similar problems.... Do any of them make sense to you?” Or he might use self-disclosure such as: “I used to have the same problem and I found it really useful to Does that appeal to you?” However, the final choice of strategies to be used is always left up to the peer.

The next step involves a critical assessment of the various strategies that have been generated. The balance-sheet method is a useful tool to increase awareness of the pros and cons of the various options.

The criteria for choosing strategies are similar to the ones suggested earlier for goal setting. They are concrete, specific, realistic, and compatible with the peer's values. Following the above example, after careful consideration, the peer might decide on the following strategies:

- a. stop eating junk food
- b. join an exercise class
- c. consult a dietician

- d. go for daily walks

The final step involves developing a clear step-by-step plan with a time frame whenever possible, to achieve the desired goals. To improve the chance for success, an action plan will take into account the things in the peer's life that stop or help them reach their goals. **For example**, the above person who wants to lose weight might decide that it will be easier to stop eating junk food if s/he makes a point of not having it around the house. Also, s/he might feel that his/her commitment to lose weight might be stronger if s/he joins a friend for daily walks. The final action plan might look something like this:

- a. Starting tomorrow, I will stop buying and eating junk food.
- b. Starting tomorrow, I will join my friend three times a week for a half hour walk.
- c. Within the next week, I will register in a beginner's aerobic class. I will participate at least twice a week.
- d. Within the next week, I

Handout 37

Guidelines for Choosing Issues/Problems

People with a mental illness often experience multiple problems and issues in living. Following are some guidelines suggested by Egan (1994) for choosing the problems or issues to be worked on through peer support:

1. Choose a problem for which you have the knowledge. If not, refer to the appropriate resource including the case manager.
2. Choose a problem that can potentially be solved within the time you have to work with the peer.
3. If the peer is experiencing a crisis, help him/her manage the immediate problem first.
4. Choose a problem the peer thinks is important to work on.
5. Choose a problem that seems to be causing discomfort and pain to the peer.
6. Choose a problem that, if managed, will lead to at least a partial improvement in the peer's life.
7. Complex problems may be broken down to manageable sub-problems that can be worked on first.

As suggested by Egan, the peer support worker can help the peer choose issues s/he wants to work on by using simple probes such as:

- a) "What do you want to change?"
- b) "If you could have one thing you don't have, what would it be?"
- c) "What would you want to be different in your life?"
- d) "What changes do you want in your present lifestyle?"
- e) "What would you like to do differently?"
- f) "What would you want that you don't have now?"
- g) "What do you need in your life that you don't have now?"

SECTION 3

MAJOR

MENTAL

ILLNESS

*There are different methods of presenting information on mental illness. The trainer may use whatever model they feel is most effective for them. All of the major mental illnesses do need to be discussed.

SESSION 7

Recovery (60 minutes)

Purpose

- To provide peer supporters with an understanding of Recovery as a process

Method

- Read and discuss Handout 38, page 87 – Defining Recovery and Supporting Feelings
- Provide a list of resources with information on Recovery

Break 15 minutes

Anxiety Disorders (90 minutes)

Method

- Invite someone who has experience with anxiety disorders to present their knowledge and experience.
- Read - Anxiety Disorders (Handout 39, page 92)
- Discuss what resources are available in the community to assist people who experience anxiety disorders.
- Peer support exercise; use scenarios that will help peer supporters focus on communicating with people who deal with anxiety disorders.

Eating Disorders (15 minutes)

Method

- For homework - read - Eating Disorders (Handout 40, page 96)
- Provide a list of resources available in the community to assist people who experience an eating disorder.

Handout 38

Defining Recovery and Supporting Feelings

Being diagnosed with or experiencing a mental illness can be traumatic. It yanks the rug out from under who we think we are and what we think we can do. It affects the way our friends and family relate to us, and us to them. Because we are dealing with trauma, we need more than “learning the facts”. We also need to learn how these traumatic experiences affect emotions. We call this part “supporting feelings”.

For many of us, mental illness short-circuits or scrambles our emotions. We have to learn to figure out which intense emotions are brought on by the illness and which are the feelings anyone would have in a life situation like ours. For some of us, mental illness and the medications used to treat it, cause a numbing of our emotions, where we are distanced from feelings most people would have. In either case, we need a chance to talk about our feelings and to figure out how to handle them.

Many of us get frustrated when we have tried to talk about feelings with mental health professionals, or with our loved ones. In those situations, we end up feeling that no one is really listening to how we feel and that our feelings are not important. We may have been told “this is just part of your illness”. In this course we can talk about our emotions. We can openly discuss how we feel and how the stress of coping with mental illness affects our lives.

From talking with many people with mental illness, we know that we all tend to have painful, intense feelings and overwhelming reactions to mental illness. We believe that many of these reactions are perfectly normal mixed in with emotions that are changed by mental illness and add confusion to the trauma. We believe we can learn to cope. Once we learn what helps, we can start building our own recovery.

When we talk about recovery, we are not talking about the symptoms of mental illness going away completely, although they might for some. We are talking about regaining a sense of ourselves as a valuable person who has something to live for. Recovery will mean different things to each of us. It is a process we go through *within ourselves, but not by ourselves*. We can ask for help from service providers, from family and friends, but ultimately, we are the ones who are responsible for making decisions about ourselves.

Learning to express our feelings effectively is a tall order. But we believe we *can* do it, have the *right* to do it, and that it *will* help us in our recovery.

Patricia Deegan defines recovery like this:

“Recovery does not refer to an end product or result. It does not mean one is ‘cured’. In fact, recovery is marked by an ever deepening acceptance of our limitations. Recovery is a process. It is a way of life. Like a plant, recovery has its seasons, its downward growth into darkness to secure new roots and then the times of breaking into the sunlight. But most of

all, recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time”.

EMOTIONAL STAGES OF RECOVERY

Experiencing or being diagnosed with a mental illness has changed our lives. We tend to respond to this trauma in similar ways. The “Emotional Stages of Recovery” include three “mental events” with one of three stages (recuperation, rebuilding or recovery) that follow each mental event.

EVENT	STAGE	EMOTIONS	NEEDS
1. Crisis – psychosis, suicide attempt, mania, panic attack	1. Recuperation – a stage of dependence	Denial, confusion, despair anger	Safe place, food, lots of sleep; a caregiver; medication
2. Decision – “time to get going”	2. Rebuilding – independence	Grief, self-doubt, hope, anxiety, frustration, pride	To be heard and accepted; learning about mental illness, people skills, work skills; money, food, clothes, good place to live
3. Awakening – “I am somebody, I have a dream.”	3. Recovery /Discovery – building healthy interdependence	Acceptance of self and others, confidence, anger at injustice; helpfulness to others	A dream to strive for; people who appreciate me; intimacy – someone to love; meaningful work; play and physical activity; to advocate for self and others

(Chart based on the writings and research by Patricia Deegan, Courtenay Harding, John Strauss, William Pat Sullivan and Bill Anthony)

Event 1: Crisis

The first “mental event” is a “crisis” caused by mental illness. We may have become psychotic, suicidal, manic, panicked, or traumatized in some other way. The emotions we may feel during this phase may be painfully intense, or “numbing”. If we are numb, it must be understood that this is the body’s way of protecting us from stress we cannot handle.

Stage 1: Recuperation

The stage of recuperation follows a crisis and is a time of dependence. For many of us with major mental illness, after the chaos and trauma of an episode of mental illness, we are exhausted (physically, emotionally, mentally and spiritually). This is a time when we feel down on ourselves, on those around us, and on life in general.

Event 2: Decision

The time comes when we have recuperated enough to decide, “It is time to get going again”. That time is different for each of us. It may be a couple of months, or it may take a couple of years. No one can make this decision for us. If we don’t make the decision when we are ready, we will feel increasingly bored and empty.

Stage 2: Rebuilding

After the decision to get going, we start rebuilding our life. This is a stage of rebuilding independence, our ability to take care of ourselves. When this time comes, it is up to us to take responsibility for getting the help we need to learn and practice our living and working skills. We may feel very uncertain about what to do. We may have mixed feelings about going back into the world.

Because we are growing during this time, we can expect setbacks and successes. Think of the setbacks as steps on the road to success. Nevertheless, we will feel “up” when we succeed and “down” when we have a setback. So will those who try to help us.

We may have to try many times to find people who will respect us enough to help us grow and believe in our potential even when we fall.

Event 3: Awakening: “I am somebody. I have a dream”

As we rebuild, we come to a new sense of the “new me”. It’s like we have been through the fire and have come out a different person. We start to realize, “There is more to me than mental illness. I am a whole person.” It is not that we are better or worse than we started out to be - just different. We start to dream again about who we are and who we can be. This is the beginning of “recovery”. For many of us, this is a first-time thing: “discovery”.

Stage 3: Recovery/Discovery

This is the stage of building healthy interdependence. We develop a sense of “Who we are and what we want to be, who we care about and who cares about us”. One of the things Sigmund Freud passed on to us is that people, at the deepest level of self, need to *love, work and play*. In the recovery/discovery stage we start to feel “good” more and more often.

NEEDS

In the “Recuperation” stage, we need:

1. a safe place to rest: to sleep a lot,
2. a caregiver to provide for basic needs: nutritious food, personal hygiene, clean clothes, and
3. medications.

The help we need at this point is not ‘therapy’, but foundations, or building blocks for our recovery. We just need a safe place to sleep, regular nutritious food, a shower, clean clothes, and someone to let us know they care. We need to be free of the pressure to ‘get going’ or ‘snap out of it’. We will probably need an effective combination of medications and it may take some trial and error to find medications and the right dosages that work.

By stage 2 of Rebuilding, we are full of emotion and have a different set of needs. We need to ‘sound off’, learn to cope, and learn about the illness.

The Rebuilding needs are:

1. to be heard and believed,
2. learning: about mental illness, people skills, work skills,
3. money, food, clothes, a good place to live.

This is the point at which we may need therapy; although anyone who is a good listener, such as a peer supporter, can be helpful in hearing and believing us. It is good to have someone who has gone through similar struggles, who can say, “Hey, I hear you!” The classes on communication have given you some skills to be good listeners for each other. We also need to learn about mental illness. We need to learn how the mental illness affects us, what might have caused it and what can be done about it.

By stage 3 of Recovery/Discovery, we are getting it together. We need to restore the balance in our life, to find purpose in work and volunteering, to reconnect with others and the world around us. We need to play. Needs during this stage include:

1. a dream to strive for,
2. people who appreciate us,
3. intimacy – someone to love,
4. meaningful work – a chance to leave footprints,
5. fun and physical activity, and

6. to advocate for self and others.

In the recovery stage, we develop the capacity to love other people again and to be loved in return. We start to want things again. We feel hopeful about developing meaningful work, and grateful to those who help us along the way.

(This handout has been adapted from the peer support training manual developed by Maurizio Baldini, Coordinator of the Penticton Peer Support Program.)

Handout 39

Anxiety Disorders

The main characteristics of anxiety disorders are the personal experience of anxiety and avoidance behaviour. The disorders are further classified into Panic Disorders, Phobic Neuroses, Generalized Anxiety Disorder, Obsessive Compulsive Disorder and Post-traumatic Stress Disorder.

Panic Disorders

The essential features of these disorders are recurrent “unexpected” panic attacks that do not seem associated with a specific stressful situation. In other words, the panic attacks seem to come out of nowhere with no apparent triggers.

At the subjective level, panic attacks can include the following symptoms:

1. shortness of breath
2. dizziness, faintness
3. palpitations or accelerated heart rate
4. trembling or shaking
5. sweating
6. choking sensation
7. nausea and/or abdominal distress
8. numbness or tingling sensation
9. “hot flushes” or chills
10. chest pain or discomfort
11. fear of dying
12. fear of going crazy or becoming out of control
13. depersonalization* or derealization**

***Depersonalization** – A feeling of being detached from oneself, one’s body and environment. Occurrences involving the self are observed from the perspective of a detached outsider.

****Derealization** – The sense of self is preserved but occurrences are experienced as unreal.

Many individuals confuse their first few panic attacks with an asthma or heart attack. Furthermore, doctors themselves might make a misdiagnosis.

Individuals who experience “unexpected” panic attacks frequently develop anticipatory anxiety where they continually worry about the start of another attack. This may lead to social isolation for fear of embarrassment. In some cases the person might also develop **Agoraphobia** – the person develops a morbid fear of unfamiliar or open spaces. In extreme cases, the person might become totally housebound.

Panic Attack Coping Skills

The first step is to educate the person and make them aware that panic attacks are not life threatening and the symptoms experienced are the result of a sudden adrenalin surge.

The second step involves helping the individual gain awareness of particular sensations preceding the full-blown attack.

The third step involves using these preceding sensations as cues to engaging in some form of physical activity, such as exercise, running or brisk walking.

These exercises serve to use up excess adrenalin and prevent a full-blown panic attack. If the panic attack cannot be short-circuited, the person can train themselves to “go with it” by using positive self statements such as:

- “I’ve gotten through this before, I will get through this one
- “I have to take deep breaths
- “ It’s only going to last a few minutes longer”.

As a peer supporter, it is important for you to encourage peers to discuss their panic attacks with their therapist/doctor if they have failed to do so since their symptoms may reflect a medical condition such as Angina. Also, medication is available to lessen the onset of panic attacks and/or control anticipatory anxiety. Peer supporters should encourage the use of the above coping skills.

Phobic Neuroses

The essential feature of this disorder is a persistent fear of a specific object or situation. When exposure to the phobic stimulus is about to happen, the individual usually experiences marked anticipatory anxiety. The actual exposure almost invariably provokes an immediate anxiety response that can take on the intensity of a full blown panic attack.

Individuals with this disorder recognize that their fear of the phobic stimulus is excessive, but will go out of their way to avoid exposure. **For example:**

- ◆ A person with a phobia of spiders knows at a rational level that most of them are not life-threatening, but nonetheless will experience extreme anxiety even in the presence of a harmless one.

Phobic Neuroses is further classified into **Social Phobia** and **Simple Phobia**. Social Phobia is characterized by a persistent fear of social situations. The individual worries of possible criticism by others and of acting in a way that will be humiliating or embarrassing. Simple Phobia is characterized by a persistent fear of an object or situation such as fear of flying, heights, snakes, water or small, enclosed spaces.

Systematic Desensitization

This technique is used in helping individuals overcome their phobias. There are two main components:

- a) gradual exposure to the phobic stressor and
- b) training the individual through relaxation and positive self-statements to react differently towards the stressor.

As a peer supporter, you can instill hope in peers who have phobias and you can encourage them to seek help with a specialist trained in behaviour/cognitive modification therapy.

(It is up to the peer and their case manager and or doctor to decide if the phobia requires this type of treatment.)

Obsessive Compulsive Disorder

The essential feature of this disorder is recurrent time-consuming obsessions (i.e. intrusive and persistent ideas, thoughts and/or images) or compulsions (repetitive behaviours usually in response to an obsession) that significantly interfere with the person's functioning at the occupational, social and/or interpersonal level. Attempts to control the compulsions usually result in a sense of mounting tension that is immediately relieved by performing the ritualistic behaviours.

For example, a peer might be obsessed by the idea of being contaminated by germs. Such an obsession might lead /her to engage in ritualistic behaviours like washing his/her hands 20 times a day, spending hours each day cleaning and disinfecting the house and avoiding physical contact with others for fear of germ contamination.

Obsessive Compulsive behaviours can sometimes be treated successfully with intensive therapy involving a one to one professional worker who helps them to resist the compulsive behaviours through behaviour modification techniques. (This is not the role of the peer supporter.)

