



nami Family & Friends
National Alliance on Mental Illness

Developed by Suzanne Robinson, MSW © 2017



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

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

Acknowledgements

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

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

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

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

—Suzanne Robinson, 2017

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

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

What is NAMI?

National Alliance on Mental Illness



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

What does NAMI do?

National Alliance on Mental Illness



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

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

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

NAMI Education Program Belief System and Principles

We believe:

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

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

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

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

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

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

We offer you:

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

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

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

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

Section II; Introduction to Mental Health.

Mental Health Conditions

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

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

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

Facts

-  1 in 5 ADULTS and 1 in 5 YOUTH in the U.S. are experiencing or will experience a mental health condition at some point in their lives
-  Nearly 60% of ADULTS and 50% of YOUTH AGES 8-15 with a mental health condition don't receive treatment
-  STIGMA is a major reason people don't seek help

One in 5 adults experiences a mental health condition every year. One in 17 has a serious mental illness such as schizophrenia or bipolar disorder. In addition to the person directly experiencing challenges, family, friends and communities are also affected.

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

Cultural Considerations

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

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

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

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

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

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

Warning Signs of Mental Health Conditions

Know the WARNING SIGNS



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

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

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

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

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

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

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

Where to Get Help

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

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

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

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

Receiving a Diagnosis

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

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

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

Finding Treatment

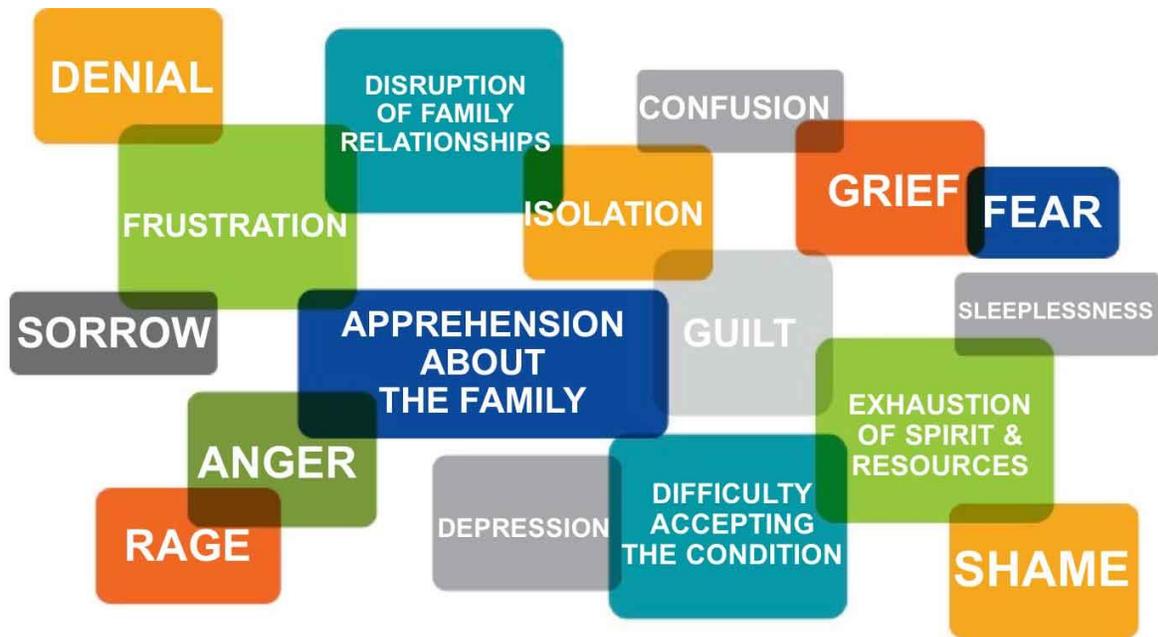
Getting a diagnosis is just the first step; knowing your own preferences and goals is also important. Treatments for mental illness vary by diagnosis and by person. There's no "one size fits all" treatment. Treatment options can include medication, counseling (therapy), social support and education.

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

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

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

Predictable Stages of Emotional Reaction among Family Members



I. Dealing with the catastrophic event

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

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

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

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

II. Learning to cope

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

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

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

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

III. Moving into advocacy

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

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

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

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

Important Points about the STAGES



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

Understanding Trauma

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

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

Secondary Trauma for Families

Families assume overwhelming responsibility

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

Families feel confined

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



Families remain uninformed

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

Families are emotionally exhausted

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

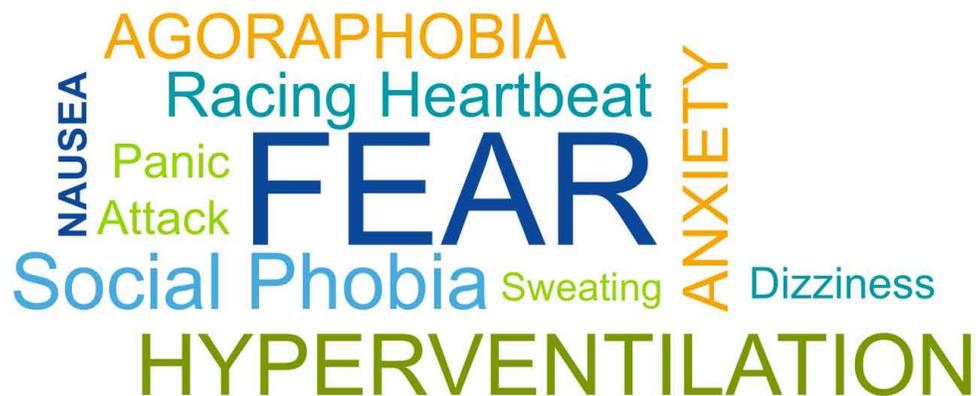
Families find inadequate support

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

Section III; Mental Health Conditions & Diagnoses.

Anxiety Disorders

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



Symptoms

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

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

Physical symptoms:

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

Types of Anxiety Disorders

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

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

Causes

Scientists believe that many factors combine to cause anxiety disorders:

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

Diagnosis

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

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

Treatment

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

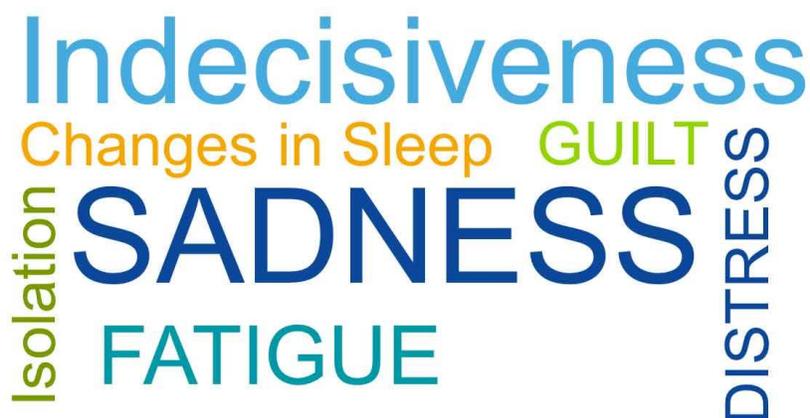
- **Psychotherapy**, including cognitive behavioral therapy (CBT)
- **Medications**, including anti-anxiety medications and antidepressants
- **Complementary health approaches**, including meditation, exercise, nutrition and equine (horse) therapy

Depressive Disorder

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

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

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



Symptoms

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

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

- Hopelessness
- Changes in movement
- Physical aches and pains

Causes

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

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

Diagnosis

To be diagnosed with depressive disorder, a person must have experienced a depressive episode that has lasted longer than two weeks. The symptoms of a depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight

- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

Treatments

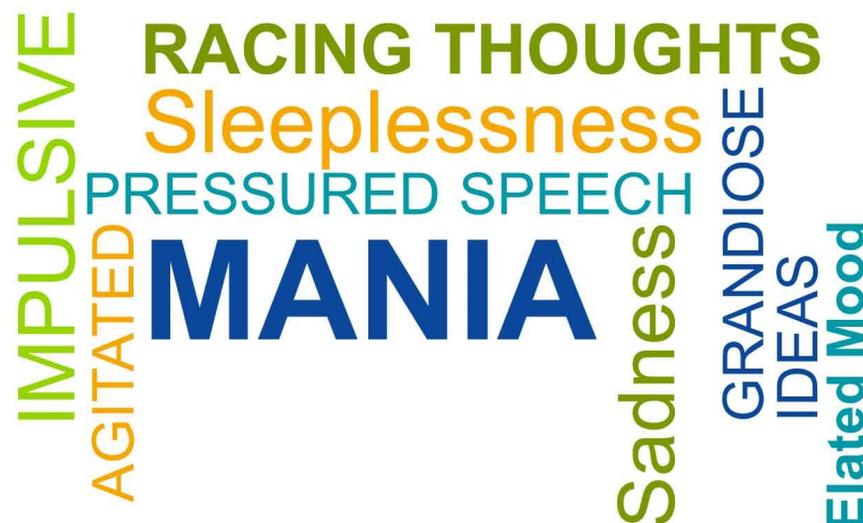
Although depressive disorder can be a devastating condition, it often responds to treatment. The key is to get a specific evaluation and a treatment plan. Treatment can include any one or combination of:

- **Medications** including antidepressants, mood stabilizers and antipsychotic medications
- **Psychotherapy** including cognitive behavioral therapy, family-focused therapy and interpersonal therapy
- **Brain stimulation therapies** including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation (rTMS)
- **Light therapy**, which uses a light box to expose a person to full spectrum light and regulate the hormone melatonin
- **Exercise**
- **Complementary health approaches**, including meditation, exercise, nutrition and equine (horse) therapy
- **Self-management strategies and education**
- **Mind/body/spirit approaches** such as meditation, faith, and prayer

Bipolar Disorder

Bipolar disorder is a chronic mental health condition that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar disorder have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience. If left untreated, the symptoms usually get worse. However, with a strong lifestyle that includes self-management and a good treatment plan, many people live well with the condition.

Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally.



Symptoms

A person with bipolar disorder may have distinct manic or depressed states. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood.

Mania

To be diagnosed with bipolar disorder, a person must have experienced mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function normally in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times; others may experience them only rarely.

Although someone with bipolar may find an elevated mood very appealing, especially if it occurs after depression, the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks. Most of the time, people in manic states are unaware of the negative consequences of their actions.

Depression

Depression produces a combination of physical and emotional symptoms that inhibit a person's ability to function nearly every day for a period of at least 2 weeks. The level of depression can range from severe to moderate to mild low mood, which is called dysthymia when it is chronic.

Causes

Scientists have not discovered a single cause of bipolar disorder. They believe several factors may contribute:

- **Genetics.** The chances of developing bipolar disorder are increased if a person's parents or siblings have the disorder. But the role of genetics is not absolute.
- **Stress.** A stressful event such as a death in the family, an illness, a difficult relationship or financial problems can trigger the first bipolar episode. In some cases, drug abuse can trigger bipolar disorder.
- **Brain structure.** Brain scans cannot diagnose bipolar disorder in an individual. However, researchers have identified subtle differences in the average size or activation of some brain structures in people with bipolar disorder.

