Expanding Mental Health Services Delivery for Depression in the Community from Burma in North Carolina: A Paraprofessional Training Program

by

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Dissertation submitted in partial fulfillment of
the requirements for the degree of Doctor
of Philosophy in the Department of
Psychology and Neuroscience in the Graduate School
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ABSTRACT

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Abstract

The scope of my dissertation project was to investigate the training of community leaders, including religious leaders, in the delivery of individual cognitive-behavioral support for depression in the community from Burma in NC. My research aims were to train community leaders a) to recognize the signs and symptoms of depression and associated problems, including intergenerational conflict, substance abuse, domestic violence and suicide; b) to use reflective listening and cognitive-behavioral therapy (CBT) skills, and c) to increase awareness of stigma toward treatment-seeking for depression and its related problems. Positive training outcomes were found for knowledge of depression and CBT strategies, and for attitudes toward treatment-seeking for depression; suggesting community leaders could be a valuable resource for expanding evidence-based mental health services delivery within the community from Burma and potentially within Burma as well, where there is a scarcity of mental health professionals. This study extends existing research on training paraprofessionals and religious leaders in the use of CBT. In particular, it adds to the knowledge base on providing mental health services within the community from Burma, which may extend to other refugee and immigrant communities in the U.S.

Dedication

To my daughters, Isabella and Scarlett, who have traveled every step of this journey with me. And to the memory of my parents, who provided me loving examples of compassion, courage and determination.

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Acknowledgements

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1. Introduction

My research addresses the following questions within the context of the community from Burma in NC: Can we translate what we have learned about the dissemination of evidence-based psychological treatments for depression to underserved communities, such as refugees and immigrants? Is it possible to expand these culturally sensitive mental health services within refugee and immigrant communities by training non-medical, non-mental health personnel to provide basic support for depression in individuals who do not require medication, and referring those who do to the medical community? Global mental health researchers, Herrman & Swartz (2007) have called for developing and evaluating interventions that can be delivered by lay people, and for assessing how health systems can scale up such interventions across all routine-care settings. In the World Health Ministers' Call to Action on Mental Health (WHO, 2011), these leaders call for "programmes that articulate collaborative linkages between traditional and modern medicine systems." They have stated that in fact in many countries, traditional and religious leaders provide much of the community mental health care because of traditional beliefs and the fact that there are far more of these practitioners than there are providers within the formal health care systems.

In addition to addressing this call for action, my project is a direct response to the fact that by 2020, depression will be second only to heart disease as the leading

cause of disability worldwide (Moussavi, Chatterji, Verdes, Tandon, Patel, & Ustun, 2007) and to the World Health Organization (WHO) report that the principal barriers to effective mental health care are the lack of trained providers and resources and the existence of social stigma associated with mental illness (WHO, 2011). Nolan, Dew and Koenig (2011) call for the use of collaborative models that effectively integrate religious leaders, faith-based groups and mental health professionals in the provision of mental health care services. Specifically, they point to this partnership as a means of expanding limited mental health services and also for lessening community stigma toward mental illness and the mentally ill.

The extant empirical studies in the scientific literature concerning these issues generally show that such collaborative models hold promise in producing effective outcomes for mental health care services. For example, evidence from India and Pakistan suggests that non-medical people can be effectively trained to work with psychiatric professionals in screening and treating depression, pointing the way to increasing available mental health services (see Gul & Ali, 2004; Patel et al., 2010; Rahman, Malik, Sikander, Roberts & Creed, 2008). Amidst these consistent calls by global mental health researchers for training nonprofessionals as a way of expanding the number of available mental health professionals, I consider that the research of Patel and colleagues (2010) in India and Rahman and colleagues (2008) in Pakistan on training paraprofessionals to work alongside the psychiatric community presents viable

models for integrating community leaders into the mental health care system; which, within the community from Burma, would increase the number of support providers. However, to date, no such studies have been carried out among refugees from Burma in the U.S., where community and religious leaders provide many psychological services.

Research suggests there are high rates of depression, trauma history, intergenerational conflict, substance abuse, domestic violence and suicide among Southeast Asian refugees in the U.S. Further, among these refugees, lack of understanding, fear and stigma keep people from visiting a mental health professional in the larger local community. At the same time, among the community from Burma in NC, focus groups and individual interviews in NC with Burmese, Karen and Chin community leaders suggest great willingness and desire to have religious and other community leaders trained to provide 1) basic support for depression, 2) information to educate community members about problems associated with depression and 3) needed links and support for contacting providers in the larger local community.

While the ratio of professional providers to potential patients is high in the larger American-born communities of NC, Orange County Refugee Health Coalition members report an estimated prevalence of depression of 20% among the community from Burma. Given that community and religious leaders have expressed their interest and willingness to be trained to identify and treat depression, it thus constitutes an ideal community in which to further lay the groundwork for exploring the possibility of

implementing a collaborative model between available and respected paraprofessionals such as religious leaders and other community leaders, and mental health professionals.

This project thus builds on qualitative fieldwork research I conducted in summer 2009 in Chiang Mai Province, Northern Thailand. In recognizing the role of the Buddhist monks in the community, it was their past experience serving in primary care-related, HIV/AIDS and psychoeducation projects, along with their sheer numbers that first motivated me to investigate the possibility of training Buddhist monks as a means of expanding the number of mental health providers. I interviewed nearly fifty monks, psychiatrists, teachers from the monk university in Chiang Mai – Mahachulalongkorn University, and other stakeholders and found a strong potential for integrating Buddhist monks into the Thai mental health care system and great willingness on the part of the monks to be trained to work alongside the psychiatric community. I then investigated the potential for using this model for expanding mental health services delivery among the community from Burma in NC. Findings from my background research on the potential for training community leaders from Burma in CBT are presented starting on p. 39.

In summary, the problem I am addressing relates specifically to the WHO's finding that there is a lack of trained providers and resources, in this case the insufficient number of mental health care providers in the community from Burma in NC to address the growing prevalence of depression and related problems. Thus, my main research

question is whether community and religious leaders from Burma can be trained to provide CBT support for depression, with the expectation that training outcomes for these leaders will be positive. Ultimately, I project that we can expand the mental health services delivery in the community from Burma in NC by training community leaders, who are natural leaders among the refugees, to recognize the signs and symptoms of depression and to provide basic support for depression. The long-term research goal is to test the integration of these non-medical personnel into the local mental health care system by enhancing their roles and establishing greater cooperation between them and the psychiatric community. Perry Griffin, a Multicultural Advocate with the Mental Health Association of the Central Carolinas and proponent of my training program has suggested that after training, these community leaders may be employable as paraprofessionals and the trainers could be employed to continue training others.

The scope of this specific project however, is to conduct a training intervention study among community leaders from Burma in NC. My research aims are a) to recognize the signs and symptoms of depression and associated problems, including intergenerational conflict, substance abuse, domestic violence and suicide; b) to use reflective listening and CBT skills, and c) to increase awareness of stigma toward treatment-seeking for depression and its related problems. Depression is targeted by this program as it is highly prevalent and often found comorbid with trauma, substance

abuse, domestic violence, intergenerational conflict and suicide – all notable problems among the community from Burma in the U.S.

2. Depression as a Leading Cause of Disability Worldwide

Worldwide, depression is a common, serious and potentially disabling illness, which is treatable with evidence-based medications, psychotherapies and other methods. In terms of the epidemiology of depression, the main aspects of the disorder are as follows: 1) the group of symptoms characterizing depression are found in all cultures; 2) the prevalence rates of major depression vary considerably between populations, with an annual prevalence rate of 9.5% for Americans age 18 and older, (Kessler et al., 2003); 3) the age of onset worldwide is in young adulthood; 4) the course of the disorder is often chronic in nature; 5) it is two to three times more common in women in most parts of the world, except in Africa; and 6) social factors, such as low socioeconomic status, low levels of education and the ongoing presence of violence, are major social determinants of the risk for depression (Patel et al., 2009). Poor mental health in general is associated with social disadvantage, human-rights abuses, poor health and low productivity, as well as increased risk of mental disorders (Desjarlais, Eisenberg, Good & Kleinman, 1995).

Prince et al. (2007, p. 859) have concluded "there can be no health without mental health." Depression is often comorbid with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes and Parkinson's disease (Cassano & Fava, 2002). Individuals with depression in addition to another serious medical illness tend to have more severe symptoms of both depression and the medical illness, more difficulty

adapting to their medical condition, and more medical costs than those who do not have comorbid depression. Depression can delay treatment-seeking, reduce the probability of detection and diagnosis, or both (Prince et al., 2007). Again, women are particularly vulnerable. In a study by Howk and Bennett (2010), women with depression reported significantly higher incidences of illness over the previous two months and were found to have significantly elevated indicators of illness at the time of the exam as compared to the non-depressed control females.

Depression has various measureable biological effects. It increases the probability of developing physical illness and accelerated aging (Wolkowitz, Reus & Mellon, 2011). Depression affects serotonin metabolism - alteration of cardiac function, platelet aggregation, and vasoconstriction (McCaffery et al., 2006); cortisol metabolism - increased cortisol, leading to inflammation, excessive clotting, and metabolic syndrome; inflammatory processes - raised inflammatory markers, which also predict the development of cardiovascular disease (Vieweg et al., 2006); and cell-mediated immunity - impairments in T-cell mediated functions, reduced natural-killer cell counts and cytotoxicity, with relevance to cancer, HIV progression, and other infectious diseases (Zorrilla et al., 2001). Depression has been found to be associated with several alterations in cellular immunity – specifically, lowered proliferative response of lymphocytes to mitogens, lowered NK cell activity, and alterations in numbers of white blood cells (Miller, Cohen & Herbert, 1999). In U.S. cohorts of HIV-positive women, chronic depressive

symptoms were associated with increased AIDS-related mortality and with rapid disease progression (Ickovics et al., 2001; Cook et al., 2004). And finally, depression often goes unrecognized and untreated even though it has a greater impact on overall health than arthritis, diabetes, angina and asthma (Moussavi et al., 2007).