Post-Traumatic Stress Disorder

This disorder might result as a response to a traumatic event that is outside the range of usual human experience. The original distressing event is usually experienced with extreme fear, terror and feelings of helplessness. The traumatic event is continually experienced again by intrusive thought recollections, dreams, and/or flashbacks. Even exposure to events that resemble in some way the original trauma can result in extreme psychological distress. Other symptoms may include:

- a. avoidant behaviour toward thoughts or activities that may arouse recollection of the trauma;
- b. hypervigilance
- c. restricted range of affect

- d. irritability and anger outbursts
- e. recurring bouts of depression and anxiety
- f. numbed or exaggerated startle response
- g. negativity about the future
- h. insomnia or disrupted sleeping patterns
- i. concentration difficulties
- j. “survivor’s guilt” if others died during the traumatic event

The original trauma may be due to naturally occurring (e.g. earthquake), accidental (e.g. plane crash) or purposeful events (e.g. sexual assault).

Post-traumatic Stress Disorder can often be successfully treated with debriefing therapy.

Generalized Anxiety Disorder

The main characteristic of this disorder is the all-encompassing, chronic experience of excessive anxiety and worry. Symptoms might include:

- a. trembling, twitching, shakiness and/or restlessness
- b. muscle soreness or tension
- c. fatigue
- d. shortness of breath
- e. palpitations/accelerated heart rate
- f. sweating, hot flashes or chills
- g. dry mouth, difficulty swallowing
- h. dizziness
- i. nausea, diarrhea, abdominal distress
- j. exaggerated startle response, irritability
- k. disturbance in sleeping patterns
- l. difficulty in concentrating

Generalized Anxiety Disorder may need to be treated temporarily with medication and, ideally, in conjunction with psychotherapy.

Anxiety disorders may need to be treated with minor tranquilizers such as Ativan. Also, some of the newer antidepressants such as Prozac have been found to be useful to control obsessive-compulsive behaviours.

Handout 40

Eating Disorders

- Eating disorders are common in our society and have steadily increased over the last three decades, especially among women, where approximately 1 in 10 is affected.
- Reasons for such an increase are probably multifold but feminists believe that a major factor in eating disorders is the world of fashion and entertainment, where the image of a beautiful body has become increasingly defined as thin.
- The idea that 'thin is beautiful' is mostly a phenomenon of the western culture in the twentieth century. In previous times, the ideal shape for women was a much plumper figure. Other cultures, which have not yet adopted western ideals, still prefer full-figured women. **For example**, in Mexico, women with large breasts and wide hips are considered beautiful and desirable. They are perceived as fertile and capable of producing milk that might translate into survival in times of famine. However, the more cosmopolitan woman in such cultures is beginning to shift her ideals to the "Hollywood" standards.
- The 'thin is beautiful' standard excludes the majority of women, who, without overeating, have been genetically predetermined to have fuller figures but are nonetheless considered fat in our culture. These unnatural standards put incredible pressure on the teenage population whose self-esteem is so linked to body image. For those unfortunate girls who genetically are not meant to be thin, the impact of "being fat" can be devastating and lead them to take drastic measures which can result in serious and life-threatening eating disorders. Especially at high risk are young women who are gymnasts, dancers, athletes, models and actors.
- Other predisposing factors to eating disorders include dysfunctional families that create unrealistic standards, expecting perfection in their children and demanding parenting skills that are not encouraging to the development of autonomy in children. Some pubescent girls may resort to drastic weight control to prevent development of a woman's body because they fear the responsibilities and autonomy necessary for survival in the adult world. Being able to control their appetite and weight gives them a sense of control that is otherwise lacking in their lives.
- Eating disorders might start out innocently with a diet that results in a weight loss that is usually validated by the peers of the teenager. Unfortunately, most diets fail in the long run, setting up a vicious circle of weight gain followed by more dieting. Eventually the young women may resort to drastic life-threatening measures such as starvation, vomiting, compulsive exercising and the use of diuretics and laxatives.

Anorexia Nervosa

- The onset of this disorder typically begins in adolescence or early adult life. The essential features include an extreme fear of gaining weight/becoming fat, and distortion in body image.
- In other words, no matter how thin the anorexic person gets, their perception is that they are fat and in need of dieting. Associated features include:
 - a. starvation and peculiar ritualistic eating practices (e.g. cutting food into tiny portions)
 - b. frequent preoccupation with thoughts of food
 - c. unusual hoarding or concealing of food
 - d. secret bingeing followed by self-induced vomiting and purging with the aid of diuretics and laxatives
 - e. daily ritualistic weighing where the slightest increase in weight is experienced as devastating
 - f. compulsive ritualistic exercising
 - g. absence of the menstrual cycle and stunted growth due to lack of proper nutrition
- Even though anorexia nervosa might have bulimic overtones, the main form of weight loss is still due to starvation.
- Predisposing factors include perfectionistic standards and mild obesity in childhood. The onset of the illness can coincide with stressful life situations. About 95% of individuals with anorexia are women.

Bulimia Nervosa

- The essential feature of this disorder is recurrent episodes of secret binge eating (usually involving high caloric foods and sweets) accompanied by the feeling of being out of control over the bingeing. Abdominal discomfort due to bingeing is initially alleviated by the self-induced vomiting, however, for people who have experienced bulimia for a long time, vomiting eventually becomes an automatic response. Associated features include:
 - a. persistent preoccupation with body image and weight gain
 - b. depressed mood, substance abuse, strong dependency needs
 - c. avoidance of food consumption in public places for fear of losing control
 - d. sporadic dieting and the use of exercise, diuretics and laxatives to prevent weight gain
- Medical problems include gastrointestinal difficulties, poor teeth due to acid damage from the vomiting, and heart irregularities due to electrolyte disturbances caused by the purging. This disorder can also be lethal if untreated.
- A predisposing factor for bulimia nervosa is obesity in childhood or teenagers with a history of dieting. 90% of people with bulimia are women.

Treatments for Anorexia and Bulimia Nervosa

- Anorexia nervosa is very difficult to treat. Hospitalization might prevent people with anorexia from dying due to starvation, and even result in some weight gain, but the improvement is usually short-lived once they are released. This disorder responds best to intensive long-term individual and group therapy. Bulimia nervosa is also difficult to treat and similarly requires long-term individual and group therapy.
- Individuals who have been afflicted by either disorder tend to have relapses under periods of great stress.
- If you are working with a consumer who has an untreated eating disorder, it is important to alert your coordinator since such disorders can be life-threatening.

Compulsive Eating

- Although not everyone who is obese overeats, there are some individuals who have a weight problem because of compulsive eating. There are many reasons why a person might feel compelled to overeat. Following are some common underlying reasons:
 - a. some women with a history of sexual abuse use obesity as a protective shield to discourage attention from men
 - b. individuals may use food as a substitute for emotional nourishment
 - c. overeating may be a coping mechanism for stress, boredom
 - d. overeating may be the result of side-effects from medications
 - e. overeating may be a side-effect of depression (chocolate has been related to lessening of depressive moods)
- If a peer is interested in overcoming compulsive eating, a first step may involve increasing awareness of triggers and underlying reasons that are related to their binges. This can be accomplished by keeping a journal which includes documenting feelings at the time the urge to eat is first noticed, what is eaten to satisfy the need, and feelings after eating.
- Individuals can substitute high caloric foods with healthier snacks to satisfy the urge to eat. A healthy eating plan can be developed, preferably with a dietician, coupled with regular exercise. Following is a discussion as to why people are not encouraged to go on restricted diets.

The Pitfalls of Dieting

- Peer support workers should never encourage anyone to go on a restricted caloric diet. Although in the short-term the person's appearance might improve by rapid weight loss, the majority of people gain back the weight once they stop dieting. Furthermore, restricted caloric intake tends to slow down the metabolism rate, which remains low, even after the dieting has ended. The usual result is a weight gain that levels off at about 10% above the weight before the diet was started. With each episode of dieting, the resulting weight becomes increasingly higher. This is known as the "yo-yo" effect where women who have dieted for many years become increasingly obese without overeating.
- Long term restricted dieting has been associated with spontaneous, out of control bingeing. For some individuals it may lead to serious eating disorders. Depression, without previous history of a mood disorder has also been associated with long-term restricted caloric intake.
- The only sensible way of losing weight is by developing proper eating habits. A proper diet consists of normal sized balanced meals, which are low in fat content. In addition, regular exercise uses up calories and tends to increase the metabolic rate. It also helps the body use up the fat intake instead of storing it as fat tissue. This is a much slower process of losing weight but in the long run it is more successful.
- If the person still does not lose weight by following proper eating habits, it is probable that they are genetically predetermined to be fuller-figured. As a peer supporter you can help them come to terms with their genetically predetermined body shape.

SESSION 8

Spirituality and Mental Illness (75 minutes)

Purpose

- To provide an opportunity to discuss the importance of spirituality in the recovery process.
- To allow peer supporters an opportunity to discuss their personal feelings about spirituality

Method

“While hope springs partly from the array of tools science has developed to combat the symptoms of serious mental illness, these are not the entire picture. Hope and courage are at the core of the person, at that dimension we call spirit.

How a person taps that wellspring of spirit, how a person both nurtures and is nurtured by the spirit, is what I call spirituality. It is not the same as religion, although the great religious traditions at their best foster a healthy spirituality.”³

- Religion and spirituality may be a difficult issue to discuss as some people have very strong views. Lead a discussion about the importance of spirituality in recovery, emphasizing the fact that peer supporters need to be neutral.
- Read Handout 41, page 101. Use it as a starting point for a discussion on the difference between religion and spirituality.

Break 15 minutes

Mood Disorders (90 minutes)

Method

- Invite someone who has experience with a mood disorder to present his or her knowledge and experience.
- Read (or assign as homework) - Mood Disorders (Handout 42, page 105)
- Discuss what resources are available in the community to assist people who experience mood disorders.
- Peer support exercise; focus on scenarios where peer supporters can use skills to communicate with people who deal with a mood disorder.

³ Stack, Jerome; article “Spirituality is not the same as religion”

Handout 41

Spirituality and Mental Illness

by Diana Nielsen

I have been wondering for a long time about the recurring bouts of depression that I have experienced for the last 30 years. A long time researcher at the University of California has suggested that there may be a 70% inherited component. This can be a comforting thought because it helps me to believe that it is not my own fault. When I get depressed, I feel down on myself and unable to think clearly. I have trouble making even little decisions and do not want to be around people or say much. Nothing I do seems to bring me pleasure and I would rather be sitting on my sofa than meeting friends, working or listening to music. Like other people, I wonder if I am doing this to myself and what I could do to get better. I do believe that it is very important to find a compatible doctor and I have been greatly helped by medication.

When we have a "physical" ailment, such as a headache or stomachache, we can often take a pill and the pain goes away. What about these diseases of the mind? I have tried to describe the feelings to people who have not experienced them. Because it seems to be a pain of the whole body, the soul if you will, I have wondered if mental illness could in some way for some people be a disease of the soul.

Rabbi Scopitz from Temple Beth Davis is the Director of Pastoral Care at the Rochester Psychiatric Center. I recently heard him discuss the spiritual dimensions of mental health. He reminded us that Carl Jung, one of Freud's successors, thought of mental illness as a spiritual disease. Spirituality can be identified with religion but it doesn't have to be. Thinking of God in whatever way that you do, as a Higher Power, an Energy Force, a Creator can give you a sense that you have a meaningful place in the scheme of the universe. As I listen to people speak and I read about spirituality, I kept hearing over and over the theme of the importance of feeling a connectedness with other people and the world.

A Scottish philosopher said touch, not vision, is the primary sense. We know that little babies who are not touched will not thrive. Rabbi Scopitz suggested that to encounter God is to encounter oneself in the most intense way possible, that mental illness may be an unease of sorts, a sense of disconnection and confusion from being out of touch with the world around you. We know that someone with a mood disorder has trouble feeling joy and may suffer from anxiety, fear and discomfort. He may feel isolated from family and friends. This feeling of abandonment, rejection and stigma makes it difficult to work and can lead to a downward financial spiral, which only reinforces feelings of unworthiness.

The Rabbi suggested that treatment to help reconnect the person with society so that he can reclaim his place in the world can bring healing. With intensive case management and problem solving, there is hope. Drugs also can provide relief from symptoms. Tu Moonwalker, an Apache healer, says "If someone comes to me and has an emotional problem, I can use herbs to calm him down and then use the psychology I learned to help him talk about it. Then my teaching will tell him what to do, what to learn, what to look for

and how to avoid it again." Counseling is important as well as socialization, finding good housing, meaningful work whether paid or volunteer, and recreation. For Rabbi Scopitz and other healers, caregivers are doing spiritual work.

A Native American healer Annie Kahn, who is Navaho, says "Without exception spirituality is inherent in healing. Spirituality is healing. Spirituality is power. No medicine woman will say that she has power because the power belongs to the Great Spirit. It is not hers! Everybody has a certain amount of power. You have power. All of us have power. A medicine woman may use a particular object to make things happen for her. My power is hidden in my prayer. I say 'hidden' because you can't see it. My prayer has names. The names I call upon will assist me – just as you would if I were to call upon you by your name and ask you for your help. You will naturally want to help me. These prayer names might be the Everlasting One or the Unbreakable One."

Johnny Moses, another teacher of Native American spirituality, says "the teachings are very simple and basic. The great mystery is God or the creator. The love of God moves all things. When we begin to use the love of God, we see the love of God is everywhere, in trees, animals, rocks – the same sacred breath.

Our native people believe there is one creator who is everywhere you look. We believe there are many healing spirits – which is the same as the Christian Holy Spirit. Of course, this healing spirit is the love of God, the love we feel in our hearts."

Josette Mondanaro, an M.D. who graduated from the Syracuse University Medical School, puts it another way. She found medical school dehumanizing, treating medicine as a science like physics. She does realize, however, that a vast amount of information is needed. She sees a distinction between a "bloody nose" and a "patient with a bloody nose." Again, she mentions that there is not enough appreciation of the connection between doctor and patient. "Medicine is not set up for people who see the complexity of mind and body." Her father, who was a doctor, was a strong believer in the healing properties of body and mind. If something is out of synchrony, it could create disease. That's how she practices. Applying this concept to the larger world, many people recognize that humankind is increasingly out of kilter with the rhythms of the Earth, and that this disharmony is injuring not only ourselves but the entire planet.

Dr. Mondanaro feels that "many, many times I thought I would have been more comfortable as a shaman. I'm so totally involved with the oneness of the mind and the body that there's no place for me, no comfortable niche already set out for me in western medicine. I have to make it myself." She sees spirituality as very important to healing: "I think the flesh is just the outer manifestation of the spirit. If one believes illness can be caused by witchcraft working on the spirit, it is a possibility for that believer. Miracle cures are the result of spiritual healing power rather than cures imposed from outside the body by a doctor." Belief can make something work as the power shifts from the healer to the sick person.

She sees two kinds of events where diseases of the spirit can lead to physical ailments. The first kind are primary life changes which require only minor readjustments. The secondary changes are major events which require enormous readjustments such as the death of a loved one, a divorce, or new job challenges. "If we can cope with stress and adjust to the demands,

we will not become ill. If we are not 'stuck,' our body will feel the effect resisting becoming physically sick." Traditional people are very aware of this, whereas most modern medicine doctors are not. Shamans have a sense that their community helps keep them safe. Dr. Montanaro says she feels like a left-handed person in a right-handed world.

She sees the healer as opening a space to let in her energy. Without the belief, the space is not created. She sees people who consult doctors becoming more and more cynical, expecting less and less from their doctors, challenging them to "cure them." This pessimism closes off healing so that the doctor may feel it is difficult to be able to cure. As people become more aware of their bodies and seek out doctors with whom they have rapport, healing is helped.