Diagnosis

To be diagnosed with bipolar disorder, a person must have had at least one episode of mania or hypomania. The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines four types of bipolar illness:

- **Bipolar I Disorder** is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with bipolar I, a person's manic or mixed episodes must last at least seven days or be so severe that he requires hospitalization.

- **Bipolar II Disorder** is a subset of bipolar disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a full manic episode.
- **Cyclothymic Disorder or Cyclothymia**, is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.
- **Bipolar Disorder “other specified” and “unspecified”** is diagnosed when a person does not meet the criteria for bipolar I, II or cyclothymia but has had periods of clinically significant abnormal mood elevation.

Treatment

Bipolar disorder is a chronic illness, so treatment must be ongoing. If left untreated, the symptoms of bipolar disorder may get worse, so diagnosing it and beginning treatment in the early stages is important. There are several well-established types of treatment for bipolar disorder:

- **Medications** such as mood stabilizers, antipsychotic medications and antidepressants
- **Psychotherapy** such as cognitive behavioral therapy and family-focused therapy
- **Electroconvulsive therapy (ECT)**
- **Self-management strategies and education**
- **Complementary health approaches** such as meditation, exercise and nutrition

Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them.

Symptoms typically begin during childhood, the teenage years or young adulthood, although males often develop them at a younger age than females. More than 2% of the U.S. population (nearly 1 out of 40 people) will be diagnosed with OCD during their lives. If a parent or sibling has an obsessive-compulsive disorder, there's close to a 25% chance that another immediate family member will have it.

Compulsions
Obsessions
GERM PHOBIA
REPETITIVE ACTS
FEAR
Intrusive Thoughts
Or Impulses
CHECKING

Symptoms

Just like with any mental illness, people with obsessive compulsive disorder experience symptoms differently. Most people have occasional obsessive thoughts or compulsive behaviors.

In OCD, however, these symptoms generally last more than an hour each day and interfere with daily life. Obsessions are intrusive, irrational thoughts or impulses that repeatedly occur.

Compulsions are repetitive acts that temporarily relieve the stress brought on by an obsession. Like obsessions, people may try not to perform compulsive acts but feel forced to do so to relieve anxiety.

Obsessions may include:

- Thoughts about harming or having harmed someone.
- Doubts about having done something right such as turning off the stove or locking a door.

- Unpleasant sexual images.
- Fears of saying or shouting inappropriate things in public.

Compulsions may include:

- Hand washing due to a fear of germs.
- Counting and recounting money because a person can't be sure they added correctly.
- Checking to see if a door is locked or the stove is off.
- "Mental checking" that goes with intrusive thoughts is also a form of compulsion.

Causes

The exact cause of obsessive-compulsive disorder is unknown, but researchers believe that activity in several portions of the brain is responsible. More specifically, these areas of the brain may not respond normally to serotonin, a chemical that some nerve cells use to communicate with each other. Genetics are thought to contribute to the likelihood of developing OCD.

Diagnosis

The sudden appearance of symptoms in children or older people merits a thorough medical evaluation to ensure that another illness is not causing these symptoms. To be diagnosed with OCD, a person must have:

- Obsession, compulsion or both.
- Obsessions or compulsions that are upsetting and cause difficulty with work, relationships, other parts of life and typically last for at least an hour each day.

Treatment

For many, a combination of medicine and therapy is superior to either approach alone. While medicine may work directly on the brain, the therapies are believed to help retrain the brain to recognize the "false threats."

- **Medication:** the most common type of medications used to treat OCD are antidepressants. However, it may require a larger dose and take longer for antidepressants to impact the symptoms of OCD than those of depression.
- **Psychotherapy:** There are two types of psychotherapies that are helpful for treating OCD:
 - **Exposure and response therapy (ERT):** ERT exposes a person to the cause of their anxiety. For example, a person with a fear of germs may be asked by a doctor or therapist to put their hand on something considered

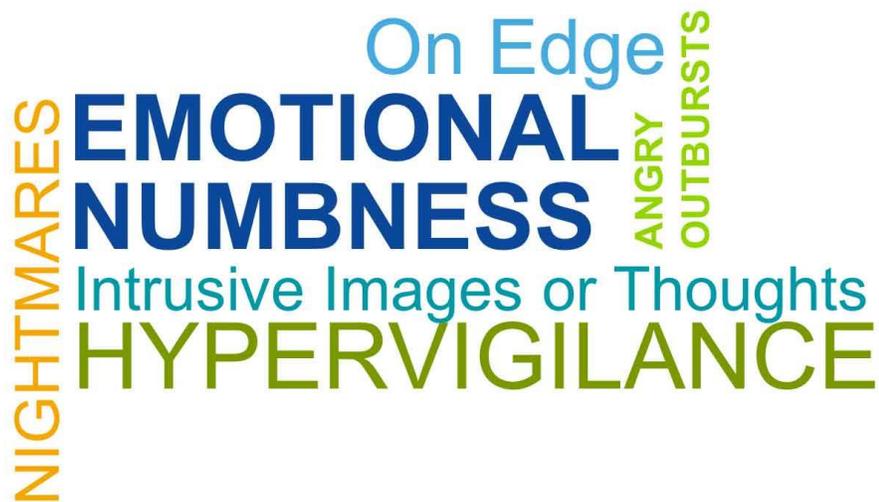
dirty, such as a doorknob. Afterwards, they will refrain from immediately washing their hands. The length of time between touching the doorknob and washing hands becomes longer and longer.

- **Cognitive behavioral therapy (CBT):** CBT focuses on the thoughts that are causing distress, and changing the negative thinking and behavior associated with them. For obsessive-compulsive disorder, the goal of this therapy is to recognize negative thoughts and, with practice, gradually lessen their intensity to the point of harmlessness.
- **Complementary Health Approaches:** aerobic exercise is a key complementary intervention that can work to improve the quality of life for people with OCD. Exercise may reduce the baseline level of anxiety a person experiences.

Post-traumatic Stress Disorder (PTSD)

Traumatic events, such as military combat, assault, an accident or a natural disaster, can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms because they are not integrated into consciousness.

Post-traumatic stress disorder (PTSD) affects 3.5% of the U.S. adult population-about 7.7 million Americans with women more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is in a person's early 20s.



Symptoms

The symptoms of PTSD fall into the following categories:

- **Intrusive Memories**, which can include flashbacks of reliving the moment of trauma, bad dreams and scary thoughts.
- **Avoidance**, which can include staying away from certain places or objects that are reminders of the traumatic event. A person may also feel numb, guilty, worried or depressed or having trouble remembering the traumatic event.
- **Dissociation**, which can include out-of-body experiences or feeling that the world is "not real" (derealization).
- **Hypervigilance**, which can include being startled very easily, feeling tense, trouble sleeping or outbursts of anger.

Recent research has found that children 1-6 years of age can develop PTSD and the symptoms are quite different from those of adults. Symptoms in young children can include:

- Acting out scary events during playtime.
- Losing the ability to talk.
- Being excessively clingy with adults.
- Extreme temper tantrums, as well as overly aggressive behavior.

Diagnosis

Symptoms of PTSD usually begin within 3 months after a traumatic event, but occasionally emerge years afterward. Symptoms must last more than a month to be considered PTSD. PTSD is often accompanied by depression, substance abuse or another anxiety disorder. Because young children have emerging abstract cognitive and limited verbal expression, research indicates that diagnostic criteria must be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children.

Treatment

- **Medications:** There is no one medication that will treat all cases of PTSD. The effective combination of psychotherapy and medication should be used together to reduce its symptoms. Given the common co-occurrence of depression, related anxiety disorders, aggression and impulsivity, selecting medications that address these related problems is recommended. Common categories of medications include antidepressants, antipsychotics and mood stabilizers.
- **Psychotherapy:** People with PTSD respond better to select, structured interventions than to unstructured, supportive psychotherapy. In addition to the following therapies, research is being conducted on dream revision therapy, also known as Imagery Rehearsal Therapy (IRT).
 - **Cognitive behavioral therapy (CBT)** helps change the negative thinking and behavior associated with depression. The goal of this therapy is to recognize negative thoughts and replace them with positive thoughts, which leads to more effective behavior.
 - **Eye Movement Desensitization and Reprocessing (EMDR)** is an eclectic psychotherapy intervention designed for trauma that employs exposure to traumatic memories with alternating stimuli (eye movements are one of several options) in structured sessions with an individual certified to perform EMDR.

- **Exposure therapy** helps people safely face what they find frightening so that they can learn to cope with it effectively. For example, virtual reality programs allow a person to experience the situation in which he or she experienced trauma.

- **Other forms of therapy** include the use of service dogs and support groups.

- **Complementary and Alternative Methods**, Recently, many health care professionals have begun to include complementary approaches in their regimens. Some methods that have been used for PTSD include:
 - Yoga
 - Aqua therapy, such as floatation chambers and surfing
 - Acupuncture
 - Mindfulness and meditation

Schizophrenia

Schizophrenia is a serious mental health condition that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is a complex, long-term medical illness, affecting about 1% of Americans. Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early twenties for men, and the late twenties to early thirties for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.



Symptoms

Just like with any mental health condition, people with schizophrenia experience symptoms differently. Symptoms include:

- **Hallucinations**, which can include a person hearing voices, seeing things, or smelling things others can't perceive.
- **Delusions**, which are false beliefs that don't change even when the person who holds them is presented with new ideas or facts.
- **Disorganized thinking**, such as struggling to remember things, organize thoughts or complete tasks.
- **Anosognosia**, which means they lack insight and are unaware that they have an illness.
- **Negative symptoms**, such as being emotionally flat or speaking in a dull, disconnected way.

Causes

Research suggests that schizophrenia may have several possible causes:

- **Genetics:** Schizophrenia isn't caused by just one genetic variation, but a complex interplay of genetics and environmental influences. While schizophrenia occurs in 1% of the general population, having a history of family psychosis greatly increases the risk. Schizophrenia occurs at roughly 10% of people who have a first-degree relative with the disorder, such as a parent or sibling.
- **Environment:** Exposure to viruses or malnutrition before birth, particularly in the first and second trimesters has been shown to increase the risk of schizophrenia. Inflammation or autoimmune diseases can also lead to a compromised immune system.
- **Brain chemistry:** Problems with certain brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neurotransmitters allow brain cells to communicate with each other. Networks of neurons are likely involved as well.
- **Drug use:** Some studies have suggested that taking mind-altering drugs during teen years and young adulthood can increase the risk of schizophrenia. A growing body of evidence indicates that smoking marijuana increases the risk of psychotic incidents and the risk of ongoing psychotic experiences. The younger the user and more frequent the use, the greater the risk. Another study has found that smoking marijuana led to earlier onset of schizophrenia and often preceded the manifestation of the illness.

Diagnosis

Diagnosing schizophrenia is not easy. The difficulty is compounded by the fact that many people who are diagnosed do not believe they have it. Lack of awareness is a common symptom of people diagnosed with schizophrenia and greatly complicates treatment. To be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Treatment

With medication, psychosocial rehabilitation and family support, the symptoms of schizophrenia can be reduced. People with schizophrenia should get treatment as soon as the condition starts showing, because early intervention can reduce the severity of their symptoms. Treatment options include:

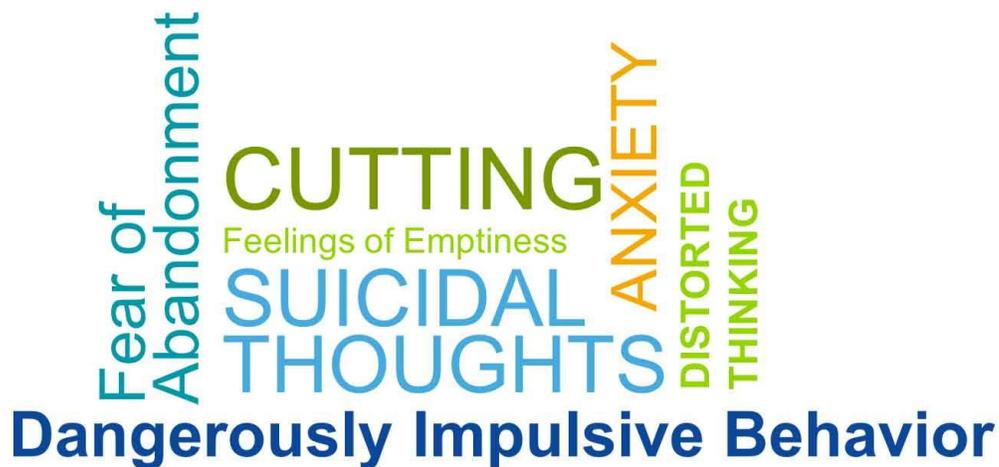
- **Antipsychotic medications:** Typically, a health care provider will prescribe antipsychotics to relieve symptoms of psychosis, such as delusions and hallucinations. Due to lack of awareness of having an illness and the serious side effects of medication, people often hesitate to take antipsychotics.
- **Psychotherapy:** such as cognitive behavioral therapy (CBT) or cognitive enhancement therapy (CET).
- **Psychosocial Treatments:** People who engage in therapeutic interventions often see improvement, and experience greater mental stability. Psychosocial treatments enable people to compensate for or eliminate the barriers caused by their schizophrenia and learn to live successfully. If a person participates in psychosocial rehabilitation, they are more likely to continue taking their medication and less likely to relapse. Some of the more common psychosocial treatments include assertive community treatment (ACT).

Borderline Personality Disorder (BPD)

Borderline personality disorder (BPD) is a condition characterized by difficulties in regulating emotion. This difficulty leads to severe mood swings, impulsivity and instability, poor self-image and stormy personal relationships.

People may make repeated attempts to avoid real or imagined situations of abandonment. BPD is ultimately characterized by the emotional turmoil it causes. People who have BPD feel emotions intensely and for long periods of time, and it is harder for them to return to a stable baseline after an emotionally intense event. Suicide threats and attempts are very common for people with BPD. Self-harming acts, such as cutting and burning, are also common.

It's estimated that 1.6% of the adult U.S. population has BPD but it may be as high as 5.9%. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. In the past, men with BPD were often misdiagnosed with PTSD or depression.



Symptoms

People with BPD experience wide mood swings and can display a great sense of instability and insecurity. Signs and symptoms may include:

- Frantic efforts to avoid being abandoned by friends and family.
- Unstable personal relationships that alternate between idealization and devaluation. This is also sometimes known as "splitting."

- Distorted and unstable self-image, which affects moods, values, opinions, goals and relationships.
- Impulsive behaviors that can have dangerous outcomes.
- Suicidal and self-harming behavior.
- Periods of intense depressed mood, irritability or anxiety lasting a few hours to a few days.
- Chronic feelings of boredom or emptiness.
- Inappropriate, intense or uncontrollable anger—often followed by shame and guilt.
- Dissociative feelings (disconnecting from your thoughts or sense of identity, or “out of body” type of feelings) and stress-related paranoid thoughts. Severe cases of stress can also lead to brief psychotic episodes.

Causes

The causes of borderline personality disorder are not fully understood, but scientists agree that it is the result of a combination of factors:

- **Genetics.** While no specific gene has been shown to directly cause BPD, studies in twins suggest this condition has strong hereditary links. BPD is about five times more common among people who have a first-degree relative with the disorder.
- **Environmental factors.** People who experience traumatic life events, such as physical or sexual abuse during childhood or neglect and separation from parents, are at increased risk of developing BPD.
- **Brain function.** The way the brain works is often different in people with BPD, suggesting that there is a neurological basis for some of the symptoms. Specifically, the portions of the brain that control emotions, decision making and judgment may not communicate well with one another.

Diagnosis

There is no single medical test to diagnose BPD, and a diagnosis is not based on one sign or symptom. BPD is diagnosed by a mental health professional following a comprehensive psychiatric interview that may include talking with previous clinicians, medical evaluations and, when appropriate, interviews with friends and family. To be diagnosed with BPD, a person must have at least 5 of the 9 BPD symptoms listed above.

Treatment

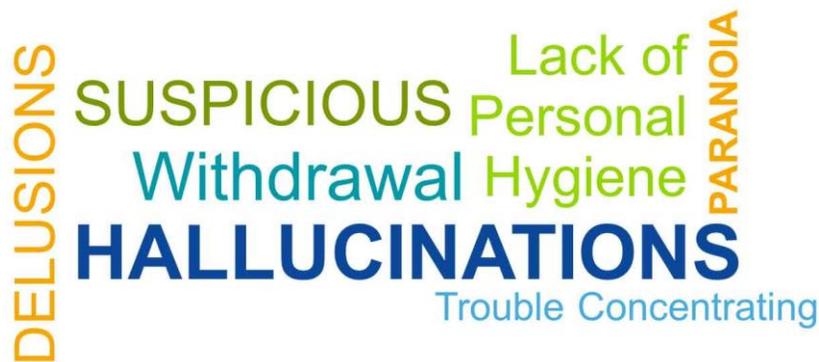
People with BPD are often treated with a combination of psychotherapy, peer and family support and medications to address co-occurring symptoms.

- **Medications** are not specifically made to treat the core symptoms of emptiness, abandonment and identity disturbance, but can be useful in treating other symptoms associated with BPD, such as anger, depression and anxiety. Medications may include mood stabilizers, antipsychotics, antidepressants and anti-anxiety drugs.
- **Psychotherapy** is a cornerstone for treating a person with BPD. In addition to dialectical behavioral therapy (DBT), which was created specifically for the treatment of BPD, there are several types of psychotherapy that are effective. These treatments include cognitive behavioral therapy (CBT) and metallization-based therapy (MBT).

Psychosis

An episode of psychosis is when a person has a break from reality and often involves seeing, hearing and believing things that aren't real. Approximately 3 in 100 people will experience an episode of psychosis during their lives. Young adults are placed at an increased risk to experience an episode of psychosis because of hormonal changes in the brain that occur during puberty, but a psychotic episode can occur at any age.

Psychosis is not an illness, but a symptom. A psychotic episode can be the result of a mental or physical illness, substance use, trauma or extreme stress.



Symptoms

Symptoms of a psychotic episode can include incoherent speech and disorganized behavior, such as unpredictable anger, but psychosis typically involves one of two major experiences:

- **Hallucinations** are seeing, hearing or physically feeling things that aren't actually there.
- **Delusions** are strong beliefs that are unlikely to be true and may seem irrational to others.

Early Warning Signs

Most people think of psychosis as a sudden break from reality, but there are often warning signs that precede an episode of psychosis. Knowing what to look for provides the best opportunity for early intervention. Some indications are:

- A worrisome drop in grades or job performance.
- Trouble thinking clearly or concentrating.
- Suspiciousness or uneasiness with others.

- A decline in self-care or personal hygiene.
- Spending a lot more time alone than usual.
- Strong, inappropriate emotions or having no feelings at all.

Causes

Several factors can contribute to psychosis:

- **Genetics.** Many genes are associated with the development of psychosis, but just because a person has a gene doesn't mean they will experience psychosis.
- **Trauma.** A traumatic event such as a death, war or sexual assault can trigger a psychotic episode.
- **Substance use.** The use of marijuana, opioids, heroin and other substances can increase the risk of psychosis in people who are already vulnerable.
- **Physical illness or injury.** Traumatic brain injuries, brain tumors, strokes, HIV and some brain diseases such as Parkinson's, Alzheimer's and dementia can sometimes cause psychosis.

Diagnosis

A diagnosis identifies an illness, and symptoms are components of an illness. Psychosis is a symptom, not an illness.

Health care providers draw on information from medical and family history along with a physical examination to make a diagnosis. If causes such as a brain tumor, infection or epilepsy are ruled out, a mental health condition might be the cause of psychosis.

Treatment

Identifying and treatment psychosis as early as possible leads to the best outcomes. Early intervention is always the best approach to treatment a mental health condition, because there is a chance of preventing the condition from progressing.

There are many specialized centers that focus exclusively on psychosis and crisis treatment in youth. The American Psychiatric Association (APA), your state chapter of the APA, primary care doctor, insurance carrier and the state or county mental health authority are other resources that can help you.

Treatments for psychosis can include a combination of psychotherapy, medication, complementary health approaches or even hospitalization. It's important to work with a mental health care professional to determine the right treatment plan.

Dual Diagnosis

Dual diagnosis is a term for when someone experiences a mental illness and a substance abuse problem simultaneously. Dual diagnosis, also referred to as co-occurring diagnosis, is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when they abuse heroin during periods of mania.

Either substance abuse or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms they experience. Research shows though that drugs and alcohol only make the symptoms of mental health conditions worse. Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.

ARREST Supporting a Habit ALCOHOL ANXIETY OPIATES
SUBSTANCE Meth ABUSE Heroin
Sudden Behavior Changes
MARIJUANA Withdrawal

How Common is a Dual Diagnosis?

About a third people experiencing mental health conditions and about half of people living with the most severe forms of the conditions also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of alcohol abusers and more than half of drug abusers report experiencing a mental health condition.

Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with other medical illnesses.

Symptoms

The defining characteristic of dual diagnosis is that both a mental health and substance abuse disorder occur simultaneously. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance abuse may include:

- Withdrawal from friends and family.
- Sudden changes in behavior.
- Using substances under dangerous conditions.
- Engaging in risky behaviors when drunk or high.
- Loss of control over use of substances.
- Doing things you wouldn't normally do to maintain your habit.
- Developing tolerance and withdrawal symptoms.
- Feeling like you need the drug to be able to function.

The symptoms of a mental health condition also can vary greatly. Knowing the warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide, can help identify if there is a reason to seek help.

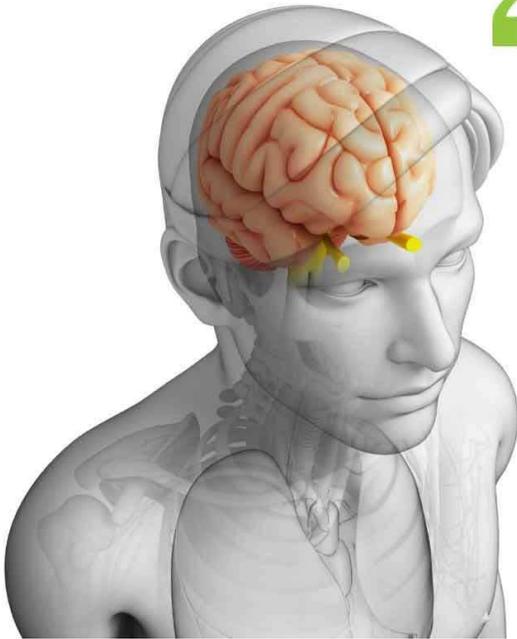
Treatment

The most common method of treatment for dual diagnosis today is integrated intervention, where a person receives care for both a specific mental health condition and substance abuse. Because there are many ways in which a dual diagnosis may occur treatment will not be the same for everyone.

- **Detoxification:** The first major challenge that people with dual diagnosis must endure is detoxification. During inpatient detoxification, a person is monitored 24/7 by trained medical staff for up to 7 days. Inpatient detoxification is generally more effective than outpatient for initial sobriety. This is because inpatient treatment provides a consistent environment and removes the person battling addiction from exposure to people and places associated with using.
- **Inpatient Rehabilitation:** A person experiencing a serious mental health condition and dangerous or dependent patterns of abuse may benefit most from an inpatient rehabilitation center where concentrated medical and mental health care is offered 24/7. These treatment centers provide therapy, support, medication and health services with the goal of treating addiction and its underlying causes. Supportive housing, like group homes or sober houses, is another type of residential treatment center that is most helpful for people who are newly sober or trying to avoid relapse.

- **Medications:** Medications are a useful tool for treating a variety of mental health conditions. Depending on the mental health symptoms a person is experiencing, different medications may play an important role in recovery. Certain medications are also helpful for people experiencing substance abuse. These medications are used to ease withdrawal symptoms or promote recovery. Medications to ease withdrawal are used during the detoxification process.
- **Psychotherapy:** Psychotherapy is almost always a large part of an effective dual diagnosis treatment plan. Education on a person's illness and how beliefs and behaviors influence thoughts has been shown in countless studies to improve the symptoms of both mental health conditions and substance abuse. Cognitive behavioral therapy (CBT) in particular is effective in helping people with dual diagnosis learn how to cope and to change ineffective patterns of thinking.
- **Self-help and Support Groups:** Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, successes, referrals for specialists, where to find the best community resources and tips on what works best when trying to recover. Members also form friendships and find sponsors that can help them stay sober.

The Biology of Mental Health Conditions



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

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

Section IV; Communication Strategies.

Offering Empathy



- **Support instead of criticizing.** People experiencing a mental health crisis are very vulnerable. When we criticize them, or make negative remarks, we take advantage of their vulnerability. This contrasts with our goal to help meet their immediate needs and support them on their way to recovery. As part of our efforts, it's critical that we respect and protect their self-esteem. Frame any recommendations in terms of what benefit we believe they may bring, rather than what we think the person is doing "wrong."
- **Encouragement instead of punishing.** The most effective way to help people start a beneficial behavior is to respond empathetically to their experience, validate their perspective, find a shared goal, listen to their ideas, and suggest our own. When we follow this process and genuinely share ideas and concerns, we will build trust with our loved one. This is the most effective way to encourage long-term change. Influencing people through intimidation or punishment is coercive and leads to more conflict and worse outcomes. Family members have direct experience with this. Joe Talbot, a parent quoted in Patricia Backlar's book, *The Family Face of Schizophrenia*, said:

"With this disease there is no fighting. You may not fight. You just have to take it and take it calmly. And remember to keep your voice down. . . [Also] punishment doesn't work with this disease. Now that I have lived with a person with schizophrenia, it makes me very upset when I see mental health workers try to correct their clients' adverse behavior by punishment, because I know it doesn't work."

- **Reward positive behavior and ignore negative behavior.** Studies have shown that people will want to behave in ways that bring them recognition and approval. Research has demonstrated that criticism, conflict and emotional pressure are highly correlated to relapse. It's better to simply wait and ignore negative behavior, if it is not actively dangerous, than to react to it or focus on it.
- **Recognize and accept all the person's symptoms.** It can be tempting to try to "fix" someone's symptoms because they may resemble intentional behaviors. It's critical that we remember that lack of motivation in a depressed person is a symptom of their condition and not something we can counteract or make go away, except for, possibly, through an effective treatment plan. We can't argue with someone's psychotic delusions or deflate someone's grandiose self-image when they're having a manic episode. These aren't social behaviors—they are medical symptoms that can be addressed through a variety of treatments. Instead, offering support and empathy can relieve the person's guilt and anxiety and make treatment more possible.
- **Patiently encourage independent behavior.** To encourage our loved one to take independent steps in their recovery process, ask them what they feel they're ready to do. Make short-term plans and goals and be prepared for changes and pauses. Progress in mental illness requires flexibility. It may require family members and providers to let go of the standards by which they measure progress and listen more to how the person with the mental health condition measures progress. Patience and waiting can be healing. Be aware that someone with a mental health condition may be anxious that when they show signs of improvement, their support system will withdraw and they'll be in greater risk. Reassure your loved one that your concern and support will be present even when there isn't in a crisis.
- **Maintain basic expectations.** Like with anyone else, we can expect reasonable, basic behaviors from people with mental illness. Everyone has a better chance of co-existing well when expectations for behavior and cooperation are clear, so we must be sure to express ours.
- **Validate the emotional content of what our loved ones express.** Being empathetic often involves listening and responding to the emotional truth of what someone is expressing. We may not agree with the details or ideas they're sharing, but we must recognize and express the validity of their emotional response to their experience. For example, if someone says, "Everyone in this house thinks I'm a

failure,” we can validate the difficulty of what they’re feeling without agreeing with the idea. We can say something like, “It must be upsetting to think we’re disappointed with you. That would be painful.” This shows we’ve listened carefully, gives them a chance to clarify any misunderstanding, and demonstrates that they can trust us with how they really feel. Once we build trust like this, we can start to clarify how we see the situation and find things we agree on as we move forward.

- **Have empathy for ourselves.** We aren’t superheroes, and many things are outside of our control. A loved one may not have the outcomes we’d like, or they may seem stuck in a difficult stage for a long time. It’s admirable to do our best to help improve the well-being of our loved one, but we can’t guarantee what exactly that will look like. We must be compassionate toward ourselves and our limits.

Learn more

For an articulate and engaging illustration of empathy, see Brené Brown’s animated video on empathy vs. sympathy: <https://www.youtube.com/watch?v=1Evwgu369Jw>

Basic Communication Guidelines



- Use short, clear, direct sentences. Long, complicated explanations can be difficult for people experiencing mental health symptoms to follow. They may stop listening.
- Keep the content of what you say simple. Discuss only one topic at a time and give only one direction at a time. Be as concrete as possible.
- Keep the level of stimulation as low as possible so your loved one will be able to listen and understand you. Keep your voice low and calm, keep your body language calm and still, and speak respectfully and carefully rather than accusing or criticizing.
- Be pleasant and firm. Saying things that contradict each other, or saying one thing and doing something that contradicts it, makes it hard for your loved one to understand and trust you. When you communicate clearly and well, you show your loved one that you have healthy boundaries and that they must respect them.
- Assume that the person may not be able to absorb a lot of what you say to them. You will often have to repeat instructions and directions. Be patient.
- If your relative seems withdrawn and reluctant to talk, pause the conversation and give them space for a while. Don't try to force a conversation. You'll have a better chance of getting the response you want when your loved one is more capable of interacting with you.

I-Statements

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

Sample I-statements:

- I feel frustrated there are dirty dishes around the house.
- I worry when you stay up late. I know how difficult it is for me to get up in the morning when I stay up late.
- I feel frightened when you stop talking to me—I worry that something might be wrong.
- I feel sad when there is fighting in the house.

Reflective Responses

Basic steps for making a reflective response:

1. Acknowledge the reality of your loved one's lived experience—that is, what is real and true to them (rather than to you).
2. Focus your response on what someone having this experience must be feeling (rather than what you are feeling).
3. Communicate that you understand what your loved one believes and how they feel.

A central part of reflective responses is staying with the emotional content of what your loved one says, instead of arguing with them about how they see the situation. Don't try to convince your loved one that what you think is true. Instead acknowledge what is real to them. Here's an example. Imagine how you would usually react if your loved one said, "Everyone at school hates me." You might think, "That's not true—everyone doesn't hate them," and try to change their mind. But we're asking you to try something different. It may not be true that everyone hates them, but your loved one's feelings of being hated are real. Their emotions are really happening.

Acknowledge what they are feeling. If your loved one says, "I hate school and I'm never going back," you can say "It sounds like you really don't like going there." If your loved one says, "I hate you and I hate living in this house!" you can say, "It must feel terrible to be so unhappy with us."

That's reflecting. You focus on the feelings that your loved one has communicated. You listen closely for the emotional content of what you're hearing, instead of getting upset about the words they're using or whether you agree or disagree with how they see the situation. You tell them what you observe about how they feel. In this way, you reflect back the essential part of what your loved one is communicating to you. This helps your loved one feel validated and heard. Feeling understood can help your loved one trust you and make more communication possible.

Examples of reflective responses:

- It must be frightening to think someone's trying to hurt you.
- You seem sad today.
- I know this is frustrating for you.
- Not being included in a group is hard.
- You sound very discouraged about school.

Section V; Treatment & Recovery

Bio-Psycho-Social Dimensions of Mental Health Conditions

The three dimensions of mental health conditions, bio-psycho-social, are interdependent.

- No one dimension can ignore the knowledge base of the other two
- Focusing on one dimension alone is not sufficient for recovery

<u>Biological/Physical</u> Medical Dimension: Science-based knowledge	<u>Psychological/Emotional</u> Personal Dimension: Psychology-based knowledge	<u>Social/Occupational</u> Rehabilitation Dimension: Services-based knowledge
<i>Focus: Medical aspects of the condition</i>	<i>Focus: Emotions and feelings</i>	<i>Focus: Re-establishing connection</i>
Symptoms; Diagnosis	The inner experience of mental health conditions	Definition and testimonials of recovery
Future course of illness (prognosis)	Normative family responses to the stresses of mental illness	Principles of rehabilitation
Acute care in critical periods	Telling our stories; validating family strengths	Vocational challenges (acquiring skills via training or school)
Medications and side effects	Coping strategies used to protect self-esteem in mental health conditions	Sources of system/community support
Adherence to treatment	Empathetic listening and responding skills	Restoration of social ties
Scientific advances in medications	Challenges of different relative roles in the family	Rebuilding after transitions (hospitalization, incarceration, relocation, deployment, separating from the military)
Early warning signs of relapse	Handling anger, frustration, and feelings of confinement	Long-term care
Impact of mental health on overall health	Coming to terms with “shattered dreams”	Increased self-determination
Insight into clinical realities of brain disorders	Self-care skills; keeping our lives going	Maximum personal fulfillment and quality of life
Best medical strategies to maximize recovery	Value of peer understanding and support	Problem solving skills
Current research on brain disorders		Communication skills
		Advocacy for better services and fair policies
		Celebrating our progress

Health Insurance Portability and Accountability Act (HIPAA)



What is HIPAA and Why is it Important?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a national standard for the protection of certain types of health care information. The U.S. Department of Health and Human Services then issued a “Privacy Rule” to implement the requirements of HIPAA. The Privacy Rule limits the circumstances in which individually identifiable health information can be used and disclosed by health care insurers, providers, and clearinghouses. The Privacy Rule refers to this type of information as “protected health information” (PHI).