In large measure because of these biological effects and its comorbidity with other serious illnesses, depression compromises the quality of life and functional capacity of tens of millions of people worldwide (Masskulpan, Riewthong, Daipratham, & Kuptniratsaikul, 2008; Bloom, 1999); presents a potent risk factor for death among the chronically ill (Wulsin, Vaillant, & Wells, 1999; Koenig, 2000); and represents an enormous social cost, especially to vulnerable populations such as women and orphans. Impairment from depressive symptoms can be cognitive, as it affects concentration; behavioral, in that it can cause decreased activity and social withdrawal; and physical, in the form of significant pain and illness (Greenberg et al., 2003). Depression negatively affects educational attainment and interpersonal relations, increasing the probability of teenage pregnancy and marital instability (Cassano & Fava, 2002; Kessler, Berglund, et al., 1997; Kessler, Foster, Saunders & Stang, 1995; Kessler, Walters & Forthofer, 1997; Von Korff, Ormel, Katon, & Lin, 1992). The fact that depression significantly impairs functioning in all domains of life; including work, home, school and social life, further emphasizes the importance of finding ways to effectively identify and treat populations who are remain underserved by the larger mental health care system.

Beyond the direct impacts on the individual, depression has a significant impact on aggregated well-being and national prosperity as well, accounting for direct and indirect costs totaling over $80 billion per year in the US alone (National Mental Health Association [NMHA], 2010). Left untreated, depression is as costly as heart disease or AIDS to the US economy (Greenberg et al., 2003). The aggregated economic burden of depression is attributable to several factors, including its prevalence rate; low treatment rate and the fact that it is treated primarily in the medical sector; and its chronic and debilitating nature. Regarding these individual and socioeconomic consequences of depression, the positive news according to the NMHA (2010) is that more than 80 percent of people with clinical depression can be successfully treated to remission when they receive early diagnosis, treatment and support. However, refugees from Burma in the U.S. do not regularly access treatment due to stigma associated with treatment-seeking; linguistic and cultural difficulties with accessing care; and the paucity of culturally-sensitive treatments and professionals capable of communicating with this underserved population – all too common structural barriers to seeking and receiving treatment.

While depression is clearly disabling and costly in all communities, it differs significantly in many cases in refugees versus local American populations in terms of presentation, etiology, risk and protective factors and potential outcomes. Therefore, it is important to examine more specifically what is known about depression among refugees and immigrants from Southeast Asia in the U.S.

3. Mental Health among Southeast Asian Refugees in the U.S.

In the United States, Asian Americans are the fastest growing minority group, two-thirds of which are either refugees or immigrants (U.S. Census, 2010). As a percentage, Southeast Asian refugees and immigrants make up 20-25% of this ever-increasing strata of the US population (Reeves & Bennett, 2004). Based on the 2010 U.S. census, the number of persons of Burmese descent living in the U.S. increased by 499% over the previous census. In 2012 alone, more than 10,000 refugees from Burma arrived in the U.S., adding to the more than 55,000 who had resettled in the country since 2006 (Ranard & Cunningham, 2012). In NC, Orange County Health Department records, which include the number of communicable disease screenings completed on new refugees, indicate that from July 2005-June 2011, 95% of the new refugees to arrive in the county were from originally Burma (Orange County, NC, Health Department, 2005-2011).

3.1 Migration and Mental Health

The Southeast Asian migration experience may be studied in terms of three main components: pre-migration, migration and post-migration resettlement. Each stage carries risk factors for mental health outcomes, such as 1) pre-migration trauma, political strife, poverty and loss of one's home and culture; 2) the nature of the migration experience, which may include separation from loved ones, and extended stays in refugee camps with harsh conditions, violence, and limited resources, and; 3) post-

migration employment and linguistic difficulties, intergenerational conflict and acculturative stress, as well as migration-related losses and possible discrimination in the receiving society, which can affect employment, social status and level of integration (Kirmayer et al., 2011).

3.1.1 Pre-migration factors affecting mental health

Several pre-migration factors affect adult mental health, including economic, educational and occupational status in the home country; the breakdown of social support, roles and network; trauma experiences; and involvement in political strife. In children, age and developmental stage at the time of migration; disruption of education; breakdown of the extended family and friendships all affect mental health (Kirmayer et al., 2011). In particular, violent experiences in the home country contribute significantly to health status and adaptation once settled in the U.S. (Fox, Cowell & Montgomery, 1994). Refugees from Burma who have settled in NC have fled ethnic and religious persecution, often times going first to nearby Thailand, Malaysia or India before coming to the States. Before arriving in NC, many Karen refugees in particular have spent years in camps along the Thai-Burma border or as illegal aliens in Malaysia, in the case of the Chin people. Refugee camps in Thailand are crowded, often unsafe, with poor health care resources and no mental health providers (Ranard & Cunningham, 2012).

3.1.1.1 Trauma

Systematic reviews and meta-analyses suggest that refugees are at significantly higher risk than the general population for psychiatric disorders associated with their exposure to violence, war, and forced migration and to the uncertainty of their status in their host countries, with up to 10 times the rate of post-traumatic stress disorder (PTSD) (Lindert et al., 2009) and elevated rates of depression, chronic pain and other somatic problems (Kirmayer et al., 2011). A history of torture is the most salient predictor of PTSD symptoms among refugees (Fazel, Wheeler, & Danesh, 2005; Beiser, 1999; Norredam, Garcia-Lopez, Keiding, & Krasnik, 2009; Steel et al., 2009).

In studying the community from Burma, we can draw on research carried out with other Southeast Asian populations with significant trauma and refugee camp experiences. In a sample of Southeast Asian refugees, a history of pre-migration trauma and refugee camp experiences were significant predictors of psychological distress five years and more after migration, regardless of ethnicity and length of time in the U.S. (Chung & Kagawa-Singer, 1993). Among 586 Cambodian adults aged 35 to 75 years, all of whom had a trauma history prior to immigrating to the U.S., seventy percent (n=338) reported exposure to violence after arrival in the U.S. High rates of PTSD (62%) and major depression (51%) were reported; with PTSD and depression highly comorbid in this population. Older age, poor English language skills, unemployment, being retired or disabled and living in poverty were also related to elevated rates of PTSD and major

depression. Over 20 years after arrival, pre-migration trauma remained associated with PTSD (OR, 2.08; 95% CI, 1.37-3.16) and major depression(OR,1.56; 95% CI, 1.24-1.97); post-migration trauma with PTSD (OR, 1.65; 95% CI, 1.21-2.26) and major depression (OR, 1.45; 95% CI, 1.12-1.86); and older age with PTSD (OR, 1.76; 95% CI, 1.46-2.13) and major depression (OR, 1.47; 95% CI, 1.15-1.89; Marshall, Schell, Elliott, Berthold & Chun, 2005). The community from Burma comprises refugees and immigrants who have arrived in NC at different times. While some have been in NC for longer periods of time and no longer consider themselves "refugees," many still experience mental health problems related to their pre-migration experiences.

3.1.2 Migration factors affecting mental health

Many aspects of the journey from the home country to the host country affect mental health, including the route and length of migration; the experience of difficult living conditions, such as in refugee camps; exposure to violence; the destruction of family and community bonds; and looming uncertainty about the future post-migration. For children in particular, several factors impact their mental health, including separation from their caregivers; exposure to violence; harsh living conditions; poor nutrition; and fear and uncertainty about the future (Kirmayer et al., 2011). Therefore, considering both pre-migration and migration factors, refugees very often arrive in the U.S. with a history and under conditions that affect their mental health and ability to adjust to American society.

Refugees may be contrasted with immigrants in terms of Kunz' (1973) kinetic model, which describes refugees as being "pushed out" of their homelands as opposed to immigrants who are "pulled toward" their new homes. This difference in the dynamics and relationship to the receiving country explains why refugees may not be as well prepared or adjust as well to American society as immigrants (Hsu, Davies & Hansen, 2004). In the case of the community from Burma in NC, many arrived identifying themselves as "refugees," but due to their long-term status now consider themselves, "immigrants;" even though they were primarily subject to the "push factors" of political strife and violence in Burma and subsequent harsh conditions in Thailand, Malaysia and India.

3.1.2.1 Unaccompanied migrant status

Among Southeast Asian refugees, unaccompanied migrant status has been found to predict both increased levels of risk of psychological distress pre-migration and also significant post-migration risk for poor mental health outcomes (McKelvey & Webb, 1995). Among the community from Burma in NC, there are children and young adults who have grown up without their parents and those who were left in the U.S. by their parents who returned to Burma or the camps of Thailand, leaving these unaccompanied youths at increased risk of developing mental health problems.

3.1.3 Post-migration factors affecting mental health

Factors in the receiving country that affect adult mental health include uncertainty about immigration or refugee status; unemployment or underemployment; loss of social status and of family and community social supports; worry over family members left behind and fears related to reunification; difficulties with language-learning, acculturation and adaptation such as shifts in gender roles. Factors affecting the mental health of children include fear and stress associated with the family's adaptation; difficulties with language acquisition; acculturative stress, such as conflicts related to ethnic and religious identity, gender role conflicts and intergenerational discord; discrimination and social isolation at school or with peers (Kirmayer et al., 2011). Adolescents in particular, are vulnerable as they are going through natural developmental changes, adjustment challenges common to refugees, and cultural conflicts associated with reconciling value differences between Southeast Asian and American cultures (Lee, 1988). Together, the stressors encountered by Southeast Asian refugees put them at high risk for substance abuse and dependence (D'Avanzo, 1997).

3.1.3.1 - Employment

Opportunities for employment and career advancement among refugees and immigrants may be affected by documentation status, lower levels of education and training, language difficulties and racial discrimination (De Castro et al., 2010). Further, many are overqualified for their jobs (Smith & Frank, 2005) and others take hazardous or

low-skilled jobs (De Castro, Fujishiro, Sweitzer, & Oliva, 2006; Seixas, Blecker, Camp, & Neitzel, 2008; Tsai & Salazar, 2007). In a WHO Commission on Social Determinants of Health report (2008), employment is considered to have a profound effect on mental and physical health and it is recognized as being means for reducing health inequalities, both directly and indirectly. Additional studies suggest negative mental and physical health consequences of unemployment and job insecurity (Burgard, Brand & House 2009; Ferrie, Shipley, Stansfeld & Marmot, 2002; Goldsmith, Veum & Darity, 1996; McKee-Ryan, Song, Wanberg & Kinicki, 2005; Mossakowski, 2009; De Castro, Rue & Takeuchi, 2010).

Conditions in the receiving country that moderate the effects of pre-migration stressors and that support employment opportunities and financial stability predict good mental health outcomes (Lindert, Ehrenstein, Priebe, Mielck & Brahler, 2009; Beiser, 2009). A 2011 focus group among community members from Burma in Orange County, NC, found that lack of job opportunities was among the main problems highlighted by community members (Orange County, NC, Health Department, 2011). At the same time, the "U.S. Refugee Resettlement Assistance" report indicates that many refugees from Burma lack the training, education, work experience and English language skills to be gainfully employed and they possess few skills that translate to the U.S. job market (Bruno, 2011).

3.1.3.2 Language barriers and bilingualism

Deficits in language skills and health literacy are compounded by cultural differences and economic barriers to accessing and understanding health information (Kreps & Sparks, 2008). Immigrants suffer higher rates of cardiac events, cancer, diabetes, strokes, HIV/AIDS and many other serious diseases (Kreps & Sparks, 2008). Poor English proficiency among immigrants is significantly related to self-reported poor health 6 months post-migration (OR=2.0, $p<0.01$). This factor has a greater effect on women, in whom poor language skills are associated with poor self-reported health two years post-migration (Pottie, Ng, Spitzer, Mohammed & Glazier, 2008). Bilingualism may be considered a protective factor among immigrants. Across immigrant ethnic groups, being bilingual is related to better self-rated mental and physical health compared with speaking only English or only the native language; these relationships are only partially mediated by family support and socioeconomic status but not by levels of stress, discrimination, acculturation or by health behaviors (Schachter, Kimbro & Gorman, 2012).

3.1.3.3 Intergenerational conflict and domestic violence

The migration process creates cross-cultural challenges for families that can lead to or intensify already existing intergenerational conflict, setting the stage for both abuse and neglect. In a sample of 285 Asian American youths, parent-child conflict and age - risk factors for suicide in majority group adolescents, predicted suicidality in this sample

as well; whereas gender did not generalize to this sample. Acculturation interacted with parent-child conflict to predict suicidality; such that lower levels of acculturation and higher levels of parent-child conflict together predicted greater suicidal thoughts and behavior. Less acculturated youths were at a proportionally greater risk for suicidal thoughts and behavior under conditions of greater parent-child conflict than were more acculturated youths. This finding highlights the importance of culture as a context for determining the significance of stressors contributing to psychopathology (Lau, Jernewall, Zane, & Myers, 2002).

In a 2011 focus group carried out by the Orange County Health Department with members of the community from Burma, domestic violence was identified as a significant social and mental health problem. A recommendation based on their findings called for educational sessions on domestic violence for both men and women. Women would be taught empowerment techniques and would learn the steps to take toward financial independence, while men would be taught conflict resolution and respect for women. Focus group participants considered such a program would help improve overall quality of life for the population (Orange County, NC, Health Department, 2011).

3.2 Current treatment-seeking among the community from Burma in the U.S.

While studies show high rates of PTSD and depression among refugees from Burma, there is little recognition or treatment of mental illness among the community.

Some mental illnesses, such as schizophrenia, are understood to be caused by spirit possession. Religious leaders are often asked to carry out purification rituals or other ceremonies to alleviate the condition. The Refugee Health Technical Assistance Center suggests that among refugees from Burma in the U.S., spiritual leaders such as Buddhist monks, Christian pastors and traditional healers, "may play a helpful role in mental health treatment, either as cultural brokers or as counselors themselves" (Ranard & Cunningham, 2012, p. 3).

4. CBT for depression

CBT is a well-researched, strongly supported treatment for clinical depression (DeRubeis & Crits-Christoph, 1998). Findings from several studies suggest that CBT reduces depressive and somatic symptoms in primary care patients and is more effective than usual care (Miranda & Munoz, 1994; Proudfoot et al., 2004; Schoenbaum et al., 2001; Simon, Ludman, Tutty, Operskalski & Von Korff, 2004). Further, CBT was shown to be more effective than usual care in reducing depressive symptoms in a sample of 207 primary care patients with recurrent depression (Conradi, De Jonge & Ormel, 2008). These researchers found a differential response to treatment based on the number of previous depressive episodes. In patients with three or fewer prior episodes, the three treatments - usual primary care, psychoeducation and CBT plus psychoeducation; led to comparable outcomes. However, in patients with four or more prior depressive episodes, CBT plus psychoeducation led to clinically superior outcomes to usual care. Therefore, Conradi and colleagues (2008) suggest that CBT may provide additional benefit to patients with many prior episodes. In this group they found that CBT may manage ruminative cognitive style, which is seen as a risk factor for recurrence.

Importantly, there is growing evidence that CBT may be administered in non-traditional ways, such as by lay providers or paraprofessionals (Patel et al., 2010; Rahman et al., 2008), or by telephone, computer or internet to support and supplement depression treatment provided in primary care (Wolf & Hopko, 2008). Research on these

alternative strategies has resulted in reduced depressive symptoms and higher levels of patient satisfaction (De Graaf et al., 2008; Proudfoot et al., 2004; Simon, Ludman, Tutty, Operskalski & Von Korff, 2004; Tutty, Ludman & Simon, 2005).

4.1 Compatibility of CBT with Buddhism

Burma, also known as Myanmar, is one of the most ethnically diverse countries in the world (Ranard & Cunningham, 2012). The majority of refugees and immigrants from Burma in NC come from the Karen, Karenni and Chin ethnic groups. In terms of religion, traditional indigenous religions, characterized largely by animism, have been overlayed with Buddhist thought and practices. In turn, with the conversion to Christianity of many, especially among the Karen people, Christian thought and practices now overlay Buddhist culture among these converts. In individual interviews, Karen Christian pastors and church members in NC have openly endorsed an easy confluence of Buddhist culture and Christian practices within their families and their daily lives. Further, all community members interviewed reported they would seek emotional and psychological support within their families and from religious and other community leaders, but not from outside the community from Burma in NC.

Researchers and scholars from a variety of disciplines have written extensively about the compatibility of CBT with Buddhist philosophy and practices in addressing their common fundamental goal of reducing suffering (see for example, Bodhi, 2005; Hinton et al, 2005; Bemak, Chung & Bornemann, 1996; Boehnlein, 1987; Sarath-Chandra,

2006). Buddhism is primarily concerned with determining the inner causes of human suffering and exploring the way to achieve release from suffering (Mikulas, 1978; Wallace, 1999, 2003; Smith, 1991), which is mainly attributable to imbalances in the mind (Gunaratana, 1985). As such, depression is considered a symptom of an unbalanced mind (Wallace & Shapiro, 2006).

CBT aims to relieve depression and support well-being by altering the cycle of negative cognitions and unhealthy behaviors through cognitive restructuring and behavior modification, both of which are key elements in Buddhist practices. Theravada Buddhism, which is the type of Buddhism practiced by 89% of the population of Burma (Central Intelligence Agency, 2012), is concerned with attaining spiritual liberation and enlightenment and has developed many theories and practices aimed at mental well-being (Aronson, 2004). Below, I address how CBT corresponds neatly to Buddhist practices concerning cognitive restructuring, behavior change, mindfulness and empiricism.

4.1.1 Cognitive Restructuring

According to the Buddha, "We are what we think. All that we are arises with our thoughts. With our thoughts we make the world." (Dhammapada, Byrom (Trans.), 1993, p. 1). The concept that how we think determines how we feel and the idea that we can change the way we feel by changing the way we think underlies CBT as well. In CBT, the process of restructuring cognitions is aimed at helping a client understand how thought

patterns exacerbate depressive symptoms. Unhealthy thoughts are replaced with new ones based on sound reasoning, in order to improve affect and decrease depressive symptoms.

CBT addresses both thoughts and beliefs that contribute to depression. In practice, therapists help clients examine their automatic thoughts and seek to identify core beliefs. Beliefs are more stable and enduring than thoughts, and they relate to both specific situations and general conditions. Beliefs may be accurate, helpful and healthy or depressogenic and otherwise unhealthy. Within Buddhism, beliefs characterize what we consider in Western psychology to be the "self". When the Buddha said we are nothing more than our thoughts, the Buddha was saying there was nothing permanent in our existence, and also that what we think of as ourselves is generated by our own minds (Ñanamoli & Bodhi, 1995). Within Buddhism, it is considered that the person must first recognize his mistaken conception of himself and the world before he can experience mental well-being (Wallace, 2005; Wallace & Hodel, 2006).

CBT is concerned with the interaction between thinking, feeling and action, and the concept that a person's beliefs and perceptions ultimately determine his relationship to the outcomes of an activating event. Likewise, within Buddhism, perceptions create a person's world and determine his responses to that world, as well as his responses to older perceptions that resurface repeatedly over time. Buddhism thus considers

perceptions to be the root cause of all mental tendencies and in some cases, mental illness (Sarath-Chandra, 2006).

4.1.2 Behavior Change

In addition to awareness and alteration of one's cognitions, CBT and Buddhism both emphasize taking action to change one's feelings and life, in general. A Buddhist saying expresses this idea: "One does not become an outcast, or a Brahmin, by birth. It is by one's deeds or actions that one should be judged as an outcast or a Brahmin." (Sutta Nipata, Hare (Trans.), 1947, p. 21). De Silva (1984) pointed out that within Buddhism, action and behavior are integral to mental and psychological development; they are not considered to be independent of each other. Throughout the Buddhist canon, the importance of mind and mind-control is frequently stressed. The Dhammapada – The Path of Virtue states, "The control of thought, which is difficult to restrain, fickle, which wanders at will, is good; a tamed mind is the bearer of happiness" (Byrom [Trans.], 1993, p. 23). Choice and action are required to control thought and allay suffering.

CBT involves teaching coping skills to help address daily life and stressful situations with a clear, calm mind. The goal is to help clients identify healthy ways to interact with others, and guide them in engaging in actions and activities that will support them in feeling less depressed. These actions include replacing behaviors that are contributing to the client's depression with healthier behaviors. Along with reducing the number of negative thoughts and behaviors, CBT therapists also teach clients how to

break down large, complex tasks into smaller, more manageable actions to improve their chances for success. Additionally, they help clients challenge negative thoughts and fears associated with those actions in order to decrease avoidance and anxiety, thus leading to more experiences of success and improved mood; which in turn, may enhance self-confidence and a willingness to take further action.

With regard to treating depression in Thailand – another country practicing Theravadan Buddhism, Mikulas (1983) studied the application of behavior modification techniques among this Buddhist population and found the people open to the ideas and practices of behavior modification (p. 94). Mikulas suggested that by demonstrating to the people the ways in which behavior modification techniques, such as self-control, rewards and punishments, behavioral tasks, and thought control, were the same as those proposed by the Buddha, people would find it easier to accept and adhere to them more readily. Further, based on Mikulas' work among Thai Buddhists, De Silva (1984) suggested that the adaptation of behavioral programs for Buddhists would be relatively easy because of the compatibility between Buddhism and behavior modification strategies.

Buddhists tends to consider action as the source or precursor to thought (Jones, 1979). At the same time, restraint in conduct is considered necessary to attain right concentration, ultimate insight and enlightenment (cf. Tachibana, 1926, p. 110). These concepts are reflected in Buddhist practice and techniques for behavior change, which

include strategies for changing overt behavior, as well for mental discipline (de Silva, 1984).

4.1.3 Mindfulness

> The Buddha said, "The mind is luminous, but it is being tainted with transitory mental impurities (such as, greed, hatred, and delusion) and requires strength to unveil the sword of compassion, as this is the only cure for suffering. If one can maintain mindfulness and self-awareness at all times, one's mind will be luminous and serene and will be liberated from the burden of all mental impurities and from suffering" (Tanphaichitr, 2005, p. 15).

Buddhism and CBT both purport that emotional difficulties are attributable to patterns of cognition, perception and behavior (Mace, 2007). In Buddhism, mindfulness is a way of paying attention and being present with acceptance and without judgment; the opposite of being mentally on 'automatic pilot,' according to Mace. Regarding the effect of mindfulness on behavior modification, Kazdin indicated that "control over behavior can be enhanced by observing one's own conduct" (1978, p. 333). In Western psychology, mindfulness-based approaches to psychotherapy involve teaching clients to be aware of and to accept their thoughts and feelings, rather than engaging in avoidance or rumination. Through this process, mindfulness-based treatments seek to reduce symptoms of depression and anxiety by creating distance from negative

thoughts and feelings, thereby interrupting the negative feedback loop of unhealthy thoughts and behaviors. The individual is then less fearful of breaking from old behavior patterns and replacing them with new actions (Fiske, Wetherell & Gatz, 2009).

Mindfulness training leads to improved mental health, including improved subjective well-being, decreased psychological symptoms and emotional reactivity, and improved behavior regulation (Keng, Smoski & Robins, p. 1052). Empirical evidence suggests that mindfulness and the ability to accept one's internal life are negatively associated with experiential avoidance and psychopathology (Brown & Ryan, 2003; Dalrymple & Herbert, 2007; Fresco, Segal, Buis & Kennedy, 2007; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In addition, Buddhist doctrine suggests that mindfulness meditation can lead to some control of physical sensations, including pain; lead to both physical and mental relaxation; and help achieve calmness and better sleep (De Silva, 1984). In the context of behavior modification, Mikulas (1981) specifically suggested sleep as a potential target for a mindfulness-based intervention.

Baer and Sauer (2009) argue that "mindfulness can be conceptualized as a nonreligious construct suitable for scientific study and that it can be integrated with CBT in interesting and fruitful ways" (p. 324). Individuals can learn to practice mindfulness apart from any religious involvement (Kabat-Zinn, 2000; Linehan, 1993). Several mindfulness-based interventions have developed out of the cognitive-behavioral tradition (Hayes, Follette, & Linehan, 2004) and are in fact, considered the

"third wave of CBT" (Hayes, 2004). These include for example, Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (DBT; Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999). Together with Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1982, 1990), these treatments share a similar conceptualization of mindfulness (Baer & Sauer, 2009) and use of acceptance strategies for supporting individuals in strengthening their emotion regulation skills and relieving psychological distress (Nickerson & Hinton, 2011).

Empirical evidence suggests that MBCT, a treatment integrating mindfulness into CBT, is effective in reducing rumination and depressive symptoms, and in reducing relapse rates after recovery from a depressive episode. There is further empirical evidence of the effectiveness of integrating mindfulness practices into CBT to treat depression (see Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Williams, Teasdale, Segal, & Soulsby, 2000; Teasdale, Moore, Hayhurst, Pope, Williams, & Segal, 2002; Ma & Teasdale, 2004; Hargus, Crane, Barnhofer, & Williams, 2010; Kuyken, W., Byford, S., Taylor, R.S., Watkins, E., Holden, E., White et al., 2008; Barnhofer, Crane, Hargus, Amarasinghe, Winder & Williams, 2009).

In addition to MBCT, mindfulness practices have been integrated into other psychological interventions to treat depression as well as a range of other conditions and disorders. DBT, which was originally designed to treat chronic suicidal and other

self-injurious behaviors, integrates principles of Zen Buddhism with CBT (Robins, 2002). DBT aims to improve emotion regulation while focusing simultaneously on acceptance and behavior change. DBT has been modified to treat chronic depression in older adults in a study comparing older adults receiving antidepressant medication (ADM) alone to a group receiving ADM plus DBT skills training and telephone coaching (Lynch, Morse, Mendelson & Robins, 2003). Results suggested that the addition of DBT skills training and telephone coaching may improve outcomes in older adults receiving ADM.

ACT (Eifert & Forsyth, 2005; Hayes, 2004, 2005; Hayes et al., 1999) was developed based on the theory that avoiding negative thoughts and emotions in order to lessen psychological distress ultimately heightens distress and behaviors that would lead to fulfillment of valued personal objectives. ACT is a mindfulness-based treatment that focuses on creating greater psychological flexibility through skills-training aimed at improving an individual's willingness to encounter their experiences more deeply, identify their values, and commit to values-based behaviors (Keng et al., 2011; Hofmann & Asmundson, 2008). Empirical evidence suggests ACT is an effective treatment for reducing depressive symptoms (Zettle & Hayes, 1986; Zettle & Rains, 1989; Lappalainen et al., 2007; Forman, Herbert, Moitra, Yeomans, & Geller, 2007).

Originally developed to treat chronic pain, MBSR (Kabat-Zinn, 1982, 1990) is a group-based intervention that teaches mindfulness meditation; encourages acceptance;

and supports cognitive and behavior change with less emotional reactivity and judgment. In clinical trials, MBSR has been found effective in reducing depressive symptoms (Shapiro, Schwartz, & Bonner, 1998; Speca, Carlson, Goodey, & Angen, 2000; Sephton et al., 2007, Anderson, Lau, Segal, & Bishop, 2007; Grossman, Kappos, Gensicke, D'Souza, Mohr, Penner et al., 2010).

4.1.4 Empiricism

Both Buddhism and CBT utilize an experiential, empirical approach to addressing suffering and reducing distress (De Silva, 1984; Mikulas, 1978, 1981). In a sermon from the Kalama Sutta, the Buddha taught followers not to accept anything on hearsay, authority or pure argumentation. Rather, the Buddha said they should accept only that which is empirically and experientially verifiable (Anguttara Nikaya, Vol. i, p. 188; Translation, 1932-1936, Vol. i, p. 171; Kalupahana & Kalupahana, 1982, p. 196; Ñanamoli Bhikku, 1978, p. 175.)

In summary, the religions practiced by community members from Burma in NC vary from animism to Buddhism to Christianity and Islam, with considerable overlay of traditions and practices. Buddhism has profoundly influenced community members from all ethnic groups and religions. Buddhism and CBT share the common goal of relieving suffering and both seek to do so through a combination of strategies that address the interrelated realms of thought, feeling and action. A key element of Buddhism, mindfulness practice, has been shown to be an effective component in achieving

psychological well-being and behavior change when integrated into CBT (Baer, 2003; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Lynch, Trost, Salsman, & Linehan, 2007). Additionally, both Buddhism and CBT rely on a framework that is at once experiential and empirical. Thus, based on these cultural considerations, the compatibility of CBT and Buddhism, and empirical evidence supporting CBT for the treatment of depression, community and religious leaders from Burma are ideal candidates to train as paraprofessionals in CBT skills to support members from the community from Burma in NC. The aim of my study, therefore, is to expand the number of CBT-trained providers to support people with depression among this community, where at present there are no trained mental health professionals from within the community.

5. Addressing a principal barrier to change

WHO researchers consider it a "silent scandal" that while depression can be reliably diagnosed and treated in primary care, fewer than 25% of those affected have access to effective treatments (Moussavi et al., 2007). The main impediments to widespread effective mental health care according to the WHO (2011) include the lack of trained providers and resources; and the existence of social stigma associated with mental illness. Receiving effective treatment for depression is important as it may not only alleviate psychological distress but also improve functioning by reducing symptoms associated with medical illness (Mohr, Hart & Goldberg, 2003). Thus, finding ways to make support more readily available among underserved populations such as refugees and immigrants, who have high rates of depression but limited access to mental health professionals, or resistance and fear of accessing available services, remains a critical issue. My project addresses the first of these two factors suggested by the WHO – increasing the number of mental health services providers by training paraprofessionals. I will train community leaders as paraprofessionals in the use of CBT to support people with depression in the community from Burma in NC.

5.1 Expanding mental health services delivery by training paraprofessionals

Paraprofessionals are defined as "providers without postgraduate training in a designated mental health specialization program" and "non-experts or lay

psychotherapists" (Montgomery, Kunik, Wilson, Stanley & Weiss, 2010, p. 46). Christensen, Miller & Munoz (1978) characterized paraprofessionals simply as "people who have received minimal training for a particular type of intervention" (p. 249). Two main advantages of using paraprofessionals are the ability to greatly expand the provision of services and at the same time avoid increasing the cost of mental health care, as paraprofessionals are nearly always less expensive than professionals and take less time to train (Montgomery et al, 2010). Use of paraprofessionals may help improve access to mental health services, thereby lessening disparities in access to mental health services by underserved minority groups and remote populations (Musser-Granski & Carrillo, 1997; Vega & Lopez, 2001; Christensen et al., 1978).

Around 1960, a shift occurred from the limited provision of psychological treatments by psychiatrists to broader mental health care alternatives including psychologists, social workers and psychiatric nurses. Demand for mental health services continued to outstrip the supply of providers and the use of paraprofessionals became more common practice. In fact, several studies dating as far back as the early 1960's have found paraprofessionals to be equally or more effective than professionals in treating many different types of clients (Balch & Solomon, 1976; Carkhuff & Truax, 1965; Karlsruher, 1974; Magoon & Golann, 1966; McReynolds, Lutz, Paulsen, & Kohrs, 1976; Truax & Lister, 1970; Lindstrom, Balch & Reese, 1976). More importantly with regard to my project which trains community leaders as paraprofessionals in the use of CBT,

when looking specifically at the provision of CBT for depression, paraprofessionals were found to be as effective as professionals in delivering CBT and reducing depressive symptoms in clients (Montgomery et al., 2010).

Researchers have investigated the training of paraprofessionals in the provision of psychological treatments in a variety of contexts and types of interventions and populations. Durlak (1979) published one of the first review articles in this area and found that paraprofessionals were equally or more effective than professionals in improving patient outcomes. Hattie, Sharpley and Rogers (1984) re-analyzed Durlak's research and extended it by adding four additional articles. Ultimately, they too found paraprofessionals to be "at least as effective, and in many instances more effective, than professional counselors" (p. 540). In turn, Berman and Norton (1985) re-evaluated the work of Hattie et al. and found that paraprofessional and professional therapists were approximately equal in terms of efficacy. Additionally, several subsequent review articles have supported the use of paraprofessionals in delivering psychological treatments (Atkins & Christensen, 2001; Christensen & Jacobson, 1994; Faust & Zlotnick, 1995).

Boer, Wiersma, Russo and Bosch (2005) reviewed the literature on the effectiveness of paraprofessionals providing any type of psychological treatment for anxiety and depressive disorders and reported a significant effect for paraprofessionals compared to no treatment. Subsequently, Montgomery and colleagues (2010) published

the first systematic review of trials comparing the outcomes of mental health professionals and paraprofessionals using CBT for anxiety and depressive symptoms. They reviewed the studies of Bright et al, (1999); Shelton & Madrazo-Peterson, (1978); Russell & Wise, (1976); and Thompson, Gallagher, Nies & Epstein, (1983). These reviews have revealed some very interesting, as well as encouraging consistencies across previous research regarding the potential effectiveness of using paraprofessionals. For example, the role that educational attainment does or does not play on the effectiveness of paraprofessionals was addressed by Thompson et al., (1983) who used the lowest requirement for education on the part of professionals – no formal mental health training or experience, with educational level from high school to post-graduate training in a non-mental health field. This aspect of Thompson et al.'s study renders it particularly relevant to underserved populations such as refugees and immigrants from Burma in the U.S., where the majority of paraprofessionals available to expand mental health services delivery may not have extensive formal education.

As mentioned above, empirical evidence from India and Pakistan also suggests that lay people may be effectively trained as counselors to assess and treat depression, working alongside local medical professionals (Gul & Ali, 2004; Patel et al, 2010; Rahman et al, 2008). The investigators in Goa, India (Patel et al., 2010) chose to train their participants in interpersonal therapy. In a similar vein, paraprofessionals in this study will be trained in CBT as it is considered culturally compatible with Buddhist

thought and practices, which underlie the culture of both Buddhist and Christian populations from Burma. Further, I take a similar approach to that of Nolan and Johnson who interviewed and subsequently trained Tanzanian Christian clergy in the treatment of schizophrenia; however, I am focused on training Buddhist monks, Christian pastors and other community leaders in the treatment of depression. In particular, the use of religious leaders as paraprofessionals is a common approach given their position of respect in their communities, their role as trusted advisor and their general availability. Thus, a better understanding of the use of religious leaders in general as paraprofessionals is an important component of this project.

5.1.1 Training religious leaders in mental health treatment

Religious leaders present a group of respected, trusted community stakeholders, wielding influence over their congregants as they provide spiritual guidance and support (Farrell & Goebert, 2008). In the United States, the clergy plays an important role in mental health care services delivery, where it is estimated that one quarter of people seeking treatment do so first from a clergy member (Wang, Berglund & Kessler, 2003).

The American Association of Pastoral Counselors (AAPC) traces the integration of religion and psychology in psychotherapy back to the 1930's when Minister Norman Vincent Peale and psychiatrist, Smiley Blanton, M.D. jointly established the American Foundation of Religion and Psychiatry, which was later re-named the Blanton-Peale

Institute. The role of pastoral counseling has developed from religious counseling to pastoral psychotherapy, which combines theology with the behavioral sciences. The AAPC was founded in 1963 as a nonsectarian, interfaith organization charged with certifying pastoral counselors, accrediting pastoral counseling centers and approving training programs. It represents pastoral counselors from 80 different faiths, including Protestantism, Catholicism and Judaism. At present, pastoral counseling accounts for three million hours of treatment nationwide annually in U.S. institutional and private settings. And the number of AAPC-certified pastoral counselors has tripled in the last 20 years (American Association of Pastoral Counselors, 2011).

Researchers have investigated ways to improve the level of clergy referral behavior to better understand their collaboration with professional mental health service providers and to evaluate ways to strengthen the clergy's role in supporting community mental health. In a study of referral behavior among Asian American immigrant Christian clergy, researchers found that a clergy member's prior mental health education, knowledge of mental illness, education level, time spent providing individual counseling and referral to general practitioners were positively associated with making mental health referrals (Yamada, Lee & Kim, 2012). Bohnert and colleagues (2010) suggest that clergy could play an important role in making treatment referrals for substance abuse and recommend that they may benefit from training to identify alcohol use problems. Molock and colleagues (2008) studied suicide prevention among African

American youth in African American churches and they proposed a "gatekeeper model" for training lay helpers and clergy to recognize the risk and protective factors for depression and suicide, to make referrals to the appropriate community mental health resources, and to deliver a community education curriculum to support at-risk youth in their churches (p. 323).

Thus, a plethora of studies suggests that religious leaders can be trained to effectively provide mental health services (see for example, Kirchner, Farmer, Shue, Blevins & Sullivan, 2011; McCabe, Lating, Everly, Mosley, Teague, Links et al., 2007; Young, Griffiths & Williams, 2003; Todres, Catlin & Thiel, 2005). However, further training may be needed to address gaps in knowledge, such as recognizing the signs and symptoms of mental disorders; and a predisposition on the part of some clergy to believe they are equipped to treat organic mental illness, which in fact may require medical attention as the first line of treatment. Farrell and Goebert (2008) surveyed 98 clergy members to evaluate the ability of Hawaii's Protestant clergy to recognize and treat mental illness among Hawaii's Protestant clergy and found that 71% reported feeling inadequately trained to recognize mental illness. The most common cause of mental illness that clergy members cited was medical (37%), however in their responses to two case vignettes, many clergy members reported that they would provide counseling rather than referral. When clergy did make referrals, 41% believed shared religious beliefs between parishioner and provider were important, and 15% thought

shared beliefs were absolutely necessary. Farrell and Goebert stressed the need for better collaboration between clergy and mental health professionals. Further, they suggest that incorporating a client's belief system into treatment may help improve crisis interventions for religious individuals.

Because of the prevalence of using clergy as a first line of access in the U.S., many researchers have suggested the need for further interventions training clergy members to recognize mental disorders and their severity, provide quality treatments of sufficient intensity (Wang et al., 2003), and collaborate with local medical and mental health care professionals (Farrell & Goebert, 2008; Leavey, Loewenthal, & King, 2007; Oppenheimer, Flannelly & Weaver, 2004; Weaver, Samford & Koenig, 1997; McMinn, Chaddock, Edwards, Lim & Campbell, 1998; Anderson, Robinson, & Ruben, 1978; Quinn & Talley, 1974). These recommendations may be particularly relevant among the community from Burma where, based on my individual interviews and group meetings with community leaders and members, people feel reluctant to access mental health services in the larger community, and religious and community leaders play an important role in providing psychological support and services. As trusted religious leaders, Buddhist monks and Christian pastors occupy positions of respect in their communities. My interviews with Christian and Buddhist clergy from Burma indicate that they are cognizant of the growing need for mental health services among their community, and they have expressed their interest and willingness to be trained.

6. Background research – Exploring the potential for training paraprofessionals in CBT

I have taken a multidisciplinary approach to studying the question of how best to expand mental health services delivery to underserved populations. With a view to exploring my interest in integrating psychological with religious support services and training community leaders to provide basic mental health services, I attended a weekly adult Sunday school series in 2008-2009 at a Chapel Hill church. The group included mental health professionals from Duke and UNC and alumni from Duke Divinity School who officiated at the church. We addressed how to integrate mental health care into church support and programs, the role of religion in psychological treatments, and the nature of current church outreach to members requiring mental health services. Upon learning of my interests in these types of issues, others in the class alerted me to relevant research on these topics and conversed with me about my interest in integrating community leaders into the larger mental health care system.

Encouraged by this first foray into the issue, I sought an opportunity to go to Thailand and further explore the possibilities of better integrating Buddhist monks as mental health paraprofessionals into the Thai mental health care system. My current dissertation project, which is based in the community from Burma in NC, thus builds on the qualitative research I conducted in Northern Thailand in the summer of 2009 on a fieldwork grant from the Duke Global Health Institute. The scope of that initial project comprised a set of interviews of nearly fifty Buddhist monks, psychiatric professionals,

teachers from the monk university – Mahachulalongkorn, and other stakeholders in Chiang Mai. My research aims were to a) ascertain the nature of the psychological services provided by community leaders - Buddhist monks, b) discern the nature and extent of any stigma related to depression and treatment-seeking, c) understand the current level of integration of the monks within the mental health care system, and d) investigate the potential for enhancing their role and establishing greater cooperation between them and the psychiatric community. I wanted to investigate the potential for training community leaders - Buddhist monks, in CBT to treat depression and to understand the attitudes and willingness of monks and psychiatric professionals toward working together.

6.1 Background research along the Thai-Burma border

In 2010, I followed up my fieldwork in Chiang Mai with research among the community from Burma along the Thai-Burma border at the Mae Tao Clinic in Mae Sot, where I was able to interview an Australian-trained clinical psychologist from Burma regarding efforts to address the mental health needs of refugees and train lay people to provide basic support for trauma patients. While in Mae Sot, I also interviewed members of the Assistance Association for Political Prisoners (AAPP), all of whom were former political prisoners in Burma. Specifically, I asked about the mental health problems of political prisoners and refugees in the camps on the outskirts of Mae Sot and what they did to cope with their difficulties. They reported extensive trauma

histories, high levels of depression, substance abuse and domestic violence. Further, they indicated that there is very little willingness among them and other refugees from Burma to talk about their feelings and experiences, and no access to mental health services. Many of the refugees in Orange County at one time lived in these particular refugee camps outside Mae Sot.

Later, in July 2012, I met with political leaders from Burma across the border in Northern Thailand to learn about the mental health problems and needs of their people. In a country with .477 mental health providers for every 100,000 people and a concentration of these providers in urban areas that is 2-4 times greater than in rural areas (WHO & Ministry of Health, Union of Myanmar, 2006), these leaders reported widespread trauma, depression, substance abuse and domestic violence. And while they recognized the need for mental health treatment, they reported there is none available in their immediate area. The qualitative research I conducted over the from 2009 - 2012 thus helped me gather some of the crucial background data and understanding to successfully conduct this project.

Back at Duke during the 2011-2012 school year, I wrote my Major Area Paper, entitled *Dissemination of Psychological Treatments for Depression in Non-Traditional Settings*, which helped me better understand the issues related to disseminating and implementing evidence-based treatments developed in a high-income country within a different cultural setting; such as in low or middle-income countries, and within pockets

of underserved populations, including refugees within the U.S. Further, it allowed me to explore the literature for studies on the cultural factors and other considerations related to training lay people, including religious leaders, in psychological treatments.

6.2 Investigating the potential for training community leaders from Burma in NC

From August through November 2012, I met with members of the community from Burma in Raleigh, Orange County and Charlotte, NC. I have interviewed clergy, lay community leaders and individual community members from the Burmese, Karen and Chin ethnic groups, who come from both Christian and Buddhist backgrounds. I carried out a similar interview with the Burmese Buddhist monks and Karen Christian pastors in Orange County that I carried out with the Buddhist monks in Northern Thailand. Further, I have met with the Advisory Council of a Karen church; a Karen farmers group in Carrboro; Chin Christian refugees in Raleigh; and Karen community members living and working in Orange County. Some meetings have taken place in English and some have been facilitated by a Burmese or Karen-speaking interpreter.

During summer 2012 in Thailand, I spoke at length with Susan Clifford, Program Manager for Refugee and Immigrant Health for Orange County in NC. Upon returning to NC in August, she invited me to join the Refugee Health Coalition of Orange County, which is made up of mental health and community services providers, refugees and immigrants. Also, she introduced me to Jennifer Morillo, Refugee and Immigrant Health Coordinator for the State of NC, who in turn introduced me to several other state

and regional leaders in health care services delivery for NC's refugee and immigrant populations. Together, they have helped me identify potential participants for my study. In response to a direct question as to their view on the potential and wisdom of training community leaders in CBT to treat depression, both Jennifer Morrillo and Susan Clifford enthusiastically endorsed the idea. They were particularly open and encouraging about the prospect of training community leaders to provide CBT and integrating them into the delivery of mental health services. And, they directed me to leaders within the community from Burma, as well as state workers who could assist me in carrying out my research.

Through the Refugee Health Coalition, I have received inquiries and offers to collaborate and exchange ideas with several academics and mental health providers in the region. Further, as a member of the Refugee Health Coalition, I have received ongoing guidance on recruitment issues from state-level refugee health officials, local mental health professionals, religious and community leaders from Burma, researchers from the local academic community and refugee advocacy groups.

6.3 Findings - Psychological Services Provided by Religious Leaders

When interviewing religious leaders in Thailand and in Orange County, I inquired of them how they view their role in the community, their understanding of mental illness and community mental health problems, and the type of support they offer. I wanted to know to what extent they were already involved in providing mental health services and

to whom they were administering in this regard. Thus, one of the first things I had to determine was who comes to the temple or church to speak to these religious leaders? What are their demographic characteristics? Is it predominantly men or women who attend? Additionally, is there an age factor? Do older or younger people come to converse with the monks or pastors? I also needed to know if they came alone or with their partner or with their family? To what extent do they visit on a regular basis or do they limit their visits to auspicious holidays? I also wanted to ascertain if there were serious philosophical differences in their concept of mind or the seat of consciousness when compared to a Western definition of such. With this, I would then be better able to explore potential similarities and differences in what it means to people from Thailand and Burma when a person is depressed? What does depression look like to a monk or pastor and to a person visiting him?

First, every religious leader – Thai and Burmese, confirmed in simple terms that he considers himself the community leader and spiritual counsel of the people in his area, community or congregation, in the case of the pastors. Pastors also described their role as being central community and religious leaders.

I found that the majority of temple-goers served by the monks I interviewed are elderly women in Thailand; whereas in the Orange County temple, women of all ages were the primary temple-goers. Many of these people come to the temple on a daily or weekly basis, but do not ask to speak to the monk every time they visit. People of all ages across all socioeconomic levels visit the temples on Buddhist holidays; again not always asking to speak with a monk. Elderly people often come alone to the temple. But the

Thai and Burmese monks indicated that more often they came with their spouse, children or friends. And at the same time, Karen churches are attended by whole families who generally spend an entire day at the church in worship and other church-related activities.

Further, when asked what types of problems people brought to them, typically, the Thai and Buddhist monks and the Karen pastors' first response was financial distress. This was closely followed by intergenerational difficulties and other personal-family issues and conflicts, including isolation due to younger family members moving away from home and the consequent breakdown of the extended family; as well as pain, physical illness and bereavement. Intergenerational conflict, substance abuse, domestic violence, and suicidal thoughts were noted by Burmese monks in Orange County as major issues people bring to the temple. The breakdown of the family, economic distress, linguistic barriers to assimilation and emotional costs of immigration have broken apart families, causing parents to leave children behind in Burma and the refugee camps of Thailand; as well as leading parents to leave children in the U.S. uncared for while they return to Burma or Thailand.

Just as with the monks in Thailand, I found that when a person visits the Burmese Buddhist monk in NC for counsel, the monk carries out what amounts to a Mini-Mental State Exam (Folstein, Folstein & McHugh, 1975); evaluating the person's general appearance, body language, posture, breathing, speech, use of language and thought processes, mood, behavior and clarity of mind. Then, he listens for the pressing problem and relates it to teachings from Buddhist texts. Thus, the monk does the

majority of the talking during the visit. The monk typically offers a blessing as well, and may meditate with the person or chant in the person's presence. Karen pastors provide similar support but relate a person's difficulties to solutions found in biblical teachings. Also, these pastors are actively involved in supporting education among all ages in their congregation and in preserving Karen language and culture.

6.3.1 Stigma toward depression and treatment-seeking in the community from Burma in NC

In my interviews with mental health professionals and community leaders from Burma in Orange County, they reported that when a person from Burma is depressed over an extended period of time, they tend to withdraw from work and social relations. They feel shame about not being able to fulfill role responsibilities and expectations. One mental health provider in the larger community stated that, "stigma toward treatment-seeking is so great that it keeps women from attending any type of support group." The provider continued that, "any association with the support group was stigmatized for these women." This was a significant observation that led me to hypothesize that the more significant issue with regard to stigma is toward treatment-seeking, rather than toward depression – the disorder itself. It appears that stigma among the refugee and immigrant community from Burma is more extensive that what I observed in the Thai population. Based on the common trauma history of so many community members, I hypothesize that stigma may be related to a lack of understanding and acceptance of mental illness and beyond that, to a fear and general

mistrust of anyone considered an authority figure in the larger community, which may include medical and mental health professionals.

6.3.2 Potential for a greater role for community leaders

My interviews and observations have confirmed there is indeed a need among the community from Burma in NC to train more people in mental health services delivery and that community leaders were ideal candidates to fill this paraprofessional role. Also important, it appears highly likely they would find support among NC mental health professionals in this role. Given these conclusions, I next needed to explore the possibility of actually gaining the support of key religious leaders, who are among the main community leaders at present and assess their perspective on potential support for and success of such a training program. I therefore interviewed Karen Christian pastors and Burmese Buddhist monks. I asked mental health providers from the Refugee Health Coalition if they thought the community leaders could be trained to effectively offer CBT-based support to community members with depression. All the mental health professionals, religious and other community leaders from Burma I spoke with agreed that the community leaders could be trained to effectively deliver a CBT-based support for depression, taking into account both intellectual and cultural considerations.

In addition to confirming the interest and potential success of the community leaders, I also needed to specifically explore what mental health professionals thought

about the potential involvement of community leaders in a more formalized role as paraprofessionals. I wanted to know what they considered religious leaders most needed to learn to be effective mental health care providers. When the local mental health professionals in NC were asked how monks currently help their treatment of patients, they indicated that ongoing social support and guidance in meditation, relaxation and prayer were key areas where monks were effective. When asked how monks might hinder their treatment of patients, mental health providers in Thailand cited that monks attempt to treat conditions that the mental health providers deemed required medication, such as major depression and schizophrenia. In the latter case, psychiatrists in Thailand reported that the monks often delayed treatment-seeking by prescribing long hours of meditation that the psychiatrists thought actually exacerbated psychotic symptoms.

Mental health professionals invariably indicated that the most important thing the religious leaders and other community leaders needed to know were the signs and symptoms of mental disorders, along with listening skills. In their current roles, both Thai and Burmese monks engage more in talking and guiding than in listening. All the mental health professionals I interviewed emphasized that reflective listening skills would be paramount to the monks' training and to effective support of patients with depression.

Just over 90% of the monks indicated it was an imbalance of the mind and approximately 75% believed that they could treat any imbalance of the mind with Buddhist teachings alone. The same results were observed among the Burmese monks in NC. One quarter of monks was aware and accepts that mental health professionals sometimes give medications to treat mental illness. Not surprisingly, I found that more educated monks had more knowledge of mental illness, treatment and organic mental illness. In both Thailand and the US, among the 75% of monks who believe they can treat even organic mental illness, such as schizophrenia, they have varying degrees of understanding of the psychiatric community. Primarily, the monks view psychiatrists as medical doctors; however, nearly 10% of my Thai sample indicated they were unaware of the meaning of mental illness, psychotherapy and psychiatry. Community leaders from Burma in NC reported that depression is characterized by somatic symptoms. Several mentioned that it is common in both the Burmese and Karen languages to say, "I want to die," to indicate one is feeling sad or depressed; but that this is not meant literally. These differences point to the need for native speakers of these languages who are trusted members of the community to be trained as paraprofessionals to provide basic support for depression, linking people up to services in the larger community, when needed.

7. Development of the Training Program for Paraprofessionals

Based on this rich background research, I have developed a training program for paraprofessionals that will enable them to deliver a CBT-based support for depression. In writing my training curriculum, I had the benefit of studying the training manual prepared by Rahman and colleagues (2008) as a model for how to structure and present the materials for training paraprofessionals in CBT skills for depression. Rahman and colleagues (2008) trained "lady health workers" – high-school educated women in Pakistan to provide CBT for depression in the communities they served. Even though my goal is to train community leaders among refugees and immigrants from Burma in the U.S., I benefitted greatly by studying Rahman's training model, structure and the level of complexity of their manual. It provided me a good starting point for presenting this information to a lay audience.

Considerable evidence from studies with Buddhist populations from Southeast Asia suggests CBT is compatible with Buddhist thought and practice. Specifically, CBT and Buddhism share common elements: cognitive restructuring, behavior modification, empiricism and mindfulness. While many in the community from Burma have converted to Christianity in recent generations, focus groups of Christian Karen leaders in NC have acknowledged the influence of Buddhist thought on their culture and way of thinking.

In research activities such as this which seek to cross cultural lines, I consider it important to never make assumptions about cultural nuances. In particular, the community from Burma in NC is characterized by a mosaic of ethnic and religious diversity, with Christian devotion overlaying a Buddhist history among some members. I discussed the Training Program for Paraprofessionals with community and religious leaders to gauge their interest in participating. Burmese and Karen religious and community leaders reviewed the training manual to be used with the community leaders to confirm it is culturally sensitive, appropriate and compatible with community cultural values. Also, they assured that the language was understandable and the concepts commonly shared and understood. I have done a brief 5-item multiple choice test among a group of 10 randomly chosen English-speaking Karen community leaders and found that based on this limited assessment, the concepts used in the manual and assessment tool were readily understandable to them. My training manual will be translated into both Burmese and Karen – the primary languages spoken by community members from Burma in NC. Trainings took place in each language by native speakers trained in the knowledge, techniques and skills presented. Also, one group was conducted in English at the request of group members. In addition, after both my dissertation committee and the Duke IRB approved my project, and the training manual and assessment tools were translated, I gain tested these materials among a group of 10 randomly chosen Burmese, Chin and Karen community leaders to assure that the language and concepts used were readily understandable.

8. Conclusion

Despite the availability of effective pharmacotherapy and psychological treatments, the vast majority of individuals with depression worldwide remain under-diagnosed and under-treated (Angst, 1999). Given the far-reaching effects of depression on individual health and well-being, on every level of social relations, and on national economic prosperity and development; it is imperative that researchers, funding agents, and policy-makers address the scarcity of mental health resources and work to diminish social stigma related to mental illness. Global mental health must be a global health *priority* if we are to effectively address the prevention and treatment of infectious diseases and chronic illnesses; ongoing health practices; health care inequalities; and the rights, protection and health of vulnerable populations, such as women and children. Global mental health research includes not only studying the underserved populations of low- and middle-income countries; but also comprises the investigation of culturally-sensitive treatments, mental health services delivery and lessening of stigma among underserved populations in high-income countries.

My project specifically addresses one of the two barriers to effective mental health care identified by the WHO – the lack of trained providers and resources. Among refugees and immigrants from Burma in this country, there is a profound shortage of mental health professionals who speak the languages of Burma and have the cultural understanding to provide needed culturally-sensitive treatment for

depression. Thus, there is a grave need to supplement the mental health services available in the larger community with a corps of CBT-trained paraprofessionals that could be effectively integrated into the mental health care system. My study investigates the possibility of increasing mental health support within the community from Burma in NC by training community leaders to provide CBT-based support for depression and to link up community members to services in the larger community for related problems such as substance abuse, domestic violence and suicidal behavior.

My project represents an innovative way to apply CBT at the community level by providers outside the traditional mental health care system to benefit the underserved community from Burma. This is a community that would otherwise receive little or no mental health services and includes many members who suffer from high rates of depression, trauma history, substance abuse, domestic violence, intergenerational conflict, and in some areas, suicide. Refugees and immigrants from Burma trust and are able to communicate with their own community and religious leaders in a way that they are unable to with mainstream mental health professionals. Further, my project aims to extend the use of a CBT-based support for depression to those who most need it but who may never seek mental health services from the larger community.

My project is a community level intervention that tests whether community and religious leaders from Burma may be trained to provide support for a disabling mental illness – depression, and to integrate individuals into the larger community by directing

them to resources and providers in the larger local community when necessary. In order to expand mental health services delivery to underserved populations, such as refugees, innovative thinking will be required to adapt evidence-based treatments that are culturally sensitive and potentially provided by leaders from within these communities; thereby bypassing prevailing cultural and linguistic barriers to accessing services in the larger community.

Based on my background research, I have found a strong potential for integrating community leaders from Burma into the mental health care system and great willingness on the part of community leaders to be trained to provide support for depression to community members. In short, the preliminary qualitative work I have completed over the past four years at Duke, in Thailand, along the Thai-Burma border and among the community from Burma in the NC has helped assure the feasibility, quality of design and conceptualization of my project.

Positive training outcomes would suggest community leaders could be a valuable resource for expanding evidence-based mental health services delivery within the community from Burma and potentially within other refugee and immigrant communities in the US. In addition, these findings may suggest a future larger scale community-based intervention to integrate these paraprofessionals into the mental health care system to work alongside mental health professionals from the larger local community. Additionally, this study would extend existing research on training

paraprofessionals in the use of CBT support for depression by including religious leaders as paraprofessionals and it would add to the knowledge base for providing mental health services within refugee communities. Finally, my project represents one of the first efforts to bring all the ethnic and religious groups together from the community from Burma in NC to work toward a common goal, which has inspired hope and support in a local Karen pastor, who stated that my project has the potential to bring everyone together in a meaningful way for the first time, so that their children can begin to live and work together in this country.

9. Hypotheses

I tested the following hypotheses:

1. We posited an interaction of group assignment and time, such that there would be a greater change in training group participants' knowledge of the signs and symptoms of depression and associated problems – intergenerational conflict, substance abuse and dependence, domestic violence and suicide; as well as reflective listening and CBT skills from pre-training to the completion of training, compared with changes in knowledge among wait-list control participants over the same period.
2. We posited an interaction of group assignment and time, such that there would be a greater positive change in training group participants' attitudes toward treatment-seeking for depression from pre-training to the completion of the training program, compared with the change in wait-list control participants' attitudes over the same period.

10. Methods

10.1 Design

My research design involved comparing training outcomes of CBT-trained community leaders before and after training, as well as comparing post-training outcomes with wait-list control participants. Intervention group community leaders received a 4-session 12-hour interactive training program on the signs and symptoms of depression and associated problems; awareness of stigma toward depression and treatment-seeking; and CBT skills. All participants from the intervention and control arms of the study provided demographic data and completed a Short Acculturation Scale. A measure of knowledge was administered to intervention group community leaders prior to and immediately following the training program. An assessment of attitudes toward depression, people with depression and treatment-seeking for depression was administered to intervention group community leaders prior to and immediately following the training program. The same assessments were administered to an equal number of wait list control participants. These participants were offered the training intervention after completion of the study. A group of seven Karen-speaking wait list control participants elected to complete the training program subsequent to the intervention group training programs and data collection.

This study was designed to evaluate the potential for training refugee community leaders to provide basic CBT-based support for depression and informally

integrate them into the local mental health care system. The study was approved by the Institutional Review Board of Duke University, Durham, North Carolina, USA.

10.2 Participants

Thirty-eight community leaders from Burma in North Carolina were recruited from the Research Triangle area to participate in the Training Program for Paraprofessionals. In terms of demographics, all participants were community leaders from Burma. Participants were ethnically Burmese, Karen, Chin or Rakhine; and Christian or Buddhist by religion. The educational level of participants ranged from elementary school to high school to bachelor's and master's degrees. Approximately 67.6% (n=25) of participants were Karen-speaking and 32.4% (n=12) were Burmese-speaking. Most participants had at least a working knowledge of a second language from Burma; primarily Burmese, Pwo Karen, Chin or Arakanese. Demographic information was collected on age, gender, ethnicity, language, religion, education, and community leader status. Additional data on the migration experience was gathered, including country of origin and country of residence immediately prior to coming to the US, age upon arriving in the US, and occupation before and after coming to the US. Table 1 below presents the background characteristics of the participants. The demographic questionnaire for participants is presented in Appendix A.

Table 1. Characteristics of training and control groups

Characteristic	Training Group (*n*=19)	Control Group (*n*=18)	Significance *
Age, in years, *M (SD)*	35.11(13.86)	38.00(12.95)	.78
Males, *n* (%)	12 (63.16%)	9 (50%)	.41
Ethnicity, *n* (%)			.37**
Burmese	1 (5.26%)	0	
Karen	14 (73.68%)	12 (66.67%)	
Chin	4 (21.05%)	4 (22.22%)	
Rakhine	0	2 (11.11%)	
Religion, *n* (%)			.34
Christian	16 (84.21%)	15 (83.33%)	
Buddhist	3 (15.79%)	3 (16.67%)	
Education, *n* (%)			.31
Grades 1-12	15 (78.95%)	15 (83.33%)	
College/Graduate/Professional	4 (21.05%)	3 (16.67%)	
Occupation, *n* (%), prior to coming to the USA			.10
Student and Blue Collar	9 (47.37%)	10 (55.56)	
White Collar-Professional	10 (52.63%)	8 (44.44%)	
Occupation, *n* (%),USA			.51
Student and Blue Collar	17 (89.47%)	16 (88.89%)	
White Collar-Professional	2 (10.53%)	2 (11.11%)	
Immigration - Age entering USA, *M(SD)*	31.21 (13.70)	30.89 (13.93)	.94

Notes: **p*-values were obtained by *t*-tests for continuous variables and by chi-square tests and Fisher's exact test for classification variables

**When comparing Karen and Chin ethnicities by 2 groups (Training and Control), Fisher's exact test=.31

10.2.1 Eligibility

The main inclusion criterion was status as a "community leader" within the community from Burma, meaning an individual to whom other community members go for guidance and support; including official and unofficial community leaders and religious leaders, such as Buddhist monks and Christian pastors. Unofficial community leaders included those who do not hold a particular title, such as pastor or monk, but who fulfill a vital role in supporting others in the community and linking them up to needed services in the larger community. I presented the program to nearly one hundred community members and local mental health professionals. All community leaders were identified with the help of Karen pastors, Burmese Buddhist monks, local mental health professionals from the Refugee Health Coalition of Orange County, and volunteers and academics who work tirelessly at the grass-roots level with the community members from Burma.

10.2.2 Randomization

Participants were randomized to either the training intervention group or the wait-list control group. Those in the wait-list control group were offered the training intervention after data collection had been completed. One such group has been scheduled for Karen wait-list control participants for late Spring 2014.

10.3 Setting

The project took place at two distinct settings in Carrboro and Durham, NC: 1) the Refugee Resource Center in the Carolina Apartment's Clubhouse on Rt. 54 in Carrboro, NC for both Burmese-speaking and Karen-speaking training groups; and 2) the Five Oaks Seventh-Day Adventist Church for English-speaking Karen participants. Each training site was chosen for its ease of access by participants. Further, consideration was given to the preference by some participants to attend training sessions with members of their same ethnic group and in their first language.

10.4 Procedure

The 4-session 12-hour interactive training program took place in a location that was nearby, easily accessible and familiar to the participants. The program was adapted from the longer 21-hour program I developed for use with Buddhist monks in Thailand. This adaptation was based on input from six meetings with refugees from Burma in Carrboro and Raleigh and four meetings with Christian and Buddhist religious leaders. A consensus was reached that a 4-session 12-hour training program was more feasible among these groups, considering their work schedules, school commitments and family responsibilities. The training program curriculum had the following objectives: a) to recognize the signs and symptoms of depression and related problems, including intergenerational conflict, substance abuse, domestic violence and suicide; b) to use reflective listening and CBT skills, and b) to increase awareness of stigma toward

treatment-seeking for depression and its related risk factors. Community leaders were taught to refer people to mental health workers in the larger community when encountering problems related to substance abuse, domestic violence or suicide. Mental health professionals to whom people would be referring were invited to address participants in the sessions when their area was discussed. These included professionals from Compass Center for Women and Families, a family violence prevention center; Freedom House Recovery Center, which supports individuals with a substance abuse and mental illness; and the Emergency Psychiatry Service at UNC Hospital. For example, a mental health professional from Compass Center – a primary rape crisis and domestic violence center in Chapel Hill, NC, was introduced to Burmese- and Karen-speaking training participants in their respective second sessions. She described the services provided at Compass Center and answered many questions posed by community leaders.

As planned, I was present to guide all training sessions. And considering emic/etic distinctions (Pike, 1967), the Burmese language training program was led by a native Burmese speaker and community leader. And the Karen language training was led by a native Karen speaker and community leader. These bilingual native speakers were identified based on their interest in being a trainer and their facility with English. They were trained in advance to present the program to other community leaders and to stimulate discussion on the material. Their instruction included all material in the

training manual, as well as guidance on how to create a safe, comfortable atmosphere that promotes discussion, humor and willingness to ask questions and participate in group exercises. I trained two individuals – one Karen-speaking and one Burmese-speaking, and compensated them $15 per hour for 12 hours of preparatory training; as well as $15 per hour for each hour they trained participants for an average total of $360 per trainer.

The Training Manual for Paraprofessionals was translated into Burmese and Karen and back-translated into English; the manual is presented in Appendix B.

Participants were assessed regarding their demographic profile, level of acculturation, knowledge of depression, and attitudes toward depression and treatment-seeking.

After completing the training program and all assessments, a completion ceremony was held for training participants. Each was compensated $50 for his participation and presented with a Certificate of Completion. Pastors and community leaders indicated that in addition to the financial benefit, the Certification of Completion would be a meaningful gift for participants. It was explained to all participants that this certificate would not be recognized by the state or local government. Rather, it was an acknowledgement of their completing the 12-hour interactive training program.

10.5 Outcome measures

Primary outcome measures were administered to intervention group and wait list control participants pre-training and post-training. A demographic questionnaire and acculturation measure were administered pre-training. Additional outcome measures were administered throughout the training to intervention group participants to monitor learning and evaluate the program's adherence to training goals.

Paraprofessional provider assessments included an Assessment of Depression Knowledge, presented in Appendix C, which was administered to the paraprofessionals and wait list controls at baseline and at the end of the training program. This 10-item multiple choice measure tests for understanding of significant aspects of depression and CBT treatment for depression. Each participant received a total score based on the sum of the individual items answered correctly.

Examples of the questions on the Assessment of Depression Knowledge are as follows:

- Major depression is diagnosed when 5 or more symptoms of depression are present for most of the day, nearly every day [for how long?]
- Physical symptoms of depression include [which of the following?]
- Which of the following is a sign of suicide risk?
- You can best identify key thoughts in cognitive therapy when?

- Which of the following is most likely to help clients engage more in CBT sessions?

While I developed the Assessment of Depression Knowledge for use in this study and it has not been tested for reliability and validity, six of the ten items were derived from the Therapist Depression Knowledge Questionnaire developed by Simons, Padesky, Montemarano, Lewis, Murakami, Lamb et al. (2010).

An Assessment of Attitudes Toward Depression, individuals with depression and treatment-seeking for depression, as presented in Appendix D, was administered to paraprofessionals before and immediately following the training program.

Section A contains a vignette related to depression and a five item subscale adapted from the Attitudes to Mental Illness Questionnaire (AMIQ; Luty et al., 2006), which is used to measure stigmatization and stigma associated with treatment-seeking. Luty et al. (2006) report that the results of factor analysis show excellent construct validity. Their factor analysis with principal component analysis with varimax rotation suggested that one component – "stigmatization" was responsible for 80.2% of the variance with significant contributions from all five questions. Specific constructs involving other people's projections of a patient's future and social distance were the bases of some of the questions. However, Luty et al. could not discretely identify these

particular factors on their factor analysis. In addition to construct validity, they reported good test-retest reliability, Pearson's correlation coefficient was 0.702.

Examples of the questions related to the vignette in Section A are as follows: Please read the following statement: 'John is depressed and took a Tylenol overdose last month to try to hurt himself.'

Please underline the answer that best reflects your views:

1. How likely do you think it would be for John's wife to leave him?
    a. Very likely^{+2}/Quite likely^{+1}/Neutral^{0}/Unlikely^{-1}/Very unlikely^{-2}/Don't know^{0}
2. John and his family will be embarrassed if John speaks with the doctor about his sadness.
    a. Strongly agree^{+2}/Agree^{+1}/Neutral^{0}/Disagree^{-1}/Strongly disagree^{-2}/Don't know^{0}

Section B of the Assessment of Attitudes Toward Depression was adapted from the *Attitudes About Depression Questionnaire,* which was used to measure changes in attitudes toward depression in the multicenter trial in which Latin American primary care physicians were trained in the World Psychiatric Association (WPA) module on depression (Levav, Kohn, Montoya, Palacio, Rozic, Solano et al., 2005). Each item is a statement followed by a 5-point Likert scale where 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree. Some items have to be reverse-scored.

Examples of the questions in Section B are as follows:

- Depression is a way that weak people confront life's problems.
- I am comfortable addressing the problems of people with depression. [reverse-scored]
- Depression will go away without the help of doctors and mental health professionals.
- Depressed people should share their personal problems with their family only.

To score the Assessment of Attitudes Toward Depression, the points for each response to items in Sections A and B were totaled for a final score. Higher scores reflect greater stigma toward depression and people with depression; lower scores reflect less stigma.

All participants completed a Short Acculturation Scale for Burmese-speaking and Karen-speaking Refugees, presented in Appendix E and F respectively, which was administered at baseline. This 12-item multiple choice test assesses an individual's level of acculturation based on his self-reported use of native languages and English, as well as his integration of native and American individuals and media into his daily life. Each participant received a total score, with higher scores reflecting greater acculturation. The Short Acculturation Scale was widely used and validated among Latin American populations (Marin & Marin, 1991), and was later adapted for use in Filipino American

immigrants (Dela Cruz, Padilla & Agustin, 2000). Among these immigrants, the Short Acculturation Scale was found to have good construct validity of .85, and an overall Cronbach's alpha coefficient for internal consistency of .85.

Examples of questions on the Short Acculturation Scale are as follows:

1. In general, what language(s) do you read and speak?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

2. In which language(s) do you usually think?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5

3. The persons you visit or who visit you are:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

4. If you could choose your children's friends, you would want them to be:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

In addition, in order to monitor learning by paraprofessionals, three brief 5-item multiple choice quizzes were administered at the start of sessions 2, 3 and 4. These quizