MODULE 2:
THE COMPLEX SIMPLICITY OF WELLNESS

What's the difference between illness and wellness?
In illness the critical letter is "i" which represents isolation.
In wellness the critical letters are "we."
-- Mimi Guarneri

Introduction

The goal of this module is to explore the many different dimensions of wellness (beyond just mental or physical) and why it is important for peer supporters to promote wellness (better living situation, better nutrition, etc…) for others.

Objectives

The learning objectives for this assignment are for you to be able to:

- Identify *at least* six of the eight dimensions of wellness
- Recognize *at least* three of the most prevalent health issues
- Demonstrate *at least* three ways peer supporters can promote wellness among those they support
- Locate *at least* three resources for further study

What to complete

Your assignment is to read this self-study module and complete the assignments prior to coming to the training.

Plan about one hour to complete this section of the workbook.

Contents

Assignment #1: What is your picture of health and wellness?

(1) My picture of health and wellness is:

Use the space below, or a separate sheet of paper to sketch (or describe) something that represents health and wellness to you.

(2) A change I would like to make, related to my own health and wellness is:

Briefly describe a change you know would be good for you, but you haven't taken action on (or have tried but not been able to stick with).

Be prepared to share the change you would like to make at the training.

Eight dimensions of wellness

For people with mental health and substance use conditions, wellness is not the absence of disease, illness or stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. [1]

Wellness means overall well-being. It incorporates the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Each aspect of wellness can affect overall quality of life, so it is important to consider all aspects of health. This is especially important for people with mental health and substance use conditions because wellness directly relates to the quality and longevity of one's life.

That's why SAMHSA's Wellness Initiative encourages everyone to incorporate the Eight Dimensions of Wellness in their lives:[2]

[1] Dunn, H.L. (1961). *High-Level Wellness*, Beatty Press: Arlington, VA

[2] Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

The eight dimensions are:

- **Emotional**—Coping effectively with life and creating satisfying relationships
- **Environmental**—Good health by occupying pleasant, stimulating environments that support well-being
- **Financial**–Satisfaction with current and future financial situations
- **Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills
- **Occupational**—Personal satisfaction and enrichment from one's work
- **Physical**—Recognizing the need for physical activity, healthy foods and sleep
- **Social**—Developing a sense of connection, belonging, and a well-developed support system
- **Spiritual**—Expanding our sense of purpose and meaning in life

Source: http://www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx

Wellness research

Everyone faces challenges in their lives but those with mental health and substance use conditions face even more types of challenges when it comes to health and wellness. Looking beyond the obvious to see more of the underlying causes of these challenges can help us as peer supporters be more aware of the issues our peers face and respond accordingly.

Why the focus on wellness?

Wellness has become a major focus in mental health and peer services in the past few years. This new emphasis on health and wellness is, in part, the result of studies that brought to light the significant health disparities within the mental health community.

Studies over the decade of the 1990's began to demonstrate that people with mental health diagnoses were dying earlier than the general population.[3]

These findings led the National Association of State Mental Health Program Directors (NASMHPD) to undergo a 16-state study of people using public mental

[3] Felker B, Yazel JJ, Short D. Mortality and medical comorbidity among psychiatric patients: a review. *Psychiatric Services,* 1996;47(12):1356–1363; Dembling BP, Chen DT, Vachon L. Life expectancy and causes of death in a population treated for serious mental illness. *Psychiatric Services*. 1999;50(8):1036–1042; Hwang S. Mental illness and mortality among homeless people. Acta Psychiatr Scand.2001;103:81–82; Kamara SG, Peterson PD, Dennis JL. Prevalence of physical illness among psychiatric inpatients who die of natural causes. *Psychiatric Services,* 1998;49(6):788–793

health services[4] and the seminal report, "**Morbidity and Mortality in People with Serious Mental Illness**,"[5] is one result.

The main findings of the study were that people with severe mental illness:

- Die an average of 25 years earlier than the general population.
- Die from "preventable" illnesses such as cardiovascular (heart) and respiratory diseases, diabetes and suicide at much higher rates than the general population.