The Privacy Rule limits the use and disclosure of PHI by “covered entities.” It does not affect other organizations or individuals. Covered entities can use and disclose PHI with no restriction only for treatment, payment, and health care operations. All other uses and disclosures must be authorized by the individual or be authorized under a section of the Privacy Rule.

- Don't be intimidated when someone mentions HIPAA
- Family members need to understand what kind of information they can get regarding their relative's diagnosis, treatment plan, medications, etc.
- Getting a signed release from your loved one is one way to access this information
- HIPAA does NOT prohibit you from sharing information, observations and concerns with your loved one's treatment providers

An overview of the Privacy Rule:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

Collaborative Care



Therapeutic Intervention Techniques



The most effective treatment usually involves a combination of:



Psychotherapy - to address the psychological



Medication - to address the biological

Treatment settings

Treatment settings:

- **Outpatient** mental health services are provided while the individual continues to live at home and continues their regular routines with work, school and family life. For this reason, outpatient services are considered the least restrictive form of treatment.
- **Inpatient** means that the individual is admitted to a treatment environment that requires staying overnight. It may be a hospital, a residential treatment center, or a crisis unit of some sort, but the treatment is provided while the individual is on site at the treatment facility 24 hours a day.
- There are also “mixed” types of treatment settings called **day treatment**, or **partial hospitalization** programs. In these programs, the individual goes home at night, but spends much of the day at a treatment facility participating in structured therapeutic activities.

Regardless of whether treatment services are provided in an outpatient, partial hospitalization, day treatment or inpatient setting, there are a variety of different therapeutic techniques that can be used.

Psychotherapeutic Interventions

Intervention	Description
Behavior Therapy	Helps the individual change negative behaviors and improve behaviors through a reward and consequences system. In behavior therapy, goals are set and small predetermined rewards are earned to reinforce positive behavior.
Cognitive Behavioral Therapy (CBT)	Teaches individual how to notice, take account of, and ultimately change the thinking and behaviors that impact their feelings. In CBT, the individual examines and interrupts automatic negative thoughts that make them draw negative and inappropriate conclusions about themselves and others. CBT helps the person learn that thoughts cause feelings, which often influence behavior.
Cognitive Enhancement Therapy (CET)	Cognitive rehabilitation training program for adults with schizophrenia or schizoaffective disorder who are stabilized and maintained on antipsychotic medication and not abusing substances. CET is designed to provide cognitive training to help improve impairments related to neurocognition (including poor memory and problem-solving abilities), cognitive style (including impoverished, disorganized, or rigid cognitive style), social cognition (including lack of perspective taking, foresight, and social context appraisal), and social adjustment (including social, vocational, and family functioning), which characterize these mental disorders and limit functional recovery and adjustment to community living. Participants learn to shift their thinking from rigid serial processing to a more generalized processing of the core essence or gist of a social situation and a spontaneous abstraction of social themes.
Dialectical Behavior Therapy (DBT)	CBT approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatically emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Exposure Therapy	Educates and teaches individuals about how to manage fears and worries to reduce their distress. The individual is gradually exposed to threatening situations, thoughts or memories that make him/her excessively anxious or worried.
Eye Movement Desensitization and Reprocessing (EMDR)	A nontraditional type of psychotherapy. It's growing in popularity, particularly for treating post-traumatic stress disorder (PTSD). PTSD often occurs after experiences such as military combat, physical assault, emotional or sexual abuse, natural disasters or car accidents. EMDR doesn't rely on talk therapy or medications. Instead, EMDR uses the individual's own rapid, rhythmic eye movements. These eye movements dampen the power of emotionally charged memories of past traumatic events. The premise is that EMDR weakens the effect of negative emotions and that disturbing memories will become less disabling.
Family Education and Support	Evidence-based practice in adult mental health. Designed to achieve improved outcomes for people living with mental illnesses by building partnerships among individuals, families, providers and others supporting the individual and family. May be led by clinicians or by other family members (NAMI programs are in this category).
Interpersonal Therapy (IPT)	Designed for treatment of symptoms of depression. Examines relationships and transitions, and how they affect a person's thinking and feeling. Focuses on the individual and helps them manage major changes in their lives, such as divorce and significant loss, including the death of a loved one.
Psycho-educational Multifamily Groups (PMFG)	Treatment modality designed to help individuals with mental illness attain as rich and full participation in the usual life of the community as possible. The intervention focuses on informing families and support people about the illness, developing coping skills, solving problems, creating social supports, and developing an alliance between consumers, practitioners, and their families or other support people. Practitioners invite five to six individuals and their families to participate in a psycho-education group that typically meets every other week for at least 6 months. "Family" is defined as anyone committed to the care and support of the person with mental illness. People in recovery often ask a close friend or neighbor to be their support person in the group. Group meetings are structured to help people develop the skills needed to handle problems posed by mental health conditions.

Intensive Home and Community-Based Interventions

Intervention	Description	Average Length of Treatment
Multisystemic therapy (MST)	Short-term and intensive home-based therapy. MST therapists have small caseloads, designed to meet the immediate needs of families. The MST team is available 24 hours a day, seven days a week to work with families.	4 months with approximately 60 hours of contact with the MST Team
Mental Health Intensive Case Manager (referred to as MHICM, mental illness case management in the VA)	Generally, relies on a single case manager who is assigned to work closely with the family and other professionals to develop an individualized comprehensive service plan for the individual and family.	Long term (no limit)
Wrap Around Services	A philosophy of care that includes a definable planning process involving the individual and family that results in a unique set of community services and natural supports individualized for that individual and family to achieve a positive set of outcomes.	Long term (no limit)

Complementary Health Approaches

Traditional medical and therapeutic methods have improved over the years, but often they do not completely lessen or eliminate symptoms of mental health conditions. As a result, many people use complementary and alternative methods to help with recovery. These nontraditional treatments can be helpful but it's important to remember that, unlike prescription medications, the U.S. Food and Drug Administration (FDA) does not review or approve most of them.

The National Center for Complementary and Alternative Medicine (NCCAM) favors the term "Complementary health approaches," which encompasses three areas of unconventional treatment:

- Complementary methods where non-traditional treatments are given in addition to standard medical procedures
- Alternative methods of treatment used instead of established treatment
- Integrative methods that combine traditional and non-traditional as part of a treatment plan

Data is still lacking on the effectiveness and safety of many complementary practices, but there are studies supporting that some of these strategies seem to have minimal, if any, adverse effects.

Natural Products and Activities

Some people find that taking supplemental vitamins and minerals lessens the symptoms of their mental health conditions. There are several ways these substances may help.

- **Omega-3 fatty acids** are groups of chemicals found in several different foods, including certain fish, nuts and seeds. Studies have found that certain types of omega-3 fatty acids are useful in the management of both medical and mental illnesses. Research shows that for young people experiencing an episode of psychosis for the first time, treatment with omega-3 fatty acids may help decrease their risk of developing a more chronic and serious form of schizophrenia.
- **Folate** is a vitamin required for the human body to perform many essential processes on a day-to-day basis. Also called folic acid or vitamin B9, folate is a compound that the human body is unable to make on its own. Some people with mental health conditions have been shown to have low folate levels and may benefit from treatment with additional folate supplementation. At the current time,

the FDA has approved only one form of folate—l-methylfolate (Deplin)—for use in the treatment of depression and schizophrenia. L-methylfolate has not been approved as a primary treatment, but rather as an additional form of treatment.

- **Medical foods** are another type of product containing natural ingredients. These are foods made with or without specific nutrients to help treat a health condition. For example, gluten-free foods are designed to give people with celiac disease the nutrients they need but without the gluten which makes them sick. Like supplements, medical foods are not as closely monitored by the FDA as prescription medicines.
- **Mind and Body Treatments:** Many people find that physical activity is beneficial to their well-being. Some types of mind and body treatments are:
 - Yoga
 - Exercise (aerobic and anaerobic)
 - Meditation
 - Tai chi

Some of these, such as meditation, are mental exercises, while others are mostly concerned with muscle movement. However, all mind and body treatments can improve mood, anxiety and other symptoms of mental health conditions. In addition, physical activity can help reduce weight gain, fatigue, and other side effects of many conventional medicines used to treat mental health conditions.

- **Equine Therapy** or equine-assisted psychotherapy (EAP), is a form of animal-assisted therapy that teaches individuals how to groom, care for and ride horses. The goal of horse therapy is to use experience with horses to improve emotional and behavioral outcomes.

Small studies and anecdotal evidence have shown equine therapy can help reduce symptoms of anxiety, depression and impulsiveness common to many mental health conditions. However, more data is needed to test its effectiveness.

IMPORTANT! Make Sure to Check with Your Doctor. Even simple vitamins can interact with medication. While something may be safe to use with one prescription medicine, it can make others less effective or toxic. Also, any new exercise or outdoor activity should be discussed with a doctor. People taking certain medicines for depression, schizophrenia or other conditions should make sure to stay cool and drink enough water to avoid heat stroke. Other medicines can lower body temperature, so special preparation may be needed for cold weather.

Medications & How They Work

MEDICATIONS & How They Work



Common Emotional Experiences that Affect Treatment Decisions



Lacking insight into the condition: “I’m not ill”

Lack of insight is a phenomenon where someone with a mental health condition doesn’t perceive that something concerning is happening with their health. This happens when a person is genuinely disconnected from the perceptions and beliefs shared by a wider community. A person lacking insight is unable to see the validity of other points of view. Because they don’t sense that anything is unusual, they don’t think there’s a reason to consider treatment.

This is a common phenomenon called “anosognosia.” It’s especially common in schizophrenia and in episodes of mania. It’s so common that it’s considered one reliable sign of these conditions when making a diagnosis. People with depression also may not recognize when their condition is serious.

When people lack insight into their condition, they may continue to believe nothing is wrong, even if their symptoms improve with treatment. Many of the people who go voluntarily to the hospital go because someone has urged them to, but do not believe they need to.

Using denial as a protective coping strategy: “I don’t need treatment”

When a person is overwhelmed or unequipped to address what’s happening, they may deny that the problem exists or ignore it, hoping it will go away. They may recognize that something is wrong but find it too painful to acknowledge to themselves or to others. As we’ve reiterated, people use denial to cope with many upsetting events and medical crises, not just mental health conditions. Being in denial temporarily protects the person. When someone is in denial, choosing treatment would be admitting that something is medically wrong. If they are in denial and do take medication anyway, they may be unlikely to tolerate side effects when they don’t see the benefits.

Missing the thrill of mania: would rather feel pain than be numb or bored

Some mental health treatments reduce the intensity of your emotions. Some people report not having emotions at all when taking certain medications. When a person's emotional baseline changes, they must develop a new sense of what is normal, which can be frustrating and demoralizing. A person may prefer to tolerate the ups and downs of their condition rather than give up feelings they're used to having or not feeling at all. When that's the case, it's understandable that someone might experiment with stopping and starting medication.

Wishing to be seen as a person, not an illness; not wanting to be seen as broken

People who choose to seek treatment and experience it as beneficial may decide not to continue long-term, even if they're receiving benefits from it. Many people don't like the idea of having a chronic condition that involves going to therapy or taking a medication indefinitely. People often say they feel they're seen or treated as "just" their diagnosis, rather than as a full person with a variety of traits, needs and hopes.

This experience is true of people with many health conditions, not only mental health ones. Being involved in treatment or taking medications long-term can seem like admitting you'll never return to how you used to be. That can be extremely difficult to accept. When people start improving, they may stop treatment or stop taking medication because it seems, and they hope, that their need for treatment has gone away.

Being reluctant to accept things as they are, or partial acceptance

When a person is unable to accept a situation or condition, it's often because their experience feels too painful to tolerate. It may seem easier to disregard the problem even if there are negative consequences in the future.

Section VI; Crisis Planning.

Supporting Your Loved One During Treatment



- If your loved one with the mental health condition is willing to discuss treatment, help them to understand how medications and talk therapy work and how they can help
- You need to have a workable plan for monitoring medications (for treatment and safety)
- All medication issues need to be discussed openly
- Sometimes adherence increases by avoiding the “mental illness” connotation of these medications (addressing the impact of the treatment on the symptoms that are causing distress rather than the diagnosis itself)
- It’s helpful to keep written records of the medications your loved one has taken, the dosages and the side effects that have been troublesome
- Confidentiality will not be a barrier to communication with a treatment provider if your relative gives permission. If permission isn’t granted you may speak to the provider but the provider cannot give you information in return.
- If your relative refuses treatment, then you must prepare yourself for another period of crisis

“Don’t rely only on medication and don’t refuse to try it.”

-Peter Jensen taken from NAMI Basics

Universal Warning Signs of Relapse

Noticeable changes in these behaviors or emotions:

Feeling more tense or nervous	Enjoying things less
Having more trouble sleeping	Feeling more aggressive or pushy
Feeling that people are talking about me	Feeling too excited or overactive
Change in level of activity	Eating less
Having more trouble concentrating	Having trouble relating to family
Having more nightmares or bad dreams	Having more religious ideas
Hearing voices or seeing things	Having frequent aches and pains
Feeling more depressed	Preoccupied with one or two ideas
Feeling that someone else was controlling me	Drinking more alcohol
Stopped caring how I looked	Having trouble making sense when talking
Feeling badly for no apparent reason	Using/abusing more drugs (marijuana, opioids, heroin, inhalants)
Losing interest in things I like doing	Feeling like I was forgetting things more
Feeling angrier over little things	Feeling worthless
Seeing friends less	Thinking about hurting someone else
Thinking about hurting myself	Feeling like I was going crazy

Source: McFarlane, W., Terkelson, K.. "New Approaches to Families Living with Schizophrenia. Institute," 62nd Annual Ortho-Psychiatric Meeting, NY.

Crisis Planning



- Nowhere is it more important to maintain an empathetic mindset toward our loved ones than when they're experiencing an increase in symptoms that creates a crisis situation. It's rare that people suddenly lose total control of thoughts, feelings and behavior.
- Family members or close friends will see signs like sleeplessness, ritualistic preoccupation with certain activities, suspiciousness/paranoia, unpredictable outbursts, and so on.
- Separate the disorder from the person you love, and view their behaviors, even the scary ones, objectively; that is, from the perspective of protecting the person living with the condition as well as the rest of the family.
- The goal during a crisis is to prevent things from getting worse and to provide immediate protection and support to the person experiencing the crisis.
- Addressing early warning signs can often prevent a full-blown crisis.
- Trust your intuition. If you're feeling frightened or panicked, the situation calls for immediate action. Remember, your primary task is to help your loved one regain control, to keep everyone safe and to not escalate the situation.
- Remain calm. If you're alone, contact someone to join you until professional help arrives.

Calling 911 and Talking with Police

If a situation escalates into a crisis, you may have to call the police. There are a few things you can do to keep the situation as calm as possible.

On the Phone

Share all the information you can with the 911 dispatcher. Tell the dispatcher that your loved one is having a mental health crisis and explain his/her mental health history and diagnosis. If the police who arrive aren't aware that a mental health crisis is occurring, they cannot handle the situation appropriately. Many communities have crisis intervention team (CIT) programs that train police officers to handle and respond safely to psychiatric crisis calls. Not every police officer is trained in a CIT program, but you should request that a CIT be sent if possible.

During a Crisis

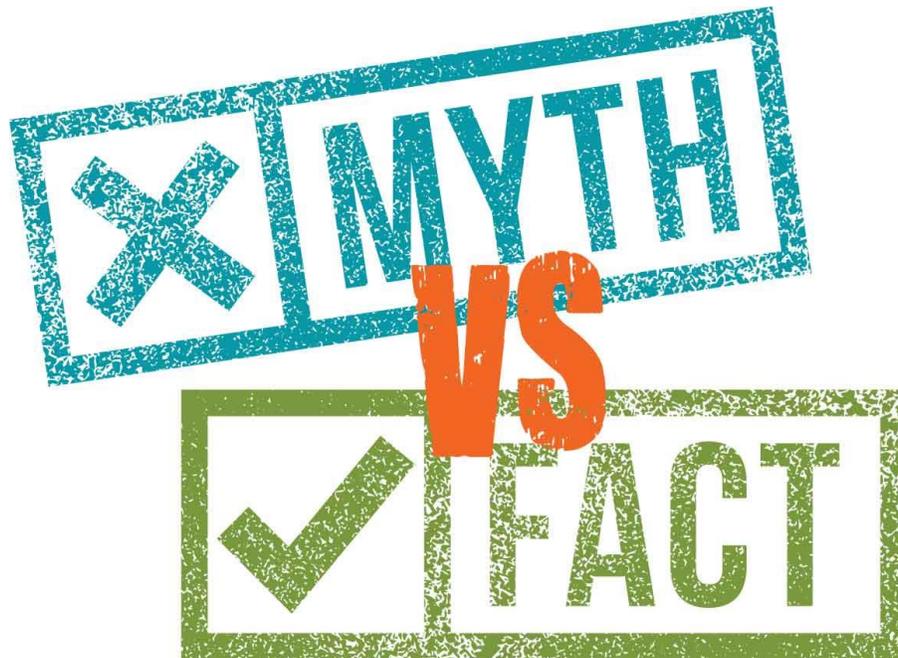
Police are trained to maintain control and keep the community safe. If you are worried about a police officer overreacting, the best way to ensure a safe outcome is to stay calm. When an officer arrives at your home, say "this is a mental health crisis." Mention you can share any helpful information, then step out of the way. Yelling or getting too close is likely to make the officer feel the situation is escalating.

Be aware that your loved one may be placed in handcuffs and transported in the back of a police car. This can be extremely upsetting to witness, so be prepared.

What Can the Police Do?

- **Transport a person who wants to go to the hospital.** A well-trained CIT officer can often talk to a person who is upset, calm him down and convince him to go to the hospital voluntarily.
- **Take a person to a hospital for an involuntary evaluation.** In certain circumstances, police can force a person in crisis to go to the hospital involuntarily for a mental health evaluation. The laws vary from state to state.
- **Check on the welfare of your loved one if you are worried and can't reach him or her.** Call the non-emergency number for the police department in your community and explain why you are concerned. Ask them to conduct a welfare check.

Mental Health Myths & Facts



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

Fact: You have no way of knowing what your loved one is experiencing, but be assured that it is real to them

Suicide Myths & Facts

Myth: People who talk about suicide never attempt it.

Fact: Most of the time, people who attempt suicide have provided clues to their intentions.

Myth: Talking about suicide with someone may give them ideas.

Fact: Talking about suicide with a loved one gives them an opportunity to express thoughts and feelings about something they may have been keeping secret. Discussion brings it into the open and provides an opportunity for intervention.

Myth: Only certain “types” of people die by suicide.

Fact: There is no specific type. While some demographic factors contribute to higher risk for suicide, it is important to remember that suicide does not discriminate. People of all genders, races, ethnicities, ages, upbringings and socio-economic statuses kill themselves. Pay attention to what the person says and does – not what he/she looks like or how you believe that person should think, feel or act.

Myth: Suicidal people overreact to life events.

Fact: Problems that may not seem like a big deal to one person, may be causing a great deal of distress for someone else. For example, a teen may have a strong reaction to an issue that an adult considers minor; a family member may not realize the impact “invisible wounds” like PTSD, TBI or moral injury have on a Veteran. We must remember the perceived crises are just as concerning and predictive of suicidal behavior as actual crises.

Myth: Suicide is an act of aggression, anger, revenge or selfishness.

Fact: Most people who die by suicide do so because they feel they do not belong or are a burden on others. They think that their death will free their loved ones of this burden. Many suicides occur in ways and in places that the person hopes will ease the shock and grief of those they left behind.

Myth: Nothing can stop someone once he or she has decided to take his or her own life.

Fact: Most people who contemplate suicide are torn. They are in pain and want their suffering to end. They don’t necessarily want to die to make that happen. But they can’t conceive of another way, and too often their cries for help go unheard.

Source: American Association of Suicidology

Warning Signs That Your Loved One May Be Thinking about Suicide

The presence of any, or all, of these symptoms does not mean that your loved one is going to attempt suicide, or that they are even thinking about it. What these signs do mean is that your loved one is having difficulty and that it's time to act.

You need to intervene immediately if they are talking about:

- Killing themselves
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Other possible warning signs, like those listed below, can be more subtle. The potential for suicide risk is greater if a behavior is new or has increased, especially if it's related to a painful event, loss, or change. Pay attention to these behaviors and don't be afraid to ask questions.

- Increased use of alcohol or drugs
- Looking for a way to kill themselves, such as searching online for materials or means
- Acting recklessly
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

Source: American Foundation for the Prevention of Suicide

Preventing Suicide through Communication

A Checklist for Parents and Families of People Living with Mental Illness to Assist in Communicating with Treatment Providers **

Created by the Oregon Council of Child and Adolescent Psychiatry, used with permission by NAMI

Purpose: Statistics from the Centers for Disease Control and Prevention (CDC) indicate that more than 44,000 people died by suicide in 2015 (the most recent year for which full data are available) making suicide the 10th leading cause of death in the U.S. The highest rates of suicide occur among people ages 45 – 54 years and second highest among people aged 55 – 64. While unintentional injury is the leading cause of death among young people ages 10-14 years, suicide was the second leading cause of death among youth ages 15-19 years and those ages 20-34 years. In 2015, 49.8% of deaths by suicide involved a firearm, 26.8% were by suffocation and nearly 15.4% were by poisoning (CDC website).

According to the American Foundation for Suicide Prevention (AFSP), no complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm. 494,169 people visited a hospital for injuries due to self-harm. This number suggests that approximately 12 people harm themselves for every reported death by suicide. However, because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. Many suicide attempts, however, go unreported or untreated. Surveys suggest that at least one million people in the U.S. each year engage in intentionally inflicted self-harm. Females attempt suicide 3 times more often than males. As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide 3 times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly (AFSP website).

Communication between family members of persons seeking treatment for mental illness and primary care providers and/or mental health practitioners improves the quality of care provided to these persons, reduces the risk of suicide and self-harm behaviors, and encourages the use of community resources to improve overall outcomes for these persons. While confidentiality is a fundamental component of a therapeutic relationship, it is not an absolute, and the safety of the patient overrides the duty of confidentiality. Misunderstandings by clinicians about the limitations created by HIPAA, FERPA, and state laws for preserving confidentiality of patients has caused unnecessary concern regarding disclosure of relevant clinical information. Communication between family members or identified significant others and providers needs to be recognized as a clinical best practice and deviations from this should occur only in rare and special circumstances.

To address a perceived deficit of communication, the Oregon Council of Child and Adolescent Psychiatry published a checklist for health providers in 2012. This companion checklist is designed to help family members access information that might be essential to preserving the life of their loved one.

Definitions

Person involved in treatment: A person receiving care for a mental illness, which may include a child, sibling, parent, or other person whom you wish to support in treatment services, herein abbreviated to “person.”

Treatment Services: May include outpatient therapy, medication management, support groups, or other treatment supports, partial hospitalization, hospitalization, or therapeutic residential treatment programs.

Provider: May include primary care providers, emergency room physicians, psychiatrists, nurse practitioners, licensed clinical social workers, licensed professional counselors, or other qualified mental health professionals.

Family: May include first-degree biological relatives, adoptive family, foster parent(s), spouse, or other individuals who occupy a similar position in the life of the person involved in treatment.

*** NOTE: If patient is a minor, parents may consult state statutes to determine when the provider may or must disclose patient's information to parents.*

For all persons with mental health issues, families should request the following:

- Has the provider requested that the person sign an authorization to speak with the family? If not, why not? If yes and the person refused, did the provider explain the therapeutic value of speaking with the family?
- Has a comprehensive risk assessment including personal interview with the person, record review, and solicitation of information from the family been completed by the provider or another qualified professional?
- Has the provider or any other professional concluded that the person is at elevated risk of suicide?
- Has the provider reviewed the records of previous mental health providers, and communicated with all others who are involved with the persons' treatment and care (e.g., therapist, family physician, case manager, et al.)?

- You should offer to provide additional history to the provider and tell the provider what you already know about the family member's illness and need for treatment, especially any episode that suggests the potential for self-harm.

Where an elevated risk of suicide is identified in persons involved in treatment, families have a compelling interest to learn the following:

- What are the diagnoses and treatment recommendations? How can the family best support the provider's recommendations? Where can one learn more about the illness which has been diagnosed?
- What is the provider's evaluation of suicide risk in this case? What are the particular warning signs (not the same as risk factors) for suicide in this person's situation? What steps should the family take if they see these factors occurring, such as taking the person to the hospital for reassessment? You may wish to ask the provider to help create a plan to monitor and support the family member. What protective factors exist, and how can these be expanded or enhanced for this person?
- What community resources are available to help the family and the person involved in treatment, including resources for case management, peer and family support groups, and improving mental health at home?
- What type of ongoing care is required? Who should provide that care? How can the family access that care?
- What can the family do to best help the person involved in treatment? What should the family not do?
- When the person transitions from one level of care to another or from one provider to another, how will provision of care be coordinated? You may wish to request that the provider assures that follow up is in place with a specific timely appointment, that the accepting provider has full knowledge of history and risk issues/records, and that the original provider confirms that family member has attended the follow up appointment.

Where the person is at university or similar setting, the family may wish to ask the Dean of Students:

- What systems are in place to support students living with mental illness and avoid self-harm? Is peer counseling available for the student with mental illness? Are the health service and/or counseling services on call 24/7? If not, what are their hours? Is there a 24-hour number to call in case of emergency?

- Is there an office to intercede with instructors for the student who feels overwhelmed or highly stressed? Will use of these resources imperil any scholarships the student might have?

Take Warning Signs of Suicide Seriously



Ask questions:

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

Don't leave them alone

Call a suicide crisis line

Got to an emergency room or call 911

Don't keep suicide warning signs a secret

Crisis numbers:

- National Suicide Lifeline at 800-273-TALK (8255)
- Veterans Crisis Line 800-273-8255 press 1

Guidelines to Help De-Escalate a Crisis



- **Don't threaten.** This may be interpreted as a power play and increase fear or prompt assaultive behavior by the individual
- **Don't shout.** If the person with the symptoms of a mental health condition seems not to be listening, it isn't because he or she is hard of hearing. Other "voices," thoughts, anxieties or paranoia may be interfering or dominating.
- **Don't criticize.** It will only make matters worse; it can't possibly make things better
- **Don't squabble with other family members** over "best strategies" or who is to blame. This is no time to prove a point.
- **Don't bait your loved** into acting out wild threats; the consequences could be tragic
- **Don't stand over your loved one** if he or she is seated since this may be experienced as threatening. Instead, seat yourself. However, if a person with a mental health condition is getting increasingly upset and stands up, consider standing up so that if they escalate to the point of becoming more threatening, you can quickly leave the room.
- **Avoid direct, continuous eye contact or touching your loved one.** Comply with requests that are neither endangering nor beyond reason. This provides the person in crisis with an opportunity to feel somewhat "in control."
- **Don't block the doorway.** However, do keep yourself between your loved one and an exit. If possible, convey calm. Although no one should feel that they need to stifle their emotions to help, research suggests that strong expressions of negative emotion may further destabilize individuals with a mental health condition.

Assistance with this section was provided by Al Horey, Western State Hospital, and Dr. Anand Pandya, MD, NAMI member

Crisis Plan

A Crisis Plan Should Include:

- Multiple Emergency Contacts – Phone, Cell phone and email
- Physician – Phone
- Psychiatrist – Phone
- Therapist or Counselor – Phone, Cell phone and email
- Case Manager – Phone, Cell phone and email
- Peer Support Specialist – Phone, Cell phone and email
- Current Medications & Dosages
- Allergies (medications, foods, etc.)
- Formal steps to be followed if a crisis reaches a point where outside help must be called
- Plans should include how the other family members will be taken care of, especially if there are children, people requiring 24-hour physical care or frail elderly involved

Relapse Plan

A Relapse Plan Should Include:

Collaboration:

- The person with the mental illness and the family/support system create and agree on the plan together

Answers to specific questions:

- How will we know you're going into crisis?
- List signs and symptoms of relapse, mild to severe

What will we do if you go into crisis?

- When mild symptom appears, we will:
- When more serious symptoms appear, we will:
- When severe/potentially dangerous symptoms appear, we will...

At what point will hospitalization be considered?

- What action or symptoms would prompt a trip to the ER?
- Which hospital is preferred?

At what point might emergency services or law enforcement be contacted?

- What action or symptoms would prompt the call?

Section VII; Support for Family Members & Friends.

Self-Care for Family Members



Life Challenges for Family Members and Caregivers

Life Challenges for the Primary Caregiver (usually spouses/ partners and parents):

- Getting through crises with your loved one while trying to meet the needs of other family members; coping with inevitable family conflict due to different perspectives, stages of acceptance and coping styles
- Learning how to deal with residual symptoms—social withdrawal, silence, suicidality and/or aggressiveness, apathy, irritability, resistance—on a “permanent” basis
- Trying to stay alert to signs of relapse and taking appropriate action; dealing with police, crisis teams, involuntary commitment; trying to get information and help from mental health professionals; finding services, taking on the primary “case-manager” role on a permanent basis
- Dealing with anxiety about relapse, alcoholism, drugs, the whereabouts of a missing loved one, treatment options, physical safety, pregnancy, nutrition, smoking, etc.
- Finding a way to balance responsibilities of work with responsibilities of care; trying to make life decisions in the face of an uncertain future
- Dealing with the impact that your loved one’s symptoms have upon your own relationship or marriage; loss of intimacy and carefree time together; worry that this primary source of support will be jeopardized or lost
- Dealing with financial worries and plans for future care

Life Challenges for the Sibling or Adult Child:

- Coping with disproportionate attention being given to the sibling or parent who has a mental health condition; growing up in an atmosphere of secrecy, confusion, silence, shame; witnessing terrifying psychotic breaks and personality changes
- Being threatened, frightened or hurt by someone who is supposed to be a caring, protective family member; experiencing the sibling or parent as “bad” rather than as someone who is experiencing symptoms of a mental health condition
- Bearing the social stigma of having a loved one who is viewed as “strange” or “scary”

- Handling the emotional needs of the caretaking parents or the neglected spouse/partner
- Having more chores and responsibility; having to “grow up fast”; pressure to be a “perfect” child to make up for the parent or sibling who has a mental health condition
- Worrying that you caused the disorder, or that you will get the condition, or that you will make the parent or sibling worse
- Worrying about how much you should do for the loved one; worrying about the time when the parent, or parents, die and caretaking will be your responsibility

Some Life Challenges for the Spouse/Partner:

All the primary caregiver challenges plus:

- Coping with loss of an intimate confidant, with the loss of a partner in the household, and often with the loss of a wage earner that the family needs; coping with an undermined sense of partnership in marriage and commitment
- Dealing with the “emotional silence” and sexual distance that occurs when a spouse/partner has a mental health condition; dealing with changed feelings toward the spouse/partner; dealing with ambivalence about divorce, about being frustrated, about being “selfish,” about wanting to have a different, better life
- Taking on the dual role of single-parent and primary caregiver; worries about money, how the mental health condition in the house is affecting the children; coping with all these demands single-handedly, without much recognition or thanks
- Deciding whether to start or expand the family after serious injury or a diagnosis of a mental health condition
- Being the target for lots of anger from your spouse/partner (who doesn’t want to be “treated like a child”) and from your children (who may believe you have the power to “solve” the family dilemma); dealing with lack of feedback that you’re an important and valuable person
- Coping with stigma, social isolation, lack of a peer group of “couples” friends; dealing with pressure or opposition from in-laws

Principles of Living a Balanced Life

Try taking these positive actions to make life better when a family member has a mental health condition:

- Do as much as you can financially and physically to improve the situation, but don't feel guilty about all you won't be able to do. If it isn't possible to maintain a degree of peace, dignity and wellbeing within the family while the person with a mental health condition lives at home, other arrangements may need to be made. If it's necessary, don't be embarrassed by seeking public support through available social services such as community clinics and state hospitals. You have every right to ask for information and help from the facilities of your state Department of Mental Health. Tax dollars are meant to help those in need of social services.
- Strive for good physical health. Both your loved one and your other family members will benefit from a healthy diet, regular exercise, and a safe living environment.
- Watch your stress level. Don't let yourself burn out. When you feel yourself getting anxious, slow down and take a deep breath. Doing something that stops or changes the direction of your thoughts can be helpful.
- Remember that no life is without stress. Learning how to cope with stress is the key to maintaining balance in life. Look for what gives you peace of mind and enjoy it: a walk on the beach or in the woods, a movie, a play, a good book, a painting, a funny TV show, a conversation with a dear friend, a prayer. The point is to let yourself go, to relax, to let your body and mind renew themselves, thus recharging your energy.
- An effort to maintain social contacts is critical. If a loved one develops a debilitating physical condition—heart disease or cancer, for instance—neighbors, friends and co-workers tend to be very supportive. If the condition is mental, the family involved may feel isolated. The family unit often withdraws, shielding themselves from stigma in society. It's better if they continue to circulate in their community in as normal a way as possible. Families are in a unique position to fight prejudice and fear that surround mental health conditions. If communication exists between families affected by mental health conditions and their neighbors, there is often a great deal of compassion and understanding expressed.

- Seek out and join a support group formed by families of people with mental health conditions. There's much comfort and knowledge shared in such groups. If a group hasn't been formed in your community, you might start one.
- Continue pursuing your own interests. Burying your hopes and desires to focus only on your loved one with a mental health condition will add to the challenges, not diminish them. If you're an artist, continue to draw and paint. If you enjoy woodworking, if you jog, if you're an active club member, continue to do those things that give you pleasure and make your life fulfilling. You will be better able to cope with challenges because you'll still be your own person. Don't let resentment build up in you because you've given up interests and dreams to meet the needs of your loved one. It will do neither one of you any good. Be kind to yourself as well as others.
- Do something for someone else. Our own problems seem less defeating when we're involved in giving support to others.

Diaphragmatic Breathing

One way to combat burnout and calm yourself is to breathe deeply using your diaphragm!



Setting Limits

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

Letting Go



Letting go...

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

Self-Care

What do flight attendants tell us when we prepare for departure?

- Put on your oxygen mask before you help your child or neighbor!
- Why? So you don't pass out before you can assist others!



A great way to take care of yourself is to attend a NAMI class, support group or presentation!

Section VIII; NAMI Resources

NAMI Programs

For information about NAMI's education programs, support groups and presentations, please go to www.nami.org/programs

NAMI Support Groups



“ I don't know where I'd be without NAMI Connection; it literally saved my life. I'm so grateful for my group and now I just want to share this program with everyone living with a mental illness. ”

NAMI Connection is a recovery support group program open to any adult (18+) with a mental health condition. It is designed to connect, encourage, and support participants using a structured support group model in a relaxed setting. Groups are confidential and free to participants, meeting weekly or bi-weekly for 90 minutes. Participants are welcome to attend on a walk-in basis, and no formal diagnosis is required. The support group is offered in Spanish as NAMI Conexión, Grupo de Apoyo y Recuperación in a limited number of states.

NAMI Connection groups are:

- Facilitated by trained people with mental health conditions themselves



“ Family Support Group training is essential to the success of our support groups. Without the training.... support groups would become nothing more than “cry” sessions or “gripe” sessions. ”

NAMI Family Support Group is a peer-led support group for family members, caregivers and loved ones of individuals with mental illness. This group provides support in a confidential environment and offers insight into the challenges and successes of others. The Spanish-language version of this program, Grupo de Apoyo para Familiares de NAMI, is available in a limited number of states.

NAMI Family Support Groups are:

- Facilitated by trained family members with loved ones who have mental health conditions

NAMI Presentations



Thank you for coming to my school and sharing our story. You have changed my life forever. The things you explained about your depression relate to how I feel. When I got home, I immediately talked to my parents and hopefully I will get some help.

I have had many thoughts of suicide...



NAMI Ending the Silence (ETS) is a 50-minute prevention and early intervention program that engages youth in a discussion about mental health. ETS dispels myths, instills a message of hope and recovery and encourages teens to reduce stigma. Teens learn to recognize the early warning signs of mental health conditions and what to do if they or someone they know is showing these signs. ETS presentations for school staff and for families are also available addressing the importance of early intervention and prevention; warning signs and how to address them; communication; strategies to support learning in school and at home.

NAMI Ending the Silence is:

- Presented by a 2-person team, one of which is a young adult with a mental health condition



nami In Our Own Voice

National Alliance on Mental Illness

“ After seeing an In Our Own Voice presentation, several of the mental health staff stated that they saw recovery as a real option for the first time ever. ”

NAMI In Our Own Voice is an interactive presentation that provides insight into what it's like to live with mental illness. The presentation includes video and discussion. The Spanish-language version of this program, En Nuestra Propia Voz de NAMI, is available in a limited number of states.

NAMI In Our Own Voice is:

- Led by two adults with mental health conditions

NAMI Classes



“ This course has given me a sense of who I am. I understand what is going on with me and I am able to cope. I have gained employment and committed to my recovery. ”

NAMI Peer-to-Peer is a free, 8-week recovery course for adults (18+) with a mental health condition. It offers information, skills, resources and a community of support. Participants learn in an environment of respect, understanding, encouragement and hope. Those interested in attending must register. No formal diagnosis is required. Topics covered include the brain and body; diagnoses; communication; relationships; treatment options; working with providers; stress reductions; goal setting and self-awareness. The course is offered in Spanish as De Persona a Persona de NAMI in a limited number of states.

NAMI Peer-to-Peer is:

- Led by trained people with mental health conditions themselves



“ I have been working at the hospital for 20 years, and this is one of the best programs I have been through for staff. We have worked hard over the years to create a more humanistic and compassionate culture. This program will definitely help us in that direction. ”

NAMI Provider is available as a 5-session course or a 4-hour introductory seminar for healthcare staff. The program offers a fresh understanding of and empathy for the lived experience of the client and the family—especially during treatment. Promotes collaboration between the person with the mental health condition, the family and the health care provider to achieve the best level of recovery possible.

NAMI Provider is:

- Led by teaching team that includes a person with a mental health condition who is in recovery, a family member of someone with a mental health condition and a healthcare professional who also has a mental health condition or is a family member



“ This is such a great step by step program that walks parents every step of the way. It is as if you are holding their hand through it all. ”

NAMI Basics is a 6-session course for parents/caregivers of people younger than 22 years of age experiencing mental health challenges. The program offers practical up-to-date information about mental health conditions and information necessary for effective advocacy with the child’s school and mental health provider. NAMI Basics also teaches problem solving and communication skills. The course is offered in Spanish as Bases y Fundamentos de NAMI in a limited number of states.

NAMI Basics is:

- Led by trained family members whose children experience mental health challenges



“ Learning as a family member will allow me to deal with my Dad’s suicide and helping my family cope. Learning as a Service Member and with a mental illness, hopefully I will be able to help my wife and family deal with what goes on with me. The training was so helpful! I appreciate the time and effort that went into this class. It was well worth the time. ”

NAMI Homefront is a 6-session course for families, partners and friends of military Service Members and Veterans. The course consists of 2-hour classes designed to help military/Veteran families understand mental health conditions and improve their ability to support their Service Member. Some of the topics covered are mental health diagnoses including PTSD and TBI, treatment options, crisis management, communication skills, the impact of combat stress and moral injury, the stigma associated with seeking mental health treatment while serving in the military and services available to both active duty personnel and Veterans. NAMI Homefront is also available online, taught live in a virtual classroom. The online classes have removed some of the barriers presented by geography, caregiving responsibilities (for families with wounded warriors and/or children) and opened the course to active duty military families concerned that attending a traditional class might jeopardize the career of a Service Member.

NAMI Homefront is:

- Led by trained military/Veteran family members with loved ones who have mental health conditions

“ The course should be on every psychiatrist prescription pad for families for their loved ones. A lot of heartache would be spared. ”

NAMI Family-to-Family is a 12-session course for families, partners and friends of people with mental health conditions. The course is designed to help participants gain a better understanding of mental health conditions, improve communication techniques, enhance coping skills and become effective advocates for their loved one. It was designated as an evidence-based program by SAMHSA (the Substance Abuse and Mental Health Services Administration) in 2013. The course is offered in Spanish as De Familia a Familia de NAMI in a limited number of states.

NAMI Family-to-Family is:

- Led by trained family members with loved ones who have mental health conditions

IMPACT of NAMI Programs



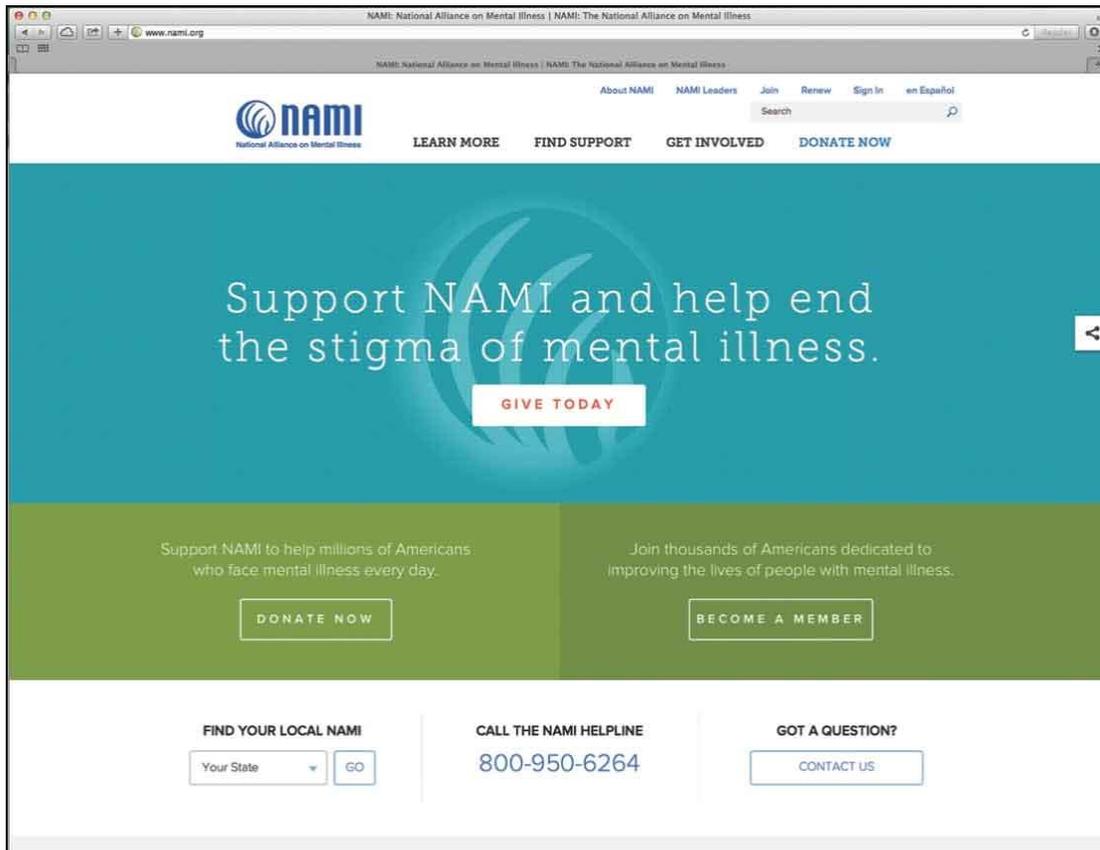
Never Lose Hope!



Remember:

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

www.nami.org



<http://www.nami.org/>

References

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

Material from the following websites was referenced in this seminar:

- NAMI (National Alliance on Mental Illness) www.nami.org
- SAMHSA (Substance Abuse and Mental Health Services Administration) www.samhsa.gov
- NIMH (National Institute of Mental Health) www.nimh.nih.gov
- VA (U.S. Department of Veterans Affairs) www.va.gov