There is another tradition coming from Hispanic culture of the curandera, a healer who believes if the patient recovers, it is God's will. God's will can bring equilibrium back into lives. After the avenues of cultural, familial and religious healing have been tried, if the curandera cannot heal, the patient will enter the mainstream of society's medical care. The belief is that the saints present petitions to God asking him to intercede. This doesn't supplant one's own prayer directed to God but reinforces it and gives the intention more meaning. Jesus, Mary, and the Holy Spirit join the family and the healer in helping the patient. One woman said she thought her gift of curing with the mind and experience brings love to the people whereas the doctor uses pills. Her patients feel that her hands and touch can help heal them.

At a conference in Rochester sponsored by the Mental Health Association called Spirituality in Recovery, I heard about ten speakers share the podium addressing this topic. They were nurses, case managers, ministers, counselors, professors and consumers. A local consumer group has created the Chestnut Café, a Christ-centered peer group for people coping with mental health issues, which serves dinner once a month. Another speaker was from Mainquest, a comprehensive treatment service program for people with chemical dependency problems which offers inpatient and outpatient services, as well as community and supportive living residences. I was touched by another speaker who is the Director of Outreach for Corpus Christi Church.

Dr. Block, a psychiatrist at Harvard, thinks doctors may miss up to 70% of symptoms that reveal anxiety and depression including headaches, fatigue, and restlessness. " By focusing solely on physical ills, a doctor may fail to treat the real problem. Middle-aged men maimed by Vietnam detest themselves for their buried hurts and their country for ignoring this hurt. They are in need of healing. Bent old men, broken old women, hated for their age, their 'uselessness' are in need of healing. As are all the beaten . . . children whose disease is having no power as well as the dying who are detested because their disease is AIDS." This is a very strong indictment.

I recently came back from a retreat where our teacher repeated often that community is stronger than willpower. This is a common theme in the reading I have done about some traditional ways of healing. I was thinking about this again last night as I attended a support group. People often ask the question "How can I find someone who will accept me the way I am and support me through my difficult times?" At the meeting people

were talking about what has helped them get through the tough times and how they can approach family members who care but may not know what to do. It helps people to listen to other people who have shared some of their experiences.

We need to bring back isolated people into harmony and balance using whatever methods we have. It is important to listen to them accepting their reality and sense of what will work for them. When we sit and talk and know the person, when we seek a connectedness between the individual and the healer, then we can dispel some of the fear that produces mistrust. We must remember the influence that the presence of the healer has on the person who is not feeling well. All these healers talked about a predictability, an order and harmony where the healer has to be tough enough so people won't panic but at the same time gentle and caring. Like most things, it takes a balance.

Plato said "As you ought not attempt to cure the eyes without treating the heart or the head without treating the body as a whole, so you should not treat the body without treating the soul, and the treatment of the soul, my good friend, is by means of certain charms, and these charms are words of the right sort. By the use of such words is temperance engendered in the soul and as soon as it is engendered and present, one may easily secure health to the head, and to the rest of the body also."

Starhawk, a traditional healer said "We challenge the emptiness of estrangement whenever we make a deep connection with another, whenever we love, whenever we create community."

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Handout 42

Mood Disorders

Introduction

Mood Disorders are characterized by the presence of a prolonged and all-encompassing emotion, such as depression or elated mood.

Mood disorder distorts the person's awareness of him/herself and the world. There are two main categories:

- a) Bipolar Disorders – where the individual fluctuate between manic and depressive episodes, and
- b) Depression Disorders – where the individual only shifts towards depressive moods.

Characteristics of a Depressive Episode

- The essential feature of a **Depressive Episode** is a prevalent dysphoric (uncomfortable, painful) mood, usually depression (irritability in children and adolescents), and/or a loss of interest in most activities. Associated features might include tearfulness, anxiety, phobias, panic attacks, obsessive thoughts and less frequently, delusions and hallucinations that are consistent with their mood.
- The individual usually describes his/her mood as depressed, sad, with an inability to experience pleasure. The person might also engage in excessive negative self-talk and self-blaming that creates feelings of guilt, shame, worthlessness, and powerlessness, which engenders an attitude of “giving up”. Life's outlook is one of doom and gloom and thoughts of death and suicide are common.
- Eating patterns are usually disturbed. Loss of appetite, which results in major loss of weight, is common. Less frequently, the individual might engage in food bingeing.
- Sleeping patterns are frequently disturbed during a depressive episode. The disturbances can include difficulty in falling asleep, early morning awakening, or the opposite, excessive sleeping with difficulty getting up in the mornings.
- Some individuals exhibit psychomotor agitation such as pacing, inability to sit still or pulling/scratching skin, hair or objects. Others experience psychomotor retardation in the form of slowed speech and body movements. Difficulty concentrating, making decisions and slowed thinking are also common.

- Individuals exhibiting a Depressive Episode are usually diagnosed as having **Major Depression**. Those individuals who have experienced more than one Depressive Episode are classified as having **Recurrent Major Depression**.
- Individuals are diagnosed with **Dysthymia** when they suffer from chronic mood disturbances such as a depressive mood and/or inability to experience pleasure. This disorder is usually not as incapacitating as a major depressive episode and delusions or hallucinations are never present.

Characteristics of a Manic Episode

- The essential feature of a **Manic Episode** involves the person experiencing a distinct period of elated, expansive or irritable mood with symptoms that include feelings of grandiosity, flight of ideas, distractibility, restlessness, hyperactivity, engagement in risky behaviours, and decreased need for sleep. Associated features might include rapid shifts from anger to short-term depression, and less frequently, delusions and hallucinations that are consistent with their mood.
- Some individuals exhibit more subdued manic disturbances (hypomania). The predominant mood is still elation, expansiveness and/or irritability with similar associated features as in manic episodes. But the disturbances are not as severe and incapacitating and delusions or hallucinations are never present.
- A person is diagnosed as having a **Bipolar Disorder** when one or more manic or hypomanic episodes are associated with one or more depressive episodes. If the mood swings are frequent but not as severe, the person is usually diagnosed with **Cyclothymia**.

Pharmacological Treatment of Mood Disorders

- There is a wide range of antidepressants available for the treatment of depression. These drugs do not seem to induce euphoric states in “normal” individuals but rather, correct an abnormal condition in depressed individuals. At the biological level, these medications seem to restore the balance of neurotransmitters in the brain.
- The monamine oxidase inhibitor antidepressants have been found useful for depression accompanied by phobic anxiety symptoms.
- Some of the newer antidepressants such as Prozac have not only been found effective in the treatment of depression, but also for controlling obsessive-compulsive behaviours.
- The first choice of treatment for people with bipolar disorders is lithium. Lithium is also used for enhancing the effect of antidepressants in unipolar disorders.

- Recently, people with bipolar disorders have also been treated effectively with anticonvulsant medications, especially in those individuals who are rapid cycling and those who do not respond to lithium.
- For some people, atypical antipsychotics, such as Risperidal and Seroquel have proven effective in treating mania that may be resistant to other medications.

Peer Support with People Experiencing Mood Disorders

- Peer support with individuals who experience mood disorders might involve helping them come to terms with their illness. This is especially true for individuals with a bipolar disorder who may during their manic phase tend to go into denial and off their medication (or treatment regime). You can educate peers by letting them know that without medication, the episodes of mania and depression tend to become more frequent and severe.
- If you notice one of your clients is exhibiting manic symptoms it is important that you tell the coordinator immediately since such an individual might need additional professional support to protect him/herself from engaging in risky and life-threatening activities.
- When you work with peers who are experiencing a depressive episode, it is important that you give empathic statements that reflect understanding of their feelings. Also, encourage them to talk about their depression in concrete and specific terms. Examples of useful probes include:
 - a) What specifically is getting you down?
 - b) How do you experience depression?
- Also since it is common for persons who are depressed to feel overwhelmed and helpless in solving their problems, it is useful to break down their issues and focus on those that are to some extent controllable.
- Depressed individuals tend to have a negative outlook on themselves and their world and have to be constantly reminded of their strengths and resources. Extra support is needed to build up their self-esteem.
- Encourage them to take small steps and take part in activities in which they are likely to succeed. Depressed individuals who are very lethargic need to be motivated to set small task goals for each day such as having a bath or going for a walk around the block.
- Explore with them past pleasurable experiences and encourage them to take part in such activities again.
- If applicable, you can use self-disclosure describing briefly your experience of depression and reminding them the “black hole” feelings usually pass. With a severely depressed

person, rescuing statements might be necessary such as “I know you are feeling terrible right now but these feelings will most likely pass and you will feel good again.”

- If you come in contact with someone who seems excessively depressed, it is advisable to contact the coordinator immediately. Severe depression requires medical treatment since the person might attempt suicide.
- Frequently peers will give you hints when they are seriously considering suicide. These hints can include:
 - a) has recently made out a will
 - b) has given away possessions
 - c) has recently written several personal letters to friends and relatives
 - d) has recently bought a weapon
- **With severely depressed and possibly suicidal peers, it is essential that you tell them you will discuss your concerns with your coordinator (or alternate) and then do so. (The coordinator will likely talk with the person who referred the peer and let them know of the concerns.)**
(The procedure may vary depending on the program, so check your policies and procedures.)
- The most common motive for suicide is the inability for the person to see any other alternatives. Therefore, try to encourage some hope by saying that even though things might seem terrible there are always options and alternatives, remind them that suicide is a final solution to what is most likely a temporary problem.

SESSION 9

Anger Management (60 minutes)

Purpose

- To facilitate a discussion of how people deal with anger.
- To outline some methods of dealing with anger

Method

- Facilitators lead a discussion with trainees about how they deal with anger. Peer supporters need to be able to manage their anger, and help diffuse angry situations and people.
- Distribute Handout 43, page 111 – Anger Questionnaire and ask trainees to complete. This can be done individually, or you can do the exercise as a group, (ask the group which they prefer) writing responses on the flip chart. Use the answers to have a discussion about anger.
- Give out remainder of anger information and discuss. (Handouts 44, page 113 – Angry Behaviour: An Ecological View and Handout 45, page 114 – The Functions of Anger)
- Assertiveness is one way of dealing with anger. Distribute Handout 46, page 116 – Contrasting Assertive, Passive and Aggressive Behaviour, Handout 47, page 117 – Assertive Behaviour, Handout 48, page 118 – Keys to Being Clear When You Are Being Assertive) and work through exercise. (Handout 49, page 119 – Assertion Skills Worksheet.)

Use of “I” Statements

One of the best ways of dealing with anger may be to say it aloud using “**I**” statements. **For example:**

- ✓ “I feel angry because you did not do your chores.”
- ✓ “I” felt hurt and angry when you called me stupid.”
- ✓ “I” am really angry at you because you failed to call me.”

A technique that may be helpful is to remember to use a format like this:

“I feel _____ (describe the emotion you are feeling, for this example we will use anger.)

When you _____ (tell the person what they are doing that makes you feel angry.

I need you to _____ “ (tell them what they can do to make you feel less angry)

Avoid saying:

- ✓ “You make me so angry, you never do your chores.”
- ✓ “You make me so angry and unhappy when you call me names.”
- ✓ “You make me so angry. You never call me.”

The first set of statements suggests the person who is experiencing the anger is responsible for, or “owns” their feelings. Also, the statements are more likely to trigger considerate responses from the person they are directed at. Alternatively, the latter statements are blaming and tend to make others defensive.

Break 15 minutes

Personality Disorders (60 minutes)

Method

- Read - Personality Disorders - Handout 50, page 122 and Handout 51, page 124 – Fact Sheet
- Discuss resources available in the community to assist people who experience a personality disorder
- Ask a professional to come in and talk about personality disorders, focusing on how a peer supporter can best support an individual who lives with a personality disorder. (This will depend on the community you live in, and what resources may be available.)

Break 15 minutes

- Peer support exercise 30 minutes

Handout 43

Anger Questionnaire⁴

1. Complete this sentence: Anger is...

2. What did you learn about anger as a child?

3. How did you express anger as a child?

4. Describe the angriest moment in your life.

5. List 3 different ways you deal with angry feelings.

6. How do you feel after you have been angry?

7. What pleasure or benefit do you get from anger?

⁴ Centre for Conflict Resolution Training, Justice Institute of B.C., 1990; *Dealing with Anger* page 6 & 7.

8. How do you uses anger as a weapon against others?

9. Do you have any positive ways of dealing with angry feelings? What are they?

Handout 44

Angry Behaviour: An Ecological View⁵

The feeling of anger is always valid. It is merely a signal from your body that something is wrong or that a problem exists. That problem or conflict may have arisen between you and the outside world, or within your needs and beliefs. It may be a real conflict or an imagined one. Rather than judge the feeling of anger in yourself or others, try to find the source of the problem and see if it can be resolved.

Angry behaviour on the other hand may or may not be a direct expression of angry feelings. In our society, angry behaviour has many payoffs. It is therefore important to assess angry behaviour in ourselves and others to determine the meaning of the behaviour in context.

Angry behaviour may be:

- An appropriate expression of feeling.
- A displaced expression of feeling.
- A confused expression of feeling.
- A ritual or tantrum behaviour which has a goal of:

Getting attention

Getting control

Communicating helplessness

Getting revenge

- A purposeful behaviour, which has the goal of intimidating or confusing the target person.

⁵ *ibid*; page 11

Handout 45

The Functions of Anger⁶

Anger can serve a positive or a negative function.

POSITIVE FUNCTIONS

Anger is an energizer.

Anger can facilitate expression of tension, conflict and feelings.

Anger is a cue that a problem exists which is causing us discomfort. This may be environmental, interpersonal or intrapersonal.

Anger can help us feel more empowered and in charge of ourselves.

NEGATIVE FUNCTIONS

Anger can disrupt our thoughts and actions through arousal.

Anger can be used to avoid other feelings.

Anger can quickly lead to aggression or withdrawal.

Anger can result in overreaction or intimidation when we confront others about their behaviour, feelings or values.

⁶ *ibid*; page 12

Other Functions of Anger⁷

Anger may actually reduce stress. It can block awareness of an emotional or physical pain. The kinds of stress which anger can dissipate include (McKay, Roger, McKay, 1989):

1. Painful affect

A mother scolds and shakes her child for returning home at 8:00 p.m. instead of 6:00 p.m. Her anger is serving to block her fear. The terror of losing a child is blocked by the angry words and angry behaviour. Other emotions blocked by anger include sadness, hurt, guilt, shame, and feelings of failure or unworthiness.

2. Painful sensation

Anger can discharge stress created by rushing to meet deadlines, physical pain, the arousal from too much stimulation, muscle tension or fatigue.

3. Frustrated drive

Anger can discharge the stress arising from blocked needs or desires, the frustration experienced when things are 'out of whack', or when being forced to do something against one's will.

4. Threat

Anger may diminish the threat when one feels attacked, controlled or abandoned. The feeling of anger blocks feelings of fear, loneliness, and loss.

⁷ ibid; page 13

Handout 46

Contrasting Assertive, Passive and Aggressive Behaviour⁸

Passive Behaviour	Assertive Behaviour	Aggressive Behaviour
PERSON Does not feel good about self. Demonstrates a lack of respect for their own needs and rights.	PERSON One feels good about self	PERSON Feels good about self at expense of another.
Does not achieve desired goal(s). Many do not express honest feelings, needs, values and concerns.	May achieve desired goal(s)	May achieve goal(s) – almost always wins arguments but hurts/angers other
Allows others to choose for self, deny their rights, ignore their needs	Chooses for self	Chooses for others – tends to overpower other people. This is what I want. What you want is of less importance or not important at all.
Hurt, anxious	Feels satisfied	May feel regret
OTHER PERSON	OTHER PERSON	OTHER PERSON
Guilty, angry, indifferent	Feels good	Does not feel good
Dislikes person	Appreciates person	Hurt, defensive
Achieves goals at person's expense	May achieve desired goals	Does not achieve desired goal

⁸ Centre for Conflict Resolution Training, Justice Institute of B.C., 1996; *Asserting Yourself Under Pressure*, page 4.