People with severe mental illness have additional risk factors that include:

- Higher rates of "modifiable" factors (such as smoking, obesity, lack of exercise, unsafe sexual behavior, IV drug use and living in shelters and other community residences increasing exposure to communicable diseases and poor nutrition).
- Vulnerability due to homelessness, incarceration, victimization, trauma, poverty, unemployment and social isolation.
- Symptoms that impact self-care or accessing medical care.
- Symptoms that mask medical conditions.
- Medications that mask symptoms of a medical condition.
- Polypharmacy and use of second-generation psychotropic medication that "may" impact illness.
- Lack of access to health care or lack of coordination between behavioral and physical health care.

Institutionalized wellness

These findings alarmed the mental health community and gave rise to committees, commissions, and campaigns calling for immediate change. State hospitals became non-smoking across the country, exercise programs were instituted in mental health services, wellness coaching and whole health peer

[4] National Association of State Mental Health Program Directors. Sixteen-state study on mental health performance measures. National Association of State Mental Health Program Directors, NASMHPD Research Institute; Alexandria (VA): 2002.
[5] National Association of State Mental Health Program Directors. Morbidity and Morality in People with Serious Mental Illness. National Association of State Mental Health Program Directors, NASMHPD Research Institute; Alexandria (VA): 2006.

support were established, and candy and soda disappeared from vending machines and were replaced with carrots and vegetable juices.

"Wellness" has become an everyday word in treatment plans, mental health service, managed care services, etc.

While service providers say they embrace "recovery," choices about personal wellness are quickly being categorized more closely to "risk" behaviors where choice and self-determination are limited. "We cannot ethically allow people to die with their rights on"[6] is the belief of many who hold administrative and policy-making positions.

The anatomy of research

Health and wellness is unquestionably integral to recovery. Research is an invaluable way to gather information to help design services that support wellness.

Research has two to three parts to it.

- The first part is the ***raw data***, which most of us never see (and probably never want to see!)
- The second part is the ***report generated from the research***. The report is the conclusions reached by the *researchers,* based on the data, and it is usually published for the academic community in journals or posted through other professional media.
- The third part, if the research is meaningful to a wider audience, is the **interpretation of the report** that appears in newspapers, magazines or internet articles, conference presentations and everyday discussions.

In summary, we have data followed by an interpretation, followed by an *interpretation of the interpretation*.

[6] Statement of a state DMH medical director during a forum about "dignity of risk" when the issue of medical choices was brought up by an audience member.

Questioning assumptions

Because health and wellness are so integral to recovery, we should question assumptions based on popular interpretations. If we investigate the purpose of the research, the populations that were actually studied, and what the findings *have* and *have not* demonstrated, a different picture may emerge.

Over-generalizing or making statements as "facts" when they are really based on secondary sources, like newspapers or web site articles, that are unsupported by the actual research, may be misleading and threaten our credibility.

Types of research

The research performed in the NASMHPD study cited earlier is called "quantitative research" and is based on numbers or quantities of things.

Typically, this kind of research also compares two different groups, one of which is called a "control" group – a group that people already have data on. An example might be seeing if people who get "usual" treatment in an agency and those who get "peer support" have different results. The last thing to know about this kind of research is that it usually only looks at one question in a study. Using the last example, the research question might be, "Who experiences a greater increase in self-esteem and belief in recovery – those getting the usual treatment or those that meet regularly with a peer supporter?"

Who was studied

So let's go back to the findings of the Morbidity and Mortality Study and look more closely to see what is there, and what isn't there.

"People with 'Severe Mental Illness'"

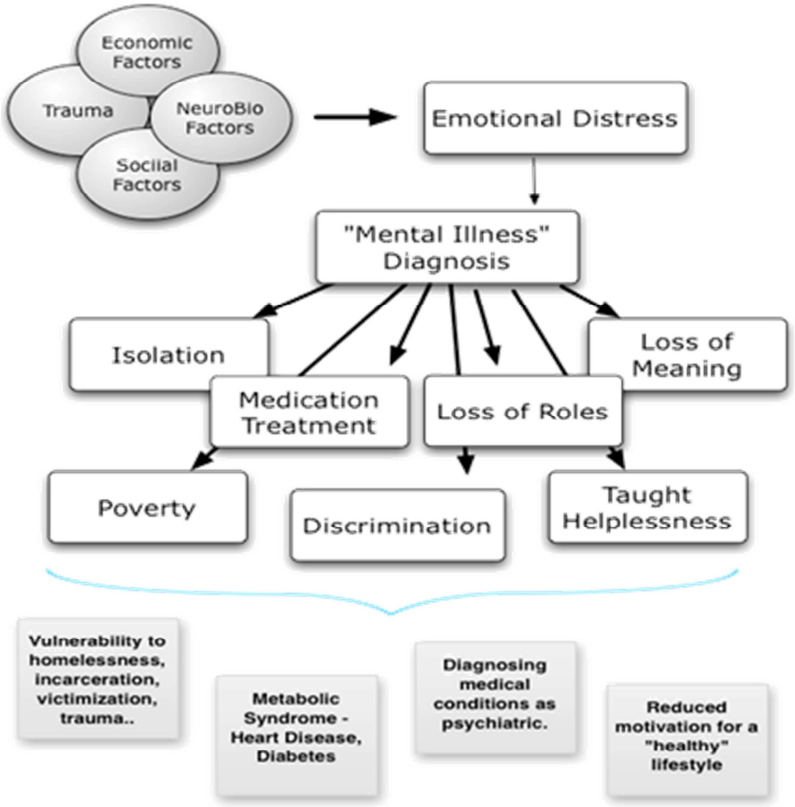
The study was based on the research from 16 states. Most states compared health data from people using ***public*** mental health services to health data from the state as a whole. A second kind of comparison was done in Maine, where they compared data of people with mental health diagnoses on Medicaid to the rest of the population of people (not with mental health diagnoses) on Medicaid.

The research did not include anyone in private care or people not accessing any treatment at all. They didn't differentiate by diagnosis – someone was considered to have "severe mental illness" by virtue of having a diagnosis and receiving services from the state (public) mental health system.

Understanding the results

Wellness is complex, multi-layered, personal, and has no simplistic answers. Understanding and using research results accurately can be a powerful aid to advocacy and credibility. Remember, many pathways lead to illness, or lack of wellness. Many other pathways lead to recovery and wellness.

Many Pathways Lead to a "Lack of Wellness"



Assignment #2 (Optional): Researching the research

Search the Internet for articles about determining the credibility of research studies. Pick three articles, consider their source, and rate their credibility on a scale of 1-10 (where 1 is low and 10 is high) and explain why.

- Article 1 1 ---------- 5 ----------10 (explain) _____
- Article 2 1 ---------- 5 ----------10 (explain) _____
- Article 3 1 ---------- 5 ----------10 (explain) _____

Assignment #3: Top five wellness challenges

According to the NASMHPD study, people with mental health and substance use conditions die decades earlier than the general population. Based on your own experience (your personal experience or the experiences of people you know), what are the top five toughest challenges people face in increasing wellness?

(1) .....

(2) .....

(3) .....

(4) .....

(5) .....

Source: *http://www.promoteacceptance.samhsa.gov/10by10/default.aspx*

Assignment #4: SAMHSA's wellness initiative – a vision and a pledge

(1) What is SAMHSA's Vision for the Wellness Initiative? (Fill in the blanks.)

We envision a future in which people with mental health and substance use disorders pursue optimal _____, _____, _____, and a full and satisfying life in the community via access to a range of effective services, supports, and resources.

To view the answers, go to:
http://www.promoteacceptance.samhsa.gov/10by10/default.aspx

(2) Take the Pledge for Wellness!

SAMHSA's Wellness Initiative aims to inspire individuals to improve physical health behaviors while exploring their talents, skills, interests, social connections, and environment to incorporate other dimensions of wellness.

To view the pledge and sign up, go to:
http://www.promoteacceptance.samhsa.gov/10by10/pledge.aspx

Assignment #5: Questions for reflection

(1) Why is it important for peer supporters to question research methods and results, and explain the findings to others in an accurate manner?

(2) Given what we've learned about the study method in the NASMHPD Morbidity and Mortality Study, what assumptions can we make about the health of people using public mental health services?

(3) Were people using private mental health services included in the study findings? Were people who received no services at all included? (How do you think those factors might influence the results?)

(4) There are many pathways that lead to a lack of wellness. What pathways can lead a person toward recovery and wellness?

(5) As a peer supporter, what is your role in helping people change "modifiable" behaviors to improve physical health, like smoking, nutrition, and exercise?

Be prepared to discuss your thoughts about these questions at the training.

Making change happen

When you've made a change in the past, how did it happen? What's the big motivator? For many people, the thing that moves us to change is a sense of dissatisfaction with what we have.

Dissatisfaction as an agent of change

As humans, we rarely do the hard work of change when things feel "just fine." We need that proverbial "kick in the pants" to make a change. At the same time, we may not always be aware of our own dissatisfaction. Some beliefs can block us from being in touch with our unhappiness:

- Not knowing we have better options
- Not believing we have what it takes to do the work (self-efficacy)
- Not believing the outcome will be positive
- Not having the support we need

Formal services can attempt to break through these beliefs, but a more natural way for people to gain hope and see different possibilities as doable is through social contact with other peers in recovery who are successful with similar changes.

Hope as an agent of change

Jerome Groopman is a medical doctor and writer for The New Yorker Magazine. In his book, Anatomy of Hope, he writes about the impact hope has on terminally ill patients. In the book he writes:

> *Hope can arrive only when you recognize that there are real options and that you have genuine choices. Hope can flourish only when you believe that what you do can make a difference, that your actions can bring a future different from the present. To have hope, then, is to acquire a belief in your ability to have some control over your circumstances. You are no longer entirely at the mercy of forces outside yourself.*[7] *(Groopman, 2004)*

[7] Jerome Groopman M.D. (2004). *The Anatomy of Hope: How People Prevail in the Face of Illness.* Random House, New York p. 26

The power of choice

The following is a true story as told by a psychiatric nurse working in a state psychiatric hospital in the 1960s[8].

> *There was a patient who came in very depressed. She wouldn't drink, and she wouldn't eat. She was getting very dehydrated, and we began watching her twenty-four hours a day. We did the watch under "one to one" supervision—we also called it "specialing." All of us would take turns and "special" one or two hours with her. Someone was usually just across the hall from her room or somewhere where they could see her directly.*
>
> *Some of the nurses could be a bit standoffish, but I was never like that, I always tried to connect with the patients. One day, just before it was my turn to watch her I realized I was thirsty and went to get some juice. I decided to bring a juice back for her. Well, when I offered it to her, she would have no part of it. I'm sure she thought there was medicine in the juice and that I was trying to trick her. She refused it flat out. So calmly, I just sat down on the mattress beside her…put my back up against the wall and watched her watching me.*
>
> *She was a big gal, and I said quietly, "I've got two glasses of juice here, and I'm thirsty, and I want one. You tell me which one I can have, and if you want the other one, there it is." She didn't speak but after a moment slowly picked a cup off the tray and handed it to me. I brought it to my lips and drank it all down straightaway. Pretty soon she picked up the other juice and drank it all, too.*
>
> *Weeks went by and eventually she got better and left. But before she left, she came to me one day and said, "You know, you saved my life that day….I was in such a hell….I didn't trust anyone, and I just knew when you came in it was different. You didn't sit in a chair across the hall. You came in and sat down beside me and made me feel I was a real person." To this day, I will never forget her and the power of a simple glass of juice. (Johnson, 2001)*

Although the nurse gives more credit to the fruit juice than to her own actions, it is clear that showing respect and offering choices can play an important role in motivating others to change.

[8] *Recollection by Bonnie Witkop Hajek, former nurse attendant, Traverse City State Hospital, 165-89. (Johnson, 2001).*

Assignment #6: Agents of change

Based on the story told by the psychiatric nurse, even though she did not identify herself as a peer, what are some of the skills the nurse used to make a connection and gain the woman's trust?

(1) .....
(2) .....
(3) .....

Internal vs. external motivation

For most of us, activities that we choose for ourselves (self-initiated or self-motivated) are more energizing and satisfying than activities that are chosen for us. Being "told what to do" leaves most of us feeling tired and drained.[9]

Now think about any lifestyle changes you had to make as a result of having a mental health condition. Recovery often requires new ways of thinking, self-awareness, and changing behaviors. As you work with others on making changes, always go back to your own experiences and remember one important thing: **IT ISN'T EASY!!!**

Supporting change

As peer supporters, it is vital for us to use a non-judgmental, strengths-based and respectful approach with others who are considering a change. While we may view a peer's barriers minor as compared to our own experiences, cultural factors and a history of trauma may make even "small" steps not so small.

Lifestyle changes are often easy to express but difficult to perform. As peer supporters, we draw on our own past lifestyle changes to understand both the barriers and things that helped us make changes. Our successful experiences from the past can offer hope and encourage peers with support through the process now.

[9] Nix, G.A., Ryan, R. M, Manly, J.B., and Deci , E.L., (1999) *Revitalization through Self-Regulation: The Effects of Autonomous and Controlled Motivation on Happiness and Vitality.* Journal of Experimental Social Psychology 35, 266–284

Planning for change and taking action

Planning for change is an activity that is emphasized by the system because it is a peer service organizations can bill for. Planning is important, but planning is just one step in the process.

We can plan all we wish but inaction on even the best plan will not change anything. As one person said, ***"If nothing changes, everything stays the same."*** Simple but true!

Action on a plan is required and peer supporters can help promote that action through a non-judgmental, strengths-based and respectful approach to support.

Assignment #7: Making life changes (preparation for class)

What are some life changes you have made in the past?

What motivated you to make those changes?

- ☐ *Reaching for a goal or something you desired?*
- ☐ *Avoiding something you didn't want?*
- ☐ *Trying to please or help someone else?*
- ☐ *Other (specify):*

Think of one change you made recently. What motivated the change?

Have you sustained the change? If so, how? If not, why not?

Based on your own experience, what strategies might you suggest to others who are considering a change?

SUMMARY CHECKLIST

After completing this workbook assignment are you able to…

- ☐ Identify *at least* six of the eight dimensions of wellness?
- ☐ Recognize *at least* three of the most prevalent health issues?
- ☐ Describe *at least* three ways peer supporters can promote wellness among those they support?
- ☐ Locate *at least* three resources for further study?

Based on what you've learned in this workbook assignment, what questions would you like to have answered at the training?

Thank you for completing this workbook assignment! We look forward to your participation at the training!

SELECTED REFERENCES

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RESOURCES FOR FURTHER STUDY

Articles and Books on Wellness

Armstrong, J. (2011). Putting Joy Back into Your Life: My Truth About "Wellness and Recovery." *SAMHSA Recovery to Practice Weekly Highlight*, Vol. 2, Issue 36. September 29, 2011. http://www.samhsa.gov/recoverytopractice/Resources/2011_weekly/2011_09_29/wh_2011_09_29.html

Business Committee. (2006). *Review and Assessment of the NIH's Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities*. ISBN: 978-0-309-65775-4, 304 pages, 6 x 9.

Centers for Disease Control and Prevention. (2011). *Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention, 2011–2015.* Atlanta: U.S. Department of Health and Human Services.

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Henderson, David C. (2007). Are the metabolic abnormalities worth the risks? Presentation 3-30-07. Downloaded on 01-20-2012. http://www.ncbi.nlm.nih.gov/pubmed/16107179

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Spiro, L. (2013). *Emotional CPR*. SAMHSA Recovery to Practice Weekly Highlight. Vol. 4, Issue 11. June 27, 2013. http://www.dsgonline.com/rtp/wh/2013/2013_06_27/WH_2013_06_27.html

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Thomson, G.E., Mitchell, F., Williams, M., Eds, (2008). Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished.

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Audio, Video, and Online Resources on Wellness

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Depression and Bipolar Support Alliance (DBSA). *Facing Us Clubhouse. Online personal wellness*. http://www.dbsalliance.org/site/PageServer?pagename=wellness_facing_us_clubhouse

Mental Health America (2013). *You Can Live Your Life Well. Campaign to Promote Wellness*. http://www.liveyourlifewell.org

Unnatural Causes: Is Inequity Making us Sick? www.unnaturalcauses.org

Selected Wellness Programs

Common Ground / Personal Medicine Toolkit – Pat Deegan Associates
https://www.patdeegan.com/commonground/other/personal-medicine-toolkit

Wellness Recovery Action Plan (WRAP™) Copeland Center for Wellness and Recovery
http://www.copelandcenter.com or http://www.mentalhealthrecovery.com

Whole Health Action Management (WHAM) – SAMHSA Center for Integrated Health Solutions
http://www.integration.samhsa.gov/health-wellness/wham/WHAM_Participant_Guide.pdf

Training Activities Related to Wellness

AVP Education Committee. (2002). *Alternatives to Violence Project (AVP) Basic Course Manual*. AVP Distribution Services, St. Paul, MN. http://avpusa.org

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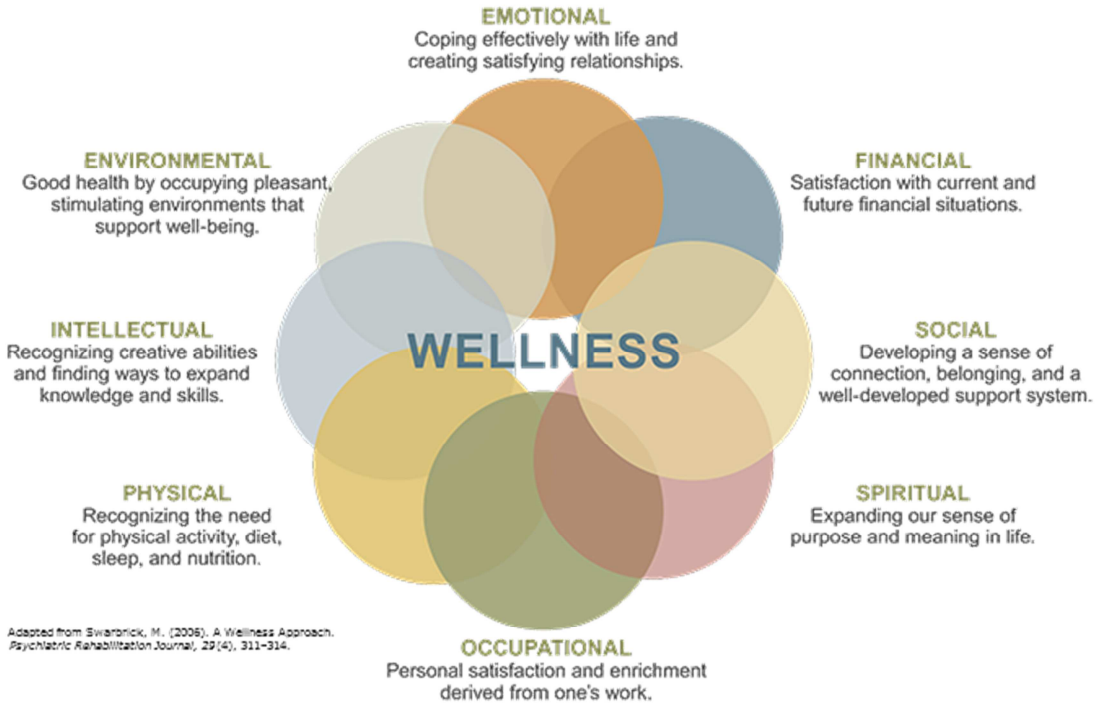
APPENDIX 2-A: WORKSHEETS AND HANDOUTS

Eight Dimensions of Wellness [10]



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- **Occupational**—Personal satisfaction and enrichment from one's work
- **Physical**—Recognizing the need for physical activity, healthy foods and sleep
- **Social**—Developing a sense of connection, belonging, and a well-developed support system
- **Spiritual**—Expanding our sense of purpose and meaning in life

[10] SAMHSA Wellness Initiative (http://promoteacceptance.samhsa.gov/10by10/dimensions.aspx). Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

Twelve Roadblocks to Listening [11]

1) Ordering, directing, or commanding
2) Warning or threatening
3) Giving advice, making suggestions, providing solutions
4) Persuading with logic, arguing, or lecturing
5) Moralizing, preaching, or telling people what they "should" do
6) Disagreeing, judging, criticizing, or blaming
7) Agreeing, approving, or praising
8) Shaming, ridiculing, or labeling
9) Interpreting or analyzing
10) Reassuring, sympathizing, or consoling
11) Questioning or probing
12) Withdrawing, distracting, humoring, or changing the subject

Five Ways to Persuade Someone [12]

1) Explain ***why*** the person should make the change
2) Give at least three ***benefits*** that would result from making the change
3) Tell the person ***how*** they could make the change
4) Emphasize how ***important*** it is for them to make the change; including the negative consequences of not doing it
5) Tell/***persuade*** the person to do it.

Four Questions to Support Change [13]

1) Why would you want to make this change?
2) If you did decide to make this change, how might you go about it?
3) What are the best three reasons for you to do it?
4) How important would you say it is for you to make this change on a scale from 0-10 (where 0 is not important and 10 is extremely important?)

[11] Motivational Interviewing Network of Trainers, Training for New Trainers (2008) p. 68. http://www.motivationalinterview.org/Documents/TNT_Manual_Nov_08.pdf
[12] ***Twelve Roadblocks to Listening*** by Thomas Gordon. Motivational Interviewing Network of Trainers, Training for New Trainers (2008) p. 68. http://www.motivationalinterview.org/Documents/TNT_Manual_Nov_08.pdf
[13] IBID