Handout 47

Assertive Behaviour⁹

1. Assertion does NOT involve the intent to hurt the other person whereas aggression does.
2. Assertive behaviour aims at equalizing the power between two people.
3. Assertive behaviour involves expressing our legitimate rights.
4. Remember: Other individuals have a right to respond to your assertiveness.
5. An assertive encounter with another individual may involve coming to an agreeable compromise or to a solution which is different than either of you had imagined in the first place.
6. By behaving assertively, you open the way for honest relationships with others.
7. Assertive behaviour is not only concerned with WHAT you say, but HOW you say it.
8. Assertive behaviour is a skill that can be learned with frequent practice.
9. Assertiveness is a choice. It may not always be the best one for you at any one time.

⁹ ibid; page 5

Handout 48

KEYS TO BEING CLEAR WHEN YOU ARE BEING ASSERTIVE

BE CLEAR	<ul style="list-style-type: none"> ★ Think about what you're going to say; don't react in the moment. ★ Speak clearly and slowly. ★ Describe what you want, then why. ★ Check for understanding.
BE SPECIFIC	<ul style="list-style-type: none"> ★ About the problem. ★ About what is acceptable. ★ About what you can and cannot do. ★ About consequences.
BE OBJECTIVE	<ul style="list-style-type: none"> ★ Describe behaviour clearly and without guessing about motives. ★ Describe behaviour without judging it. ★ Describe alternatives without judging them.

Adapted from a handout – *Asserting Yourself Under Pressure*
Centre for Conflict Resolution Training, Justice Institute of B.C., 1996

Handout 49

Assertion Skills Worksheet¹⁰

[Using “*Contrasting Assertive, Passive and Aggressive Behaviour*” (See Handout 43), as your guide, read the following statements and create an appropriate assertive message for each.]

Example:

You car pool to work every morning from [Summerland to Kelowna]. For the last few weeks you have arrived to pick up Jennifer and she has not been ready. You therefore end up in early rush hour traffic and arrive late for work.

Response:

“Jen, I understand things have been hectic for you in the mornings lately. When I arrive to pick you up at 7:00 and you’re often not out to the car until 7:30, I get frustrated and anxious. We end up caught in traffic and I’ve been late for work. It would be better for me if you could be outside by 7:00.”

1. You share a classroom with Sandra. She teaches art and you teach math. You arrived to teach your block of Math 10 and discovered the classroom in a mess. This has happened repeatedly. It takes time for you to clean the room before your class can begin.

Response:

2. You went to the equipment room for supplies and discovered Kelly had not stocked the storeroom. You are unable to begin work without the equipment and supplies you need. You are under pressure to complete your work on time.

Response:

¹⁰ *ibid*; page 26 – 28.

3. Your colleague has the habit of double-checking the information you give him/her as well as the figures you submit to accounting. You're getting frustrated by his/her lack of trust in you.

Response

4. Your boss has changed the time of the managers' meeting with almost no notice. The new time conflicts with a meeting you have arranged with one of your key clients. Both meetings are very important for you to attend.

Response

5. One of your staff just walked out "in a huff" because you asked him/her to redo a portion of a report she/he submitted. You don't feel good about the conversation and are wondering if you were being too picky. You decide to address it.

Response

6. You work with a committee that has been meeting regularly for the last few months. One of your colleagues on this committee continually interrupts while you are speaking. You have decided to address it with them privately.

Response

7. You and your best friend are having dinner together. You have just told him/her about your frustrations at work and she/he has said, "You're too sensitive – you're always over-reacting." You feel dismissed.

Response

8. You lent your car to your brother with a full gas tank. He returned it with no gas and covered in mud. You recently had it cleaned thoroughly.

Response

9. An angry parent confronts you aggressively about your style of teaching, " My Sally used to like school before she met you. You're an incompetent teacher and I won't put up with it any longer."

Response

10. Your boss just threw a report on your desk and stated, "It's got some typing errors – when are you going to take that typing course? I need this on my desk by 4:00!"

Response

Handout 50

Personality Disorders

Personality disorders are pervasive chronic psychological disorders, which can greatly affect a person's life. Having a personality disorder can negatively affect one's work, one's family, and one's social life. Personality disorders exist on a range so they can be mild to more severe in terms of how pervasive and to what extent a person exhibits the features of a particular personality disorder. While most people can live pretty normal lives with mild personality disorders (or more simply, personality traits), during times of increased stress or external pressures (work, family, a new relationship, etc.), the symptoms of the personality disorder will gain strength and begin to seriously interfere with their emotional and psychological functioning.

Those with a personality disorder possess several distinct psychological features including:

- Disturbances in self-image
- Ability to have successful interpersonal relationships
- Appropriateness of range of emotion, ways of perceiving themselves, others and the world
- Difficulty possessing impulse control

These disturbances come together to create an all-encompassing pattern of behaviour and inner experience that is quite different from the norms of the individual's culture and that often tend to be expressed in behaviours that appear more dramatic than what society considers usual. Therefore, those with a personality disorder often experience conflicts with other people and vice-versa.

There are as many potential causes of personality disorders as there are people who suffer from them. They may be caused by a combination of parental upbringing, one's personality and social development, as well as genetic and biological factors. Research has not narrowed down the case to any factor at this time. We do know, however, that these disorders will most often manifest themselves during increased times of stress and interpersonal difficulties in one's life. Therefore, treatment most often focuses on increasing one's coping mechanisms and interpersonal skills.

There are ten different types of personality disorders that exist, which all have various emphases:

- Antisocial Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Dependent Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Obsessive-Compulsive Personality Disorder

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

The most commonly diagnosed personality disorder seems to be Borderline Personality Disorder (BPD). Following is information specifically relating to BPD.

Handout 51

Fact Sheet¹¹

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is characterized by impulsivity and instability in mood, self-image, and personal relationships. It is fairly common and is diagnosed more often in females than males.

What are the Symptoms of BPD?

Individuals with BPD have several of the following symptoms:

- Marked mood swings with periods of intense depression, irritability, and/or anxiety lasting a few hours to a few days
- Inappropriate, intense, or uncontrolled anger.
- Impulsiveness in spending, sex, substance use, shoplifting, reckless driving, or binge eating.
- Recurring suicidal threats or self-injurious behaviour.
- Unstable, intense personal relationships with extreme, back and white views of people and experiences, sometimes alternating between “all good” idealization and “all bad” devaluation.
- Marked, persistent uncertainty about self-image, long term goals, friendships, and values.
- Chronic boredom or feelings of emptiness.
- Frantic efforts to avoid abandonment, either real or imagined.

What Causes BPD?

The causes of BPD are unclear, although psychological and biological factors may be involved. Originally thought to “border on” schizophrenia, BPD now appears to be more related to serious depressive illness. In some cases, neurological or attention-deficit disorders play a role. Biological problems may cause mood instability and lack of impulse control, which in turn may contribute to troubled relationships. Difficulties in psychological development during childhood, perhaps associated with neglect, abuse, or inconsistent parenting, may create identity and personality problems. More research is needed to clarify the psychological and/or biological factors causing BPD.

How Is BPD Treated?

A combination of psychotherapy and medication appears to provide the best results for treatment of BPD. Medications can be useful in reducing anxiety, depression, and disruptive

¹¹ Borderline Personality Disorder Association, Kelowna, BC.

impulses. Relief of such symptoms may help the individual deal with harmful patterns of thinking and interacting that disrupt daily activities.

However, medications do not correct ingrained character difficulties. Long-term outpatient psychotherapy and group therapy (if the individual is carefully matched to the group) can be helpful. Short-term hospitalization may be necessary during times of extreme stress, impulsive behaviour, or substance abuse.

While some individuals respond dramatically, more often treatment is difficult and long term. Symptoms of the disorder are not easily changed and often interfere with therapy. Periods of improvement may alternate with periods of worsening. Fortunately, over time most individuals achieve a significant reduction in symptoms and improved functioning.

Can Other Disorders Co-Occur with BPD?

Yes. Determining whether other psychiatric disorders may be involved is critical. BPD may be accompanied by serious depressive illness (including bipolar disorder), eating disorders, and alcohol or drug abuse. About 50% of people with BPD experience episodes of serious depression. At these times, the “usual” depression becomes more intense and steady, and sleep and appetite disturbances may occur or worsen. These symptoms, and the other disorders mentioned above, may require specific treatment. A neurological evaluation may be necessary for some individuals.

What Medications Are Prescribed for BPD?

Antidepressants, anticonvulsants and short-term use of neuroleptics are common for BPD. Decisions about medication use should be made cooperatively between the individual and the therapist. Issues to be considered include the person’s willingness to take the medication as prescribed, and the possible benefits, risks, and side effects of the medication, particularly the risk of overdose.

SESSION 10

Stress and Stress Management (45 minutes)

Purpose

- Discuss the role stress may have for a peer supporter.
- Discuss the importance of managing stress.
- Identify ways to help the peer supporter manage stress and assist their peer to manage stress.

Method

- Read Handout 52, page 127 – Stress
- Read Handout 53, page 129 – Stress Management
- Have participants do the Stress Test - Handout 54, page 132
- Give participants answers to stress test - Handout 55, page 133 and discuss.

Break 15 minutes

Schizophrenia and Other Psychotic Disorders (120 minutes)

Purpose

- To provide knowledge about schizophrenia and other psychotic disorders.
- To practice skills that will help peer supporters communicate with individuals experiencing schizophrenia or other psychotic disorders.
- To discuss resources available in the community to assist people experiencing schizophrenia or other psychotic disorders.

Method

- Invite an individual who has experienced schizophrenia or another psychotic disorder to present to trainees their experience and knowledge about the disorder.
- Read - Schizophrenia and other psychotic disorders - Handout 56, page 134 (may be done for homework)
- Discuss available resources in the community for people who experience schizophrenia or other psychotic disorders
- Peer support exercise using scenarios that will help peer supporters improve skills in communicating with people who live with schizophrenia

Handout 52

Stress

- Change in life is unavoidable and every living being is continually trying to adapt to new stimuli that are first seen as stressful. Even positive changes such as getting a promotion or marrying can be experienced as stressful in the beginning. For the most part, unexpected changes are felt as more stressful than expected ones. **For example**, a person who has been warned ahead of time of a work lay-off will most likely experience less stress than if the job loss is unexpected.
- People are complex creatures, on the one hand they need a certain amount of reliability but on the other hand crave stimulation through change. People vary in their tolerance towards change. Some individuals become “creatures of habit” where even minor changes are experienced as disruptive to their well being. **For example**, an elderly person might find it extremely stressful to move into a new residence while a younger person might look forward to such a change. A third person might not necessarily experience the stress of the move at the conscious level but nonetheless reacts by developing a disorder such as a skin rash or tense muscles. Individuals differ in the way they react to stressors. The same stimulus, which is stressful to one person, might be experienced as exhilarating to someone else. Furthermore, lack of stimulation, which is experienced subjectively as boredom, can also be a source of stress.
- Sources of stress (stressors) can be external factors such as an earthquake or internal ones like negative self-statements. However, in most cases, the experience of stress is the result of a combination of external and internal components. **For example**, a person who loses their job because of a lay-off (external stressor) might engage in negative self-talk (internal stressor) such as “I will never find a job again”, thus increasing the levels of stress experienced.
- As a peer supporter, it is always important for you to validate the peer’s expression of stress. **For example**, a teenager might experience a great deal of stress and worry after a haircut, which did not turn out to her liking, but nonetheless suits her. Statements such as “Don’t worry about it, to me your hair looks fine, and besides your hair will grow back” are not very helpful. Instead, use a statement that shows understanding of her subjective experience like: “You feel really disappointed in the way your hair turned out (empathy) and you probably worry what your friends might think of your new look (advanced empathy). If you want to hear my opinion, I think the haircut really suits you” (immediacy).
- Individuals do not always cope with stress in positive ways. Some rely on alcohol/drugs or other harmful addictions to lessen anxious feelings. A word of caution, prescription drugs for anxiety are usually addictive. Furthermore, some individuals with addictive tendencies end up overusing prescription drugs, sometimes mixing them with alcohol, which can result in a potentially lethal combination.

Therefore, it may be wise to encourage peers to explore alternatives with their therapist/psychiatrist before resorting to prescription drugs.

- Following are some coping skills, which can help individuals manage their stress levels in more adaptive ways.

Handout 53

Stress Management

Breaking Down Stress into Components

- Sometimes peers complain of feeling stressed or anxious but lack real awareness of the external and internal factors, which are “feeding” their uncomfortable state. In such cases, the first step is to help the peer recognize possible sources of stress by probing with questions such as:
 - a. Where do you think the stress is coming from?
 - b. What areas of your life do you find stressful?
 - c. In what situations do you feel stress?
- The goal with such probing is to break down the perceived stressors into several parts.

For example, a consumer might decide the major areas of stress in her life are as follows:

- ✓ Rejecting behaviour by a teenage daughter
 - ✓ Constant fighting with the husband over the children’s behaviour
 - ✓ Financial difficulties because of only one income.
 - ✓ Anxiety over a possible recurring episode of depression
- The next step involves looking at each part separately and helping the peer generate strategies and action plans for each stressor.
- Sample strategies may include:
- a. Get some books from the public library for gaining understanding of the teenage years of development.
 - b. Get a referral for family counseling
 - c. Keep better track of expenses by developing a monthly budget. Also, make extra money by babysitting.
 - d. Join a depression group for emotional support and to learn coping skills. Also, discuss with the psychiatrist a possible change of medication.
- This process usually helps the peer begin to gain a sense of control over his/her situation. The newly gained awareness of stressors combined with potential solutions might in itself reduce the stress experienced.

The Skill of Time Management

- Many individuals in our culture feel overwhelmed with commitments, which can create a lot of worry and stress. The skill of time management is a useful tool that can help a person organize their commitments with the aid of a calendar/date book. This process may help the person use time more efficiently.
- In addition to time management, peers can also train themselves to focus only on the most immediate or highest priority commitments, blocking out of awareness the tasks that have to be done further along in time.

Escape

- Distractions such as immersing oneself in a book, a movie, TV, music, daydreaming, can all be useful activities to help the person take a break from worrying. Unfortunately for some people, distractions can become addictive to the point where they avoid dealing with the stressors in a solution-oriented manner.

Meditation

- Meditation is a technique, which can be used to stop worrisome internal dialogues by putting the person in a deeply relaxed state. Research suggests meditation increases endorphins, an opiate-like substance naturally produced by the body. Endorphins are related to feelings of well being and relaxation and rise naturally just before a person falls asleep. Therefore, meditation may function for some individuals as an alternative to sleeping pills.
- The meditative state can be achieved in a variety of ways which include:
 - a. The use of a mantra which involves repeating the same word, sentence or prayer to oneself over and over again, either aloud or through internal dialogue;
 - b. Focusing on one's breathing and trying to be aware only of the inhaling and exhaling rhythm.
- A word of caution, meditation may trigger in some individuals auditory and visual hallucinations. The psychiatric community may consider such hallucinations as psychotic episodes. As a peer supporter, encourage the peer to talk to their psychiatrist first before trying such an activity.

Relaxation Exercises

- Relaxation exercises are especially useful for individuals who experience stress at the physical level. The first step involves becoming aware of the tense muscle areas in one's body. The second step involves some form of relaxation exercise such as deep breathing, systematic tensing and relaxing of the various muscles in the body and/or mental visualizations of "dissolving" the tense areas.

Replacing Negative Self-Talk with Positive Thoughts

- Individuals with low self-esteem tend to use negative self-talk and as a result experience more stress. **For example:**
 - ◆ A person who lacks confidence in his/her ability to do well in a course might say to herself "I am not smart enough and I will fail this course", thus compounding his/her perceived stress in relation to her course.
- The first step in overcoming negative self-talk is becoming more aware of self-defeating internal dialogues. This can be done by keeping a written record of specific negative self-statements, under what circumstances they happen, and their emotional affect at the time. It is also helpful to write beside the negative self-statements a positive affirmation. **For example:**
 - ◆ The peer might write, "I feel proud for challenging myself to take this course and I will try to do my best."
- The second step involves practicing stopping the negative self-talk by focusing on a pre-selected visual image such as a serene landscape.
- The third step involves repeating the positive affirmation.

Regular Exercise and Proper Nutrition

Regular exercise not only keeps the body fit but can also increase endorphin levels in the blood system. Also, poor nutrition might reduce the effectiveness of the body's coping mechanisms against stress. A balanced diet, which includes five servings of fruits and vegetables, can provide the necessary amount of vitamins and minerals that are essential to keep the nervous system working its best.

Handout 54

PART ONE

THE STRESS IN YOUR LIFE

How often are the following stressful situations a part of your daily life?

1 Never	2 Rarely	3 Sometimes
4 Often	5 All the time	

I work long hours.....1 2 3 4 5

There are signs my job
isn't secure1 2 3 4 5

Doing a good job goes
unnoticed.....1 2 3 4 5

It takes all my energy just to make it
through the day.....1 2 3 4 5

There are severe
arguments at home.....1 2 3 4 5

A family member is
seriously ill.....1 2 3 4 5

I'm having problems
with child care.....1 2 3 4 5

I don't have enough
time for fun.....1 2 3 4 5

I'm on a diet1 2 3 4 5

My family and friends count on me to solve
their problems.....1 2 3 4 5

I'm expected to keep
up a certain standard of living1 2 3 4 5

My neighbourhood is
crowded and dangerous.....1 2 3 4 5

My home is a mess.....1 2 3 4 5

I can't pay my bills on time1 2 3 4 5

I'm not saving money.....1 2 3 4 5

YOUR TOTAL SCORE

BELOW 38: You have a *Low-Stress Life*.

38 & ABOVE: You have a *High-Stress Life*.

PART TWO

YOUR STRESS SUSCEPTIBILITY

Try to imagine how you would react in these hypothetical situations.

You've been waiting 20 minutes for a table in a crowded restaurant, and the host seats a party that arrived after you. You feel your anger rise as your face gets hot and your heart beats faster.

True or False

.....
Your sister calls out of the blue and starts to tell you how much you mean to her. Uncomfortable, you change the subject without expressing what you feel.

True or False

.....
You come home to find the kitchen looking like a disaster area and your spouse lounging in front of the TV. You tense up and can't seem to shake your anger.

True or False

.....
Faced with a public speaking event, you get keyed up and lose sleep for a day or more, worrying about how you will do.

True or False

.....
On Thursday your repair shop promises to fix your car in time for a weekend trip. As the hours go by, you become increasingly worried that something will go wrong and your trip will be ruined.

True or False

.....
TWO OR FEWER TRUE: You're a *Cool Reactor*, someone who tends to roll with the punches when a situation is out of your control.

THREE OR MORE TRUE: Sorry, you're a *Hot Reactor*, someone who responds to mildly stressful situations with a "fight-or-flight" adrenaline rush that drives up your blood pressure and can lead to heart rhythm disturbances, accelerated clotting, and damaged blood vessel linings. Some hot reactors can seem cool as a cucumber on the outside, but inside their bodies are silently killing them.

October 1994,
HEALTH Magazine

Handout 55

HIGH-STRESS LIFE HOT REACTOR

You're in the danger zone – Make an extra effort to exercise, get enough sleep, and keep your family and friends close. Unfortunately, even being physically fit does little to protect you if your body is in perpetual stress mode. To survive, you may need to make major changes – walking away from life-destroying job or relationship, perhaps – as well as to develop a whole new approach to life's hourly obstacles. Such effort will be rewarded too. In one experiment, 77% of hot reactors were able to cool down – lower their blood pressure and cholesterol levels – by training themselves to stay calm.

October 1994
HEALTH Magazine

HIGH-STRESS LIFE COOL REACTOR

You're under stress – but only you know if it's hurting. Even if you normally thrive with a full plate of challenges, now you might be biting off more than you can chew. Note any increase in headaches, backaches, or insomnia; that's your body telling you to lighten your load. If your job is the main source of stress, think about reducing your hours. If that's not possible, find a way to make your job more enjoyable and stress will become manageable.

October 1994
HEALTH Magazine

LOWER – STRESS LIFE COOL REACTOR

Whatever your problems,
stress isn't one of them.

Even when stressful
events do occur – and they
will – your health
probably won't suffer.

October 1994,
HEALTH Magazine

LOWER – STRESS LIFE HOT REACTOR

You're not under stress – at least not for now. Though you tend to overreact to problems, you've wisely managed your life to avoid the big stressors. Before you honk at the guy who cuts you off in rush hour traffic, remember that getting angry can destroy thousands of heart muscle cells within minutes. Robert S. Eliot, author of *From Stress to Strength*, says hot reactors have no choice but to calm themselves down with rational thought. Ponder the fact that the only thing you'll hasten by reacting is a decline in health. "You have to stop trying to change the world," Eliot advises, "and learn to change your response to it."

October 1994,
HEALTH Magazine

Handout 56

Schizophrenia and Other Psychotic Disorders

Introduction to Schizophrenia

- Schizophrenia is a psychiatric disorder, characterized during the acute phase by severe thought and/or affect (feeling) disturbances which can include:
 - a) sensory hallucinations such as hearing voices, smelling odours, and/or seeing visions which are not real to others
 - b) delusional belief systems which can include paranoid delusions or being persecuted, having special powers, or being an important personality
 - c) flat or grossly inappropriate affect and/or dysphoric mood
- Associated features can include:
 - ✓ Hearing voices, hallucinations that may effect any or all senses
 - ✓ Confused thinking – feeling ambivalent because cannot make a decision
 - ✓ Disjointed thoughts
 - ✓ Overwhelming thoughts – thoughts snowball, build until your senses are over stimulated
 - ✓ Righteousness
 - ✓ Social withdrawal
 - ✓ Feeling that objects or events are meant as personal signs or omens
 - ✓ Religious preoccupation
 - ✓ Lack of motivation
- Schizophrenia has been one of the most misunderstood illnesses. One of the earliest myths, which is still held by some people, is that the individual affected by schizophrenia is “possessed by the devil or spirits”. It is now believed that many of the witches who were persecuted by religion and burned were actually for the most part, individuals who experienced schizophrenia. Some cultures have given special status to individuals with this illness where they are revered as healers, shamans and messengers from gods.
- Another misconception about people with schizophrenia is that they have split or multiple personalities that are unpredictable and dangerous. They are also perceived by some as being “dumb” or “retarded”. Contrary to popular beliefs, research suggests that individuals affected with this disorder are no more violent or less intelligent than the rest of the population.
- Research suggests that schizophrenia is a biologically based illness with a strong genetic link. **For example**, only 1% of the general population has schizophrenia but if there is a familial history of this illness, the chances of developing it increase dramatically.

- Some theories suggest that not everyone who has the genetic predisposition will develop the disorder. Stressful environmental factors may trigger the illness. Theories such as this have supporting evidence from research that indicates the onset of schizophrenia usually coincides with stressful events.
- Research has also shown that individuals affected by schizophrenia have significant structural differences in the brain. These structural differences have been linked with poor memory, inability to foresee logical consequences and speech impediments. Also, at the biochemical level, higher levels of dopamine are present in the brain. However, treatment of this illness seems to normalize the dopamine levels and prevent progression of structural changes in the brain.

Phases of Schizophrenia

As mentioned earlier, the onset of this illness typically shows itself during adolescence or early adulthood. However, some individuals will exhibit eccentric behaviours years before the onset of the acute phase of the illness.

The development of the acute phase is usually preceded by a prodromal phase and followed by a residual phase where the individual's functioning is not up to par. Both phases are characterized by marked social isolation; poor personal hygiene and grooming; markedly eccentric/peculiar behaviours; disturbances in communication; odd beliefs or magical thinking; unusual perceptions; marked lack of initiative, interests and/or energy; impairment in role functioning; and blunted or inappropriate affect. The last two symptoms are especially exhibited in the residual phase.

Unfortunately, rarely does the individual return to the same level of functioning as before the onset of the illness. With each relapse, there is increased residual impairment between episodes. Other factors such as lack of a social support system, and low self-esteem, might also contribute to lower functioning. This in turn, creates further stress that can trigger another episode. Therefore, a combination of medication, social support systems (psychosocial rehabilitation) and early detection and intervention are needed to lower the chances of a relapse.

The warning signs of a relapse are particular to each person but they usually resemble those of earlier episodes. **For example**, an individual might complain of foul body odours or hearing voices each time he is about to have a relapse. Another might begin to think that he has a religious mission to accomplish. Common warning signs include sleeplessness and thought disorders.

Brief Reactive Psychosis

This disorder is usually triggered by severe stress and the essential feature is the sudden onset of psychotic symptoms such as delusions, hallucinations, bizarre behaviour and disturbances in affect. However, the individual returns to pre-morbid functioning.

Schizoaffective Disorder

This is the term used when a person has a combination of a mood disorder and a psychotic disorder. The essential feature of this disorder is the presence of psychotic symptoms and mood disturbances. However, the presence of psychotic symptoms might not correspond to the mood disturbances.

Manic Schizoaffective – elation and grandiosity; may feel energized and have trouble concentrating.

Depressive Schizoaffective – loss of energy, concentration, hopelessness and suicidal thoughts at the same time as paranoia, delusions or hearing voices.

Delusional Disorder

The essential feature of this disorder is a persistent delusion or system of delusions that are non-bizarre in the sense that they involve situations that may occur in real life. Auditory and visual hallucinations are not prominent and usually are short lived. Apart from the delusions and their ramifications, behaviour is not particularly odd.

Five common delusional themes are prominent with this disorder:

1. Erotomania Type – the person has the delusion of being secretly loved by a person, usually someone famous, such as a movie star.
2. Grandiose Type – the person believes that they have great talent, intelligence, spiritual leadership or power.
3. Jealous Type – the individual believes that their loved one is unfaithful without real evidence.
4. Persecutory Type - this is the most common theme where the person believes that he/she is being persecuted, maligned and/or harassed.
5. Somatic Type – here the individual has delusions of physical ailments, such as parasitic infestations, malfunctioning body parts and foul body odours.

Because these delusions might sound quite plausible to others, some individuals can get “sucked into” the delusional system. A prime example is religious or political leaders who manage to sway a following to share their delusional system.

Pharmacological Treatment of Psychotic Disorders

- Schizophrenia is not curable currently, but the symptoms may be controlled with the use of major tranquilizers (antipsychotic drugs). These medications seem to lower the levels of dopamine which in turn results in the cessation of thought disturbances. However, the majority of individuals afflicted with this disorder have to remain on medication to prevent relapses.
- Medications used to treat schizophrenia and other psychotic disorders will be discussed next session.

- Individuals with schizophrenia might also require antidepressants to combat the commonly associated dysphoric mood.
- Brief reactive psychosis and schizoaffective disorder are similarly treated with major tranquilizers and/or depressants.

Peer Support

- When supporting someone who has schizophrenia, it is important to try to establish whether the individual is following the prescribed medical treatment. This is especially important with individuals who have been recently diagnosed and are still in denial about the seriousness of their illness. Such individuals might be prone to stop medication, after successful treatment of the acute symptoms, under the faulty belief of being cured. If you become aware that a peer is not taking the prescribed medication, it is important to inform the coordinator so he/she can take the necessary measures.
- You can discourage peers from stopping their medication by informing them that schizophrenia when untreated may increasingly damage and alter the structure of the brain and with each acute episode, their general functioning may increasingly deteriorate.
- You can also inform them that some of the unpleasant side-effects from the antipsychotics can be treated.
- As a peer supporter you can play an important role in helping peers come to terms with their illness by helping them go through the grieving process. Acceptance of the illness does not imply giving up, but rather a realistic view of the self, which takes the fact of schizophrenia into account. Ideally, peer supporters reinforce the belief in peers that they are human beings with rights that include the opportunity to be an active contributing member of society.
- Peer supporters can also educate the community, including family members about the disorder. Ignorance and misconceptions about schizophrenia has largely contributed to the marginalization and isolation of those who experience schizophrenia. One of the most important jobs you can do is to help an isolated peer reestablish a social network. Feeling a sense of belonging within a community, which offers validation and emotional support, will most likely decrease the chances of a relapse.

SECTION FOUR

Other Important Issues

SESSION 11

Prescription Drugs (75 minutes)

Purpose

- To provide the peer supporters with current information regarding medications commonly used to treat mental illness.
- To provide peer supporters with information about common side effects of psychiatric medications.
- To facilitate self-disclosure of trainees regarding their attitudes towards prescription drugs

Method

- Invite a Pharmacist or Psychiatrist to attend this session. Psychiatric medications change and it is important that up-to-date information is presented. If the trainer is unable to recruit a pharmacist to present this session, it could be helpful to consult with one to find out what the newest medications are.
- Ask group to disclose their attitudes towards prescription drugs and any personal experience with addiction people feel comfortable sharing.
- Discuss classifications of medications: Handout 57, page 141 – Prescription Drugs
 - ◆ Antidepressants
 - ✓ Tricyclics
 - ✓ Monoamine Oxidase Inhibitors (MOAI)
 - ✓ Selective Serotonin Reuptake Inhibitors (SSRI)
 - ✓ Selective Reuptake Inhibitors (SRI)
 - ✓ Selective Norepinephrine Reuptake Inhibitors (SNRI)
 - ◆ Lithium – antimanic
 - ◆ Anticonvulsants
 - ◆ Neuroleptic Agents (Major Tranquilizers; Antipsychotics)
 - ✓ Typical neuroleptics
 - ✓ Atypical neuroleptics
 - ◆ Anxiolytic Agents (Minor Tranquilizers)
 - ✓ Benzodiazepines

Break 15 minutes

Addiction (90 minutes)

Purpose

- To allow trainees the opportunity to discuss their own attitudes and experiences around addiction.
- To provide an opportunity for trainees to practice communication skills around addiction and medication issues

Method

- Read Handout 58, page 151 - Addictions
- Peer support exercise (same format as previous exercise)

Handout 57

Prescription Drugs

Following are the descriptions of common prescription drugs used to treat mental illness, their side effects and helpful hints for safe use.

Antidepressants

Antidepressants are primarily used for the treatment of mood disorders. They are effective in:

- ◆ Elevating depressed mood
- ◆ Restoring appetite
- ◆ Normalizing sleep patterns
- ◆ Restoring ability to experience pleasure
- ◆ Decreasing anxiety/controlling panic disorders
- ◆ Controlling obsessive compulsive disorders

There are four main types of antidepressants:

- ◆ Tricyclics
- ◆ Monoamine oxidase inhibitors
- ◆ Second generation antidepressants
- ◆ Selective serotonin reuptake inhibitors (SSRI)

Tricyclic Antidepressants

These are the oldest type of antidepressants and have proven to be fairly safe in healthy individuals. They seem to be more effective than monoamine oxidase inhibitors. They begin to work in seven to ten days with maximum effect after two to three weeks.

Following are some common tricyclic agents, which are listed from most side effects/sedation to least side effects.

Tricyclic Name	Trade Name
Doxepin	Sinequan
Amoxapine	Asendin
Amitriptyline	Elavil
Imipramine	Tofranil
Nortriptyline	Aventyl
Desipramine	Norpramine

Some common side effects are as follows:

- Drowsiness, dizziness
 - Dry mouth
 - Constipation, difficulty urinating
 - Hypersensitivity to sun
 - Weight gain
 - Fine rapid tremor in upper extremities
 - Blurred vision
 - Skin rashes
 - Possible bone fractures and cardiovascular problems in elderly
- ◆ Some of these side effects disappear after the body gets used to the medication.
 - ◆ Consumers are always encouraged to discuss any side effects with their physician or primary therapist.
 - ◆ Abrupt withdrawal is to be avoided as it may cause nausea and vomiting.
 - ◆ Some helpful suggestions are as follows:
 - ✓ For drowsiness:
Avoid alcohol, avoid sedative cold remedies, avoid operating machinery or engaging in tasks that require alertness until familiar with drug reaction;
 - ✓ For dizziness:
Getting up slowly may help cut down on dizzy spells;

- ✓ For dry mouth:
Can be relieved by sugarless chewing gum, sucking on sour candy or bits of ice, increasing water intake;
- ✓ For constipation:
Can be minimized by drinking lots of fluids, maintaining a high fibre diet, and exercising regularly;
- ✓ Avoid overexposure to sun, use sunscreens and protective clothing

Monoamine Oxidase Inhibitor Antidepressants (MAOI)

These antidepressants are second choice to tricyclics since they have more adverse side effects and require a special diet. However, they tend to work well with depression accompanied by phobic anxiety syndromes. These types of drugs may take four to six weeks before maximum effect is reached.

Some MAOI agents include:

MAOI Name	Trade Name
Tranylcypromine	Parnate
Isocarboxazid	Marplan
Phenelzine	Nardil

Caution: MAO inhibitors should not be taken if suffering from diabetes, epilepsy, asthma, schizophrenia, or Parkinson's disease. MAO inhibitors can cause severe high blood pressure when taken with certain drugs, alcohol and foods rich in tyrosine.

Foods to be avoided include:

- ✓ Aged cheeses: Cheddar, Swiss, Brie, sour cream
- ✓ Wines, especially red and Chianti
- ✓ Smoked or pickled fish, meat or poultry
- ✓ Sausages e.g. Salami, bologna, pepperoni
- ✓ Fava or broad bean pods
- ✓ Yeast extracts
- ✓ Meat extracts: soup cubes, commercial soups with meat extracts
- ✓ Liver
- ✓ Soya sauce
- ✓ Overripe fruit, avocados, raisins

Common side effects include:

- ✓ Drowsiness/dizziness
- ✓ Lightheadedness
- ✓ Weakness

- ✓ Constipation
- ✓ Urinary retardation

The above side effects usually disappear as the body adjusts to the medication.

Serious side effects that require immediate medical assistance are:

- ◆ Severe headaches
- ◆ Rapid heart rate
- ◆ Nausea and vomiting
- ◆ Stiff or sore neck

MAO inhibitors are discontinued two months before any surgery and at least two weeks before switching to tricyclic antidepressants.

Second Generation Antidepressants

These antidepressants are not related to tricyclics or MAO inhibitors.

Desyrel (Trazodone)

This antidepressant is especially effective for treatment of depression accompanied by anxiety. Optimum effect is seen in two to four weeks.

Common side effects include:

- ✓ Drowsiness, dizziness, lightheadedness
 - ✓ Tiredness, decreased blood pressure
 - ✓ Nausea, vomiting, constipation
 - ✓ Dry mouth, blurred vision
 - ✓ Increased libido, prolonged erection
 - ✓ Loss or increase in appetite
- To minimize dizziness and lightheadedness, take after a meal or a light snack.
 - To promote sleep and minimize daytime sedation, all or most of the daily dose is to be taken at bedtime.
 - Some of the side effects may disappear after the body adjusts to the medication, however all symptoms should be discussed with the physician.
 - Medication is stored at room temperature, away from light in a tightly closed container.

Selective Serotonin Reuptake Inhibitors

1. Fluoxetine (Prozac)
2. Fluvoxamine (Luvox)
3. Sertraline (Zoloft)
4. Paroxetine (Paxil)
5. Venlafaxine (Effexor)
6. Citalopram (Celexa)

Fluoxetine (Prozac)

- ◆ Presently, this antidepressant is widely prescribed for the treatment of depression. It is used to elevate mood and to treat the symptoms associated with moderate to severe depression. Depression is believed to be partially related to an imbalance of certain chemicals in your brain. Taking Prozac or other SSRI's helps restore the chemical balance.
- ◆ It has also been found useful in some individuals for the treatment of obsessive-compulsive behaviours and some eating disorders.
- ◆ There is some controversy surrounding this drug, some consider it more of a stimulant than an actual anti-depressant. People at high risk for suicidal ideation, are closely supervised while on this medication until significant remission occurs.
- ◆ The most common side effects include:
 - ✓ Anxiety, nervousness, agitation
 - ✓ Insomnia
 - ✓ Nausea, diarrhea
 - ✓ Headaches
 - ✓ Loss of appetite, weight loss
- ◆ Other side effects are rare and may include:
 - ✓ Sexual dysfunction
 - ✓ Tremor
 - ✓ Dizziness/light headedness, drowsiness
 - ✓ Stomach and bowel problems, constipation
 - ✓ Dry mouth
 - ✓ Muscle and joint pains
- ◆ Prozac is usually administered in the morning to prevent disturbance in sleeping patterns.

- ◆ Initial dosage should not exceed 20 mg. Per day. Gradual dose increase should not take place until a trial period of several weeks. Doses over 50mg per day are not generally more effective. Maintenance dose should be kept at lowest effective level. Lower doses should be administered in the elderly, those with kidney and liver damage, and with individuals who are on multiple medications.
- ◆ The antidepressants Luvox, Paxil and Zoloft are closely related in molecular structure to Prozac and seem to have fewer side effects. The above information applies.

Lithium (Carbolith, Lithane)

- ◆ Lithium is a naturally occurring salt and is mostly used for the treatment of bipolar mood disorders. It has also been found effective in augmenting the effectiveness of antidepressants in individuals with unipolar mood disorders (depression) who have not responded well to antidepressants alone. Lithium takes anywhere from one to three weeks to fully work.
- ◆ Lithium treatment requires regular blood test monitoring to ensure optimum levels. The last lithium dose should be taken 12 hours before the blood sample is taken. Low levels of this salt are therapeutically ineffective and high concentrations can result in serious intoxication, which can result in death.
- ◆ Dangerous side effects which require immediate medical attention include:
 - ✓ Severe nausea, vomiting, diarrhea
 - ✓ Marked shakiness or tremor
 - ✓ Slurred speech and confusion
 - ✓ Blurred vision
 - ✓ Unusual tiredness and weakness
- ◆ Note: Some individuals might be allergic to this salt, especially those who cannot tolerate aspirin.
Common side effects while body is adjusting to the new drug include:
 - ✓ Increased frequency of urination
 - ✓ Increased thirst
 - ✓ Mild nausea
 - ✓ Slight trembling of hands
- ◆ Other less serious side effects include:
 - ✓ Weight gain
 - ✓ Occurrence or exacerbation of acne, psoriasis
- ◆ Prolonged lithium use has been associated with kidney abnormalities and impairment of thyroid function.

Following are some recommendations to be followed for optimal therapeutic benefit:

- ◆ Lithium must be taken regularly and exactly as prescribed;
- ◆ Take with food to prevent upset stomach;
- ◆ Long-lasting tablet/capsule is taken whole, not crushed or chewed;
- ◆ Oral solution is diluted with fruit juice;
- ◆ Drink at least 6-8 glasses of water per day;
- ◆ Do not increase salt intake, lowers effectiveness of lithium;
- ◆ If dose is missed, take as soon as possible or wait if within two hours of next dose, never double the dose;
- ◆ Use extra care in hot weather, avoid sweating heavily

Wellbutrin, Zyban (Bupropion)

This drug is an antidepressant that works as a Central Nervous System (CNS) stimulant. It is used for treatment of:

- ✓ Mood disorders, depressive disorders
- ✓ Substance-related disorders: Nicotine Withdrawal Syndrome associated with the cessation of tobacco smoking.

The exact mechanism of the antidepressant action of Bupropion has not yet been fully determined. Bupropion does not inhibit monoamine oxidase and is only a relatively weak inhibitor of the neuronal re-uptake of norepinephrine and serotonin.

Dosage for treating depression is initially 200 mg daily orally in two divided doses, morning and evening. After three days, increase the dosage, if needed, to 300 mg daily orally in three divided doses, morning, noon and evening. Adjust the dosage according to individual patient response. If therapeutic benefit is not achieved after four weeks, increase the dosage as needed to 450 mg daily in three divided doses. **Do not exceed 450mg per day or a single dose of more than 150mg.**

Common side effects of this drug include:

- ✓ Chest pain, edema, fainting, high blood pressure
- ✓ Anxiety, change in sex drive, confusion, **seizures**
- ✓ Dry skin, hair loss, itching and rash
- ✓ Impotence, menstrual complaints, urinary frequency and vaginal irritation

Anticonvulsants

Anticonvulsants are primarily used for controlling epileptic seizures and bipolar mood disorders. Clinical response might vary from individual to individual.

That is, failure of response by one anticonvulsant might not rule out others from working. Conversely, success with one anticonvulsant does not necessarily guarantee that other anticonvulsants will be effective in a particular individual.

Following are descriptions of some common anticonvulsants:

Tegretol (Carbamazepine)

Tegretol may be used in conjunction with Lithium and Rivotril, however in combination with the latter, it might result in absence (blank) spells. This drug takes effect in about two weeks.

Depakene (Valporic Acid)

Used for rapid-cycling bipolar mood disorders, and when Lithium/Tegretol are found ineffective. May cause absence spells in conjunction with Rivotril. This drug takes effect within 30 to 85 hours.

Rivotril (Clonazepam)

Used to decrease manic episodes. Unfortunately it is habit forming (addictive) and long-term use is to be avoided.

Common Anticonvulsant Side Effects

- ✓ Drowsiness, dizziness
- ✓ Clumsiness
- ✓ Slurred speech
- ✓ Confusion
- ✓ Blurred vision
- ✓ Loss of appetite
- ✓ Nausea
- ✓ Rashes
- ✓ Easy bruising (Tegretol and Depakene)

Suggestions

- Take anticonvulsants with food/milk if irritable to stomach;
- Regular blood tests to ensure optimum levels (Tegretol/Depakene)
- Avoid dangerous contact sports and aspirin (decreased platelets);

- Avoid alcohol and operation of machinery (sedative effect)
- Avoid mixing with other sedatives including cold and hay fever remedies since it more than doubles the sedative effect.

Note: Atypical antipsychotics may be used during a manic crisis, and then withdrawn as mania settles down. Some people who have not responded to lithium have had success with Clozaril or Risperdal as an ongoing medication. (Seroquel and Risperdal seem to be used most frequently for this purpose.)

Neuroleptic Agents (Major Tranquilizers)

Neuroleptic agents also known as major tranquilizers or antipsychotics are used to treat a variety of symptoms, which include hallucinations, delusions, behavioural disturbances and nervous afflictions. Commonly prescribed neuroleptic agents include:

Haldol
 Loxapine
 Mellaril
 Perphenazine
 Modecate
 Chlorpromazine
 Thioridazine
 Fluphenazine
 Trifluoperazine

Antipsychotics usually start working within two weeks but maximum effect is usually reached in four to six weeks.

Side Effects of Neuroleptics

Common side effects that are not serious include:

- ✓ Drowsiness
- ✓ Dizziness
- ✓ Dry mouth
- ✓ Constipation
- ✓ Hypersensitivity to sun
- ✓ Skin rashes
- ✓ Sexual dysfunction
- ✓ Body's ability to regulate temperature and avoid overheating.

The above side effects usually diminish as the body gets used to the drug. However, if they persist, medical attention is needed.

Other more serious side effects that should be brought to the attention of a physician include:

- ✓ Muscle spasms usually involving the neck, eyes and back
- ✓ Stiffness of arms and legs
- ✓ Trembling hands
- ✓ Restlessness, unable to sit still
- ✓ Lip smacking

The above side effects are Parkinson's disease look-alike symptoms and may be treated by lowering the dosage of the antipsychotic or with added medication such as Benadryl and Cogentin.

Anti psychotics are never discontinued abruptly but always under the supervision of a physician.

Atypical antipsychotics

A group of drugs, called "atypical antipsychotics" were introduced in 1990. The first such drug was Clozaril. Other atypical antipsychotics include:

- ✓ Risperidal (Risperidone)
- ✓ Zyprexa (Olanzapine)
- ✓ Seroquel (Quetiapine)
- ✓ Geodon (Ziprasidone)*
- ✓ Zomaril (Iloperidone)*

*Currently available only in the United States.

Handout 58

Addiction

Introduction

- ◆ Addiction for most individuals is a downward process. The addictive behaviour increasingly becomes the central motivator that influences every other aspect of the person's life. That is, the addictive behaviour is given a higher priority to the exclusion of other behaviours that once had a high value to the individual.
- ◆ Most people think of addiction as pertaining to the use of alcohol or drugs. However, here, addiction is defined in a much broader sense encompassing a variety of behaviours such as gambling, pornography, compulsive eating, shopping, shop-lifting, and excessive exercise, meditation, T.V. viewing, etc. Even some relationships may be considered as potentially addictive.

Predisposing Factors to Addiction

- ◆ **Environmental Factors** - Not everyone has the same potential of developing addictive behaviours. Some individuals seem to have predisposing factors that increase their chances of developing dysfunctional dependencies. **For example**, children who grow up in alcoholic families tend to have a higher chance of becoming alcohol/substance abusers. Children who grow up with parents who fail to provide them with a sense of safety, validation, emotional nourishment and/or limits are also high risk for developing addictive behaviours. **For example**, it is a well known fact that teenagers with a history of emotional, physical and/or sexual abuse tend to gravitate towards alcohol/substance abuse, mostly to dull the depression/pain that they are still experiencing from their abusive home environment. Thus alcohol/drug abuse can be seen as a form of "self-medication".
- ◆ **Peer Pressure** - One can also look at the broader social factors that contribute to addiction. **For example**, a few years back, cocaine became an "in thing" to do in many circles and lead to peer pressure to join in. Unfortunately, many individuals developed a dependency on this highly addictive drug. The same can be said about cigarettes, early peer pressure leads many to begin smoking cigarettes – a highly addictive substance.
- ◆ **Biological factors** - might also be involved in the predisposition to alcohol/drug abuse. Research involving adopted children who come from alcoholic biological parents tend to support a genetic link.
- ◆ More recent research suggests that some individuals have the genetic predisposition for alcoholism. They seem to metabolize alcohol at a faster rate, achieving a feeling of well being quickly, reinforcing that behaviour.

- ◆ Individuals with psychiatric disorders also tend to be at high risk for developing alcohol/drug dependence. **For example**, someone with an anxiety disorder might find alcohol consumption sedating. Or a person who suffers from depression might initially feel an elevation in mood through cocaine consumption. Unfortunately, “self-medication” only complicates the psychiatric condition.
- ◆ Dependency on a particular substance is usually a gradual process and can be divided into roughly four stages: a) experimental, b) recreational/social, c) problem use, and d) dependency. Following is a description of these stages.

Experimental Stage

- ◆ Here, the primary motivation is that of curiosity, and the use is often not planned. **For example**, a teenager might first get high on pot or drink alcohol mainly due to peer pressure, curiosity, and the need to act “grown up”. If the individual enjoys the “high”, they might move on to the next stage.

Recreational/Social Stage

- ◆ At this stage, the decision is made to use the substance on a recreational basis. The individual begins to plan its use such as on weekends at social gatherings that involve other peers who engage in the same activity.
- ◆ At this stage, the substance use does not interfere greatly with other activities. However, gradually the ability and/or interest in interacting socially without the substance decreases. Friends who are “straight” are gradually dropped.

Regular Use Stage

- ◆ When the individual gets to this stage, substance abuse has become an integral part of his/her life and use is almost on a daily basis. Solitary use also begins to increase.
- ◆ However, the individual begins to build tolerance for the substance and does not experience the same “highs” anymore. This usually leads to greater consumption of the drug per high and /or mixing it with new drugs. **For example**, somebody who is a regular pot smoker might begin to mix it with alcohol to achieve a satisfying “high”. The user may begin to experience real “lows” which can lead to more self-medication with drugs.
- ◆ Other areas of his/her life become increasingly affected by the substance abuse. The emotional unpredictability, typical of regular drug users, begins to interfere with relationships, work and other activities. Even relationships and activities that were highly valued at some point now become secondary. By this stage of dependence, non-using friends are increasingly out of the picture in exchange for peers who are also substance abusers.

Problem Use Stage

- ◆ At the subjective level, the individual begins to feel increasingly “burnt out”. This might lead to harder drug misuse. Emotionally, there is increased hostility; irritability and angry outbursts are common.
- ◆ At this stage life begins to fall apart for the user who has increased difficulty functioning in the “normal” world. The individual becomes increasingly alienated in areas such as relationships, work, school and the law.

Dependency Stage

- ◆ Life for the individual almost totally revolves around his/her addiction. The person is now unable to quit on their own and the main preoccupation is on having a steady supply of drug(s), no matter what the cost to personal health and previously valued relationships.
- ◆ At this stage, the person needs the drugs to feel “normal” and “highs” are getting harder to achieve. This might lead to changing the method of use (e.g. start injecting) and/or mixing more potent and dangerous drugs.
- ◆ Feelings of alienation, paranoia, and suicidal ideation are common. The person is unable to see any choices except for getting another better “fix”.

Peer Support

- ◆ As a peer supporter, it is quite possible that you may be assigned to peers who have an alcohol and/or other substance abuse problem. This might include the misuse of prescription drugs.
- ◆ Substance abusers can become very sophisticated in hiding their problem. Furthermore, many individuals are in a state of denial about their dependency/addiction. That is, they fail to be honest to themselves about just how addicted they are to their particular drug and hold on to the faulty belief that if they really wanted to, they could quit. They are also very good at rationalizing to themselves and others their addictive behaviour.
- ◆ If as a peer supporter, you become aware that a peer who you are supporting has an alcohol/drug problem, avoid “preaching” to him or her on the “evils” of substance abuse. Instead, try using gently non-judgmental probing such as:
 - ✓ “When do you feel the need to drink (use)?”
 - ✓ “How do you feel before you drink?”
 - ✓ “What do you get out of drinking?”
 - ✓ “How much do you drink?”

- ✓ “Do you mix any of your prescription drugs with alcohol?”
 - ✓ “How do you feel the next day after you drink?”
 - ✓ “How do you think others perceive you?”
 - ✓ “How do you think your family members feel about your drinking?”
 - ✓ “Have you tried quitting before?”
 - ✓ “What was it like quitting?”
 - ✓ “What do you think got you started again?”
-
- ◆ Many individuals will not give you honest answers because of denial. However, if they experience you as non-judgmental they may begin to share more honest information with you and in the process gain awareness of just how serious their problem is.
 - ◆ Substance abusers, who begin to get in touch with feelings of shame and guilt about their addiction, are a step closer in tackling their problem. At that point, you may want to start providing information on their particular dependence in the form of pamphlets and books.
 - ◆ Self-disclosure is encouraged if appropriate. You may also suggest resources such as twelve step programs (e.g. Alcoholics Anonymous, Narcotics Anonymous), drug rehabilitation programs, and detoxification centres. (Be very careful with this to ensure you do not start to preach, or give more information than the peer is able to process).

Overcoming an addiction is experienced as a loss since it involves much more than just stopping the usage of the drug. It is also the loss of a life style. This usually includes leaving the old social circles behind. Therefore, support groups, where they can potentially establish a new social network, are one of the most effective interventions in helping individuals overcome addictions. (It is not the role of the peer supporter to help the peer overcome their addiction; you are simply to provide support and information if the peer wishes it.)

SESSION 12

Suicide (60 minutes)

Purpose

- To discuss signs and symptoms of possible suicidal behaviour.
- To discuss the role of a peer supporter when someone is talking about suicide, or exhibiting warning signs.
- To talk about the effect of having a peer commit suicide.

Method

- Give participants quiz on Myths of Suicide. Handout 59, page 157
- Go through the answers (Handout 59b, page 158) and discuss.
- Ask the group what they feel some of the warning signs of suicide are. Write them on easel or white board. Using the list given in Handout 60, page 159 – The Warning Signs of Suicide, add any that have been missed.
- Read and discuss Handout 61, page 161 – Helping a Suicidal Peer. –ask the group for input into how they believe we can help
- Read and discuss Handout 62, page 162 – Suicide Prevention and Crisis Intervention.
- Discuss feelings of grief, anger, guilt that may occur if a peer commits suicide. **It is not your fault - the choice to take one's own life rests entirely with the owner of that life. If you have any concerns or feelings of discomfort talk with your coordinator and get the support you need for you and your peer.**

Break 15 minutes

Loss and the Grieving Process (30 minutes)

Purpose

- To introduce a theory on loss and grieving
- To encourage trainees to express their feelings when they learned of their diagnosis of a major mental illness

Method

- Facilitators lead a discussion on how trainees felt when they were given the diagnosis of a major mental illness; specifically look at feelings of loss, grief, and anger
- Read Handout 63, page 164 – Loss and the grieving process

Handout 59

Myths about Suicide

1. Once someone decides on suicide, he or she cannot be stopped. True False
2. Talking about suicide gives people the idea. True False
3. People who talk about suicide never actually do it.
True False
4. Suicide occurs without warning. True False
5. The suicidal act is a well-thought-out expression of an attempt to cope with serious personal problems. True False
6. People who have tried suicide and did not succeed are less likely to try it again because they have gotten it out of their system. True False
7. There is a “typical” type of person who commits suicide. True False
8. Once someone is suicidal, he or she will be suicidal forever. True False
9. If a depressed or suicidal person feels better it usually means that the problem has passed.
True False
10. Young men are at the highest risk of killing themselves.
True False

Handout 59b

Answers

1. False. Most suicidal people have mixed feelings. Most do not want death, they want to end the pain (physical and/or psychological). They may be miserable, but they wish to be saved.
2. False. Asking someone about their suicidal feelings may actually make them feel relieved that someone finally recognizes their emotional pain.
3. False. Almost everyone who has attempted suicide has given some warning or clue. When someone talks about committing suicide, they may be giving a warning that should not be ignored by others who hear such comments.
4. False. Many people, including adolescents, give warnings of their suicidal intent.
5. False. Most people are “irrational” at the time of a suicidal crisis. They have very strong mixed feelings. They want to live, but are overwhelmed with despair, anxiety and hopelessness. They cannot see any other solution.
6. False. Eighty per cent of those people who die by suicide have made at least one previous attempt.
7. False. The potential for suicide exists in all of us. There is no typical type of suicidal person.
8. False. People who want to kill themselves are “suicidal” only for a limited period of time. During this time they move beyond it, get help or die.
9. False. If someone who has been depressed or suicidal suddenly seems happier, don’t assume that the danger has passed. A person, having decided to kill themselves, may feel “better” or feel a sense of relief having made the decision. Also, a severely depressed person may lack the energy to put their suicidal thoughts into action. Once they regain their energies, they may well go ahead and do it.
10. True. Males between the ages of 18 and 24 have the highest rate of killing themselves.

Handout 60

The Warning Signs of Suicide¹²

Suicide is rarely a spur of the moment decision. In the days and hours before people kill themselves, there are usually clues and warning signs.

The strongest and most disturbing signs are **verbal** – “I can’t go on,” “Nothing matters any more” or even “I’m thinking of ending it all.” Such remarks should **always** be taken seriously.

Other common warning signs include:

- Becoming depressed or withdrawn
- Behaving recklessly
- Getting affairs in order and giving away valued possessions
- Showing a marked change in behaviour, attitudes or appearance
- Abusing drugs or alcohol
- Suffering a major loss or life change

The following list gives more examples, all of which can be signs that somebody is contemplating suicide. Of course, in most cases these situations do not lead to suicide. But, generally, the more signs a person displays, the higher the risk of suicide.

Situations

- ✓ Family history of suicide or violence
- ✓ Sexual or physical abuse
- ✓ Death of a close friend or family member
- ✓ Divorce or separation, ending a relationship
- ✓ Failing academic performance, impending exams, exam results
- ✓ Job loss, problems at work
- ✓ Impending legal action
- ✓ Recent imprisonment or upcoming release

¹² www.befrienders.org/suicide/warning.htm

Behaviours

- ✓ Crying
- ✓ Fighting
- ✓ Breaking the law
- ✓ Impulsiveness
- ✓ Self-mutilation
- ✓ Writing about death and suicide
- ✓ Previous suicidal behaviour
- ✓ Extremes of behaviour
- ✓ Changes in behaviour

Physical Changes

- ✓ Lack of energy
- ✓ Disturbed sleep patterns – sleeping too much or too little
- ✓ Loss of appetite
- ✓ Sudden weight gain or loss
- ✓ Increase in minor illnesses
- ✓ Change of sexual interest
- ✓ Sudden change in appearance
- ✓ Lack of interest in appearance

Thoughts and Emotions

- ✓ Thoughts of suicide
- ✓ Loneliness – lack of support from family and friends
- ✓ Rejection, feeling marginalized
- ✓ Deep sadness or guilt
- ✓ Unable to see beyond a narrow focus
- ✓ Daydreaming
- ✓ Anxiety and stress
- ✓ Helplessness
- ✓ Loss of self-worth

Handout 61

Helping a Suicidal Peer

Let them know you care:

- * Acknowledge their feelings, i.e.: “You’re feeling _____ is that correct?”
- * Accept the person’s feelings, i.e.: “I can see why you would feel that way.”
- * Reinforce help seeking, i.e.: “I’m glad you are talking to me about this.”
- * Convey involvement, i.e.: “I’m here to listen and I care.”

Use active listening to find out what is happening:

- * Listen to the feelings being expressed.
- * Try to understand and reflect back what the person is saying.
- * Focus on the present and the recent past.
- * Reduce blame. Do not judge or criticize.

Ask direct questions about suicide:

- * “Have you thought about it?”
- * “Have you tried it before?”
- * “Have you made any plans?” Do a S.L.A.P. assessment (see below).

Problem solve:

- * Help the person think of alternatives. Explore consequences.
- * Explore how the person feels about alternatives.
- * Get a commitment to specific plans to seek help or solve the problem.
- * If the person is in a life-threatening situation, call police or ambulance (911).
- * If the person’s life is not in immediate danger, encourage them to seek professional help.
- * Assure the person that you are still available to help.

ASSESSING THE RISK: S.L.A.P.

1. How **SPECIFIC** is the person’s suicide plan? The more detail, the higher the risk.
2. How **LETHAL** is the method chosen? If they plan to use a gun or hang themselves, for instance, the risk is high. If they have chosen to overdose on pills, you may not know how lethal that overdose would be. It is best to be on the safe side and get immediate help if you have any doubt.
3. How **AVAILABLE** is the method chosen to commit suicide? If they have decided to use a gun and are from a family that hunts, the risk is high.
4. What **PERSONAL RESOURCES** are available to the person? Does the person have friends, family, counselors, or ministers who are supportive? How often do they talk to these people? The fewer the people they have who are regularly available, the higher the risk.

Handout 62

Suicide Prevention and Crisis Intervention

FACT: Approximately one person dies for every 10 suicide attempts made.

What is a crisis?

A crisis is a brief period of time during which the person involved has the potential for heightened maturity and growth, or for deterioration and greater vulnerability to future stress. There are three phases involved in a crisis:

Phase One: Impact. This consists of the individual's initial reactions to the crisis and is the phase where learned helplessness may result if efforts produce no satisfactory resolution.

Phase Two: Coping. Renewed effort initiates the second stage of crisis and most crises are resolved during this stage.

Phase Three: Withdrawal. This evolves if none of the coping attempts alleviate the distress. Withdrawal may be voluntary (suicide) or involuntary (personality disorganization).

Generally speaking suicide attempts or suicidal threats made during phase two are intended to end in rescue rather than in death. The purpose is to generate assistance rather than to end one's life. Two thirds of all attempts are actually pleas for attention and help.

When coping attempts fail the person may enter into the third phase known as withdrawal. The person subsequently stops trying to resolve the problem. The voluntary suicide attempts seen in phase three are not a "cry for help" but a serious attempt to die. Death is seen as being preferable to the ongoing pain.

Depression in both adults and youth can be seen in a variety of ways. The majority of people who kill themselves are depressed. Symptoms can include: restlessness, sleep problems, change in eating habits, concentration difficulties, feelings of loneliness, loss of interest, and fatigue. Depression follows a cycle whereby the individual is on an even keel, then the mood worsens and eventually reaches bottom, followed by a gradual recovery. It is during the gradual recovery that most suicide attempts are made because of the increase in energy. When peers feel helpless to change their situations and at the same time they show the restless expression of hostility guilt, or anxiety, they are in danger of acting upon self-destructive impulses. It is also true, however, that persons who choose suicide may become calm; agitation and distress may decrease once these individuals decide on death as the means of controlling their destiny. Consequently, sudden calmness can be like the eye of a hurricane, a bad sign that indicates impending destructiveness.

WHAT DO WE DO?

Take all death threats seriously, especially if there is a history of self-harming behaviour!

HOW CAN WE HELP?

1. Ask them directly “Are you considering killing yourself?” Experts agree that there is no evidence to support the belief that exploring suicide lethality increases the likelihood of self-destruction. It is important for the helper to explore the topic. For a peer in phase three of crisis where the potential for life-threatening behaviour often last several days for a person, suicide prevention efforts may need to include hospitalization.
2. If you feel your peer is at risk, do any or all of the following:
 - A. Don’t try to handle it yourself. There are trained professionals available to help.
 - B. Call your coordinator immediately and give the details, as you understand them.
 - C. 24-hour help is available from any of the following: (These are some of the services available in Kelowna. The trainer needs to encourage trainees to discuss what is available in their own community.)

Mental Health or After hours outreach

868-7788 or

Pager 317-1792 (available after 4 pm Monday to Friday and all weekend)

KGH Emergency Room

862-4485

KGH ERPAS (Emergency Psychiatric Assessment) Nurse

862-4275

RCMP

762-3300

Your coordinator will contact the person who referred the peer and advise them what is happening and what steps have been taken.

REMEMBER, don’t try to handle a suicidal peer on your own. Also remember, that there is only so much that anyone can do and if the suicide does complete ***IT IS NOT YOUR FAULT!!!*** The choice to take one’s own life rests entirely with the owner of that life.

Handout 63

Loss and the Grieving Process

Introduction

- When individuals experience what seems to them a major loss, they usually go through a grieving process, which involves strong emotions such as anger, guilt, helplessness and hopelessness. Each person grieves in his/her unique way and at his/her own pace. However, there is enough similarity among people which allows generalization of the grieving process into roughly five stages:
 - a. denial
 - b. anger
 - c. bargaining
 - d. depression
 - e. acceptance
- The grieving process can be triggered by many kinds of losses, which can include the death of a loved one, ending of a marriage, retirement from a job, and change of residence. As a peer supporter, it is important to remember never to minimize a peer's loss. What might seem a minor loss to you can be experienced by someone else as serious enough to require assistance in the grieving process.
- Not everyone will necessarily go through the grieving process in the above outlined sequence. Some individuals might skip a stage and only experience that stage at a later point.
- Others might never go through the whole grieving process but keep reverting back to earlier stages. **For example**, a person might get stuck at the denial stage, usually when he is symptom free (e.g. "I am cured now and don't need this medication anymore"). Then, when the illness becomes active again, he might jump to the bargaining stage (e.g. "I'll take the medication for a while but what I really need is spiritual healings"). Once he is symptom free, he may revert back to the denial stage again.
- Another point to consider in relation to the grieving process is that there are no clear dividing points between the stages, but instead, they tend to blend into each other. **For example**, someone might fluctuate between denial and anger for quite a period of time before moving on to the next stage.
- Diagnosis of a major psychiatric disorder involves for most individuals the loss of a previously held self-image of being mentally health, and the loss of potential selves.

However, other individuals might also experience a sense of relief with the diagnosis because it represents a concrete answer to what might have been puzzling them for a long time.

Following is a description of each stage in the grieving process as it might apply to a peer coming to terms with the diagnosis of a serious psychiatric disorder. It also outlines guidelines for peer support interventions to help peers move forward towards acceptance of their condition.

The Stage of Denial

- When a person is faced with a severe loss, the common initial reaction is that of shock and numbness which may last a few days or weeks. **For example**, a person who is just informed that he has schizophrenia might initially respond with statements such as “I can’t believe this is happening to me, it can’t be true”. And if awareness of the loss creates great psychological disorganization, the person might resort to denial, that is, the individual negates the reality of the loss as a defense against the painful situation. Following the above example, this person might react with denials such as “The doctor must have misdiagnosed me, I am feeling well now and I am sure the hallucinations are not going to happen again”.
- Denial acts as a buffer that allows the person time to reorganize. Therefore, as a peer supporter it would be unwise to break down the denial defenses prematurely with challenges such as “Schizophrenia is an illness and it is important that you accept this reality now”. Instead, the immediate emphasis is place on encouraging the newly diagnosed person to stay on the prescribed medication. One could use a statement such as “Your diagnosis might be wrong but it is important to stay on your medication to prevent you from having further delusions and hallucinations. If the diagnosis happens to be correct the medication will prevent further deterioration of the brain that accompanies a psychotic episode”.
- Sometimes it takes several relapses before peers finally admit to themselves that they have a serious psychiatric disorder. Unfortunately, even after several recurrences, some individuals remain in a state of denial creating a vicious circle whereby after being stabilized in the hospital they stop their medication only to trigger another relapse.
- Individuals can fluctuate in and out of denial. And those times when peers admit to themselves the reality of the psychiatric condition provide the best leverage for the helper to consolidate the acceptance of the disorder. One of the best ways to help someone come out of denial is by using self-disclosure when applicable. **For example:**
 - ◆ “When I first was diagnosed with schizophrenia, I did not want to believe it, and I pretended for a few years that my delusions and hallucinations were not

going to happen again. Instead of taking my medication, I used alcohol to deal with my problems. But after four increasingly severe relapses, I finally began to come to terms with my condition.

- ◆ I started taking care of myself and began taking my medications regularly, which has kept me, for the most part, stable. I also learned some coping skills, which have helped me manage my disorder. Now I have reached the point where I accept schizophrenia as a part of who I am. And it hasn't been the end of the world for me.
- ◆ I lead, for the most part, a meaningful and fulfilling life, which is normal in many respects. As a matter of fact, I believe that because of my illness, I have learned valuable things about myself and others that I would have never bothered exploring otherwise.”
- The social environment of the person may reinforce denial of psychiatric disorders. Family, friends, even the culture at large can potentially collude with the peer in keeping the denial from breaking down.
- **Eventually, most individuals substitute denial for less radical defenses such as rationalization as to why they developed the disorder. Some examples include:**
 - ◆ “If I had gotten into therapy when my problems first started, I might not have developed this disorder”
 - ◆ “Maybe if I didn’t come from such a dysfunctional family and had received more love and validation, I would not have gotten sick”
- Sometimes these rationalizations can lead to feelings of anger, rage and blaming towards people they hold in some way responsible for their misfortune. This can move them towards the next stage of grieving.

The Stage of Anger

- Once individuals stop denying the psychiatric disorder, they usually start searching for answers to questions such as “Why me?” “How did this happen?”. At this stage, the person begins to have feelings, which include anger, rage, envy and resentment. These feelings may potentially be directed at anybody or anything. Examples of common targets include:
 - a. the people the peer holds responsible for the illness including God and him/herself
 - b. those who fail to cure it
 - c. an innocent bystander

- As a peer supporter, you could also be the target of a peer's irrational anger. If this happens, avoid taking it personally and becoming defensive. Instead, try to use the skill of empathy and probing. **For example,**
 - ◆ "You seem to be feeling angry at me right now. Maybe you can tell me what angers you about me....Is there anyone else you are feeling angry at?". This approach may help consumers vent their anger and move on through the grieving process.

The Stage of Bargaining

- At this stage, even though peers might have accepted the fact that they have a mental illness, they may still resort to partial denial by thinking if a certain code of behaviour is followed, the psychiatric disorder will be cured. This belief might lead the person to try all sorts of magic cures such as special diets, vitamins, herbal remedies and "fringe" therapies, in exchange for prescribed medication.
- Searching for alternate forms of treatment might not necessarily be a bad thing and some might even benefit from them. However, as a peer supporter, you always want to encourage peers to discuss with their psychiatrist first any alternate forms of therapy that they might be considering as some combinations of medication and alternate therapies can be very harmful.

The Stage of Depression

- Some individuals might embark on a long series of searches for "magic cures/therapies" which result in a series of relapses before they finally come to terms with the reality of their condition. This usually triggers feelings of depression and sadness due to a sense of great loss.
- The sense of loss is usually not restricted to the loss of a previously held identity of being "mentally normal" but other losses might be involved due to the illness such as a job or a relationship. The depression might also be fuelled by the awareness of impending losses.
- The depression can also be aggravated by underlying feelings of guilt and shame. **For example,** a peer might feel guilty for having been unable to be with her children while in the hospital. Another peer might isolate himself from his social circle because he feels ashamed of his illness. Such isolation will most likely deepen the feelings of depression.
- As a peer supporter, you should allow peers to express grief instead of trying to distract them by cheerful rescuing statements. Use empathic statements that reflect their feelings of helplessness, hopelessness, sadness and despair. You may also use

probes to promote expression of perceived or anticipated losses by the peers, and possible underlying feelings of guilt and shame.

- After allowing the peer to grieve, you may eventually want to challenge perceived and/or anticipated losses that seem unrealistic. **For example**, a peer might anticipate that her husband is going to leave her because of her psychiatric condition. However, through probing you have determined that the husband seems very supportive and committed to her. The challenge could be as follows:
 - ◆ “You feel afraid your husband is going to abandon you because of your psychiatric disorder, yet when I asked you specific questions about his behaviour towards you, you have told me he came to see you every day during your stay at the hospital, gave you a beautiful ring on your wedding anniversary, is always surprising you with flowers and has as much sexual desire for you as he had before the onset of your illness. I wonder if this fear of abandonment by your husband has something to do with you not feeling very good about yourself right now.”
- At this stage, if applicable, you may also use self-disclosure with the message of “having been there” yet eventually coming out of the “black hole” to lead a productive and meaningful life in spite of the mental illness. This might instill some hope in the peer that he/she, too, can have a meaningful life.

The Stage of Acceptance

- Eventually, the grieving person might reach a stage of dignified, peaceful acceptance of being mentally ill. Acceptance is not to be confused with a resigned and hopeless attitude of “giving up”. There is rather a belief that the individual has learned something valuable. There is also a realistic sense of hope and a belief that, with proper care, relapses might be preventable to some extent. Furthermore, with medical advances, there is a sense of hope that a permanent cure may be found.
- At this stage, peer support involves not only facilitating the process of acceptance but also helping peers to define themselves in much larger terms than just being a “mentally ill person”.

- Encouragement to perceive themselves as having learned valuable lessons and as being worthwhile human beings with ongoing potential for growth through their own unique strengths and talents is essential. They also need empowerment to pursue realistic goals, which allow them to be contributing members of our society. And you, as a peer supporter, can be a great inspiration to them.

SESSION 13

Ending the Helping Relationship (60 minutes)

Purpose

- To provide trainees with an opportunity to discuss the end of a peer support relationship.

Method

- Read Handout 64, page 171 – Ending the Helping Relationship
- Discuss how the peer supporter might feel ending this relationship

Break 15 minutes

Helpful Responses Questionnaire (30 minutes)

Purpose

- To identify skills the trainees have learned through the training sessions.

Method

- Ask trainees to fill out the Helpful Responses Questionnaire
- Facilitator will compare the questionnaire trainees completed in the first session, and use this information to help form an opinion on the knowledge the trainees have taken with them from the training.

Course Evaluation (15 minutes)

Purpose

- Provide the trainers with information about the course content, manner of presentation and the effectiveness of the trainers to allow for positive changes to the course.

Method

- Give each trainee a course evaluation (Handout 65, page 172) to complete and return to the facilitator(s).

Wrap up (45 minutes)

- Give each participant a certificate (see sample, appendix 2) indicating completion of the course.
- Provide refreshments to conclude the classes on a very positive note.

Handout 64

Ending the Helping Relationship

It is always wise for the peer supporter and peer to discuss in the initial meeting how long their involvement is going to be. The peer supporter also will remind the peer of this fact occasionally, especially when the supporting relationship is near its end. This avoids sudden endings that might leave the consumer with feelings of abandonment.

Frequently, the peer supporter and peer, after working some time together, develop strong feelings for each other and the thought of ending the relationship can be felt as a significant loss for both of them. Some peers react to the coming loss of the supporting relationship by becoming superficial and distant. Other peers might deal with the future loss by bringing up new issues or talk about a crisis that they feel needs further peer support. These kinds of changes in a consumer's behaviour will serve as a red flag for talking about possible feelings of the coming separation, anxiety and loss. Such a process will help the peer supporter and the peer to put proper closure to the supporting relationship.

If further peer support is not feasible or necessary, the peer supporter can help the peer look at other support systems that could be put into place before the support relationship comes to an end.

Handout 65

Course Evaluation

Date: _____ Course Title: _____ Instructor: _____

Please answer the following questions:

How well did you understand the information presented in this course?

Did the instructor present the material in an interesting manner?

Were the instructional handouts adequate?

How suitable to your level of experience was the instruction?

How suitable to your level of learning was the instruction?

Was the instructor available for adequate time to answer questions?

What do you feel was the quality of instruction?

Poor	Average	Good	Excellent

Please give comments on how you benefited from this course.

What would you change in this course?

Additional comments: _____

Name (optional) _____

Appendix 1

OBSERVER CHECKLIST

Categorize each Peer Supporter response by placing a check mark and specific examples in the appropriate place. The purpose is for the observer to give feedback on how the Peer Supporter is using the skills that have been taught.

1. Paraphrase (✓ – for each time used)

Examples: _____

2. Empathy (✓ for each time used)

Examples: _____

3. Questions (✓ for each time used)

Examples: _____

4. Describe Body Posture _____

5. Describe eye contact _____

Appendix 2 – Sample Certificate

PEPtalk

Central Okanagan Peer Support Program Certificate of Completion

is hereby granted to

Mary Jane Smith

to certify that she has completed to satisfaction

PEPtalk Training

Granted: April 4, 2005

Appendix 3 – Practice Scenarios

PRACTICE SCENARIOS FOR ROLE PLAYING

Use the information in these scenarios as a starting point for the exercises and then develop your “character” according to what your peer supporter responds.

Scenarios: Empathy

Role Play Scenario #1

It’s been a terrible week – my stepdaughter and I have been fighting all the time. The worst thing is that my wife always takes her side. It makes me so mad.

Role Play Scenario #2

My friend who goes to the mood disorder group with me always puts me down in front of others. He makes me angry.

Role Play Scenario #3

She likes to hurt me by making sure I can hear her inviting others out for coffee and not me.

Role Play Scenario #4

I used to play tennis but the medication has wrecked my coordination and I’m shaky all the time.

Role Play Scenario #5

I saw some old friends from high school yesterday. It’s been a few years since I’ve seen them but they acted like they didn’t even know who I was.

Role Play Scenario #6

I want to get my life back. I’m tired of being sick. I have so much to do. I don’t have time for this.

Scenarios: Paraphrasing

Role Play Scenario #7

It's been a crappy week I'm tired, ... sick and tired of everything.

Role Play Scenario #8

I want my clothes back. They took my clothes and won't let me leave. This hospital is like a jail.

Role Play Scenario #9

I don't trust anyone. I've been burnt so many times because I'm too nice to people.

Role Play Scenario #10

I don't think this medication is working. All it does is make me have a dry mouth and feel spaced out.

Role Play Scenario #11

He's such an idiot. First he tells me to do this and then he changes his mind. The other day I had to walk the dog. I always have to walk the dog. And the kids, -- well he doesn't do much there either. I tell the kids to do their homework and the next thing I know he's letting them go to their friends.

Role Play Scenario #12

I don't want to go to that group. I don't like Katie.

Role Play Scenario #13

Yeah right, whatever.....

Scenarios: Empathy, Paraphrasing, Immediacy, Self-Disclosure

Role Play Scenario #14

I'm overweight – always have been. I try to diet but it's so frustrating. Now this medication is making me gain weight.

Role Play Scenario #15

(Client has a bruised and swollen left side of face and eye.)

My partner is a good man (woman) – sure he (she) hits me sometimes but I hit him (her) too. It's not all the time – only when he (she) is drinking.

Role Play Scenario #16

I don't have a family anymore. The powers that be won't let my partner come home and they took my daughter. I just moved here. I'm trying to get work. No one is helping - Oh what's the use.

Role Play Scenario #17

If I don't get out of here (hospital) by Thursday I'll get kicked out of my apartment. My landlord wants the rent cheque and I'm stuck in here.

Role Play Scenario #18

My roommate is a bitch – excuse my language – but she is. She is always talking about her problems as if they are more important than anyone else's. She takes my things and uses them without asking.

Role Play Scenario #19

I hear noises that keep me awake at night so I stay awake and watch TV most nights.

Role Play Scenario #21

I want to work. My social worker says I don't. It's not my fault I was late for the interview and my last job – well the boss was a jerk and I quit. The time before that they expected me to work Saturdays – forget it. Why do I have to do shift work? They don't pay enough. I'd rather be on welfare.

Role Play Scenario #22

I don't like the people my wife gets to baby-sit. Do you think it's okay to smoke dope out on the patio? Do you think it's right?

Role Play Scenario #23

They've changed my meds again. I don't think they know what they are doing. This one makes me feel like I'm going to have a panic attack. The guy in the other bed has panic attacks. He's told me all about them. I'm out of here tomorrow if they don't get their act together. I'm not their guinea pig.

Role Play Scenario #24

I don't want to be depressed anymore. I want to sleep, to work, and hang out with my friends. They want me to consider meds and see a counselor and go to a day hospital program. Screw them. I don't need them to tell me what to do.

Role Play Scenario #25

Paul has been in the hospital for two weeks and this is your second visit with him. He will be going back to a group home tomorrow. You are sitting in the hospital cafeteria and Paul is talking about his fears around leaving the hospital (might get sick again) and his dislike for some of the people where he lives.

Role Play Scenario #26

You have been visiting Susan for a month now and you like her humour and spirit. She worked as a lab technician for several years before she got sick. In spite of her work background and fairly "chipper" spirit, she has isolated herself and refuses to go out in public with you any more. You want to find out more about where she used to go and what her fears/embarrassment (?) is around being with other people.

References

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Centre for Conflict Resolution Training, Justice Institute of BC, 1996; Asserting Yourself Under Pressure

Centre for Conflict Resolution Training, Justice Institute of BC, 1990; Dealing with Anger

Egan, Girard, The Skilled Helper, 7th Edition, 2002.

Ministry of Health Services, Adult Mental Health Policy and Mental Health Plan Implementation Division, (2001) Peer Support Resource Manual

Neuhausler, Angela, (1995) Peer Support Worker Training Manual for Consumers of Mental Health; edited by Judith Lange.

PEPtalk Central Okanagan Peer Outreach Volunteer Training Manual

Websites that may be useful:

www.befrienders.org/suicide/warning/htm

www.cmha-bc.org

www.heretohelp.bc.ca

www.power2u.org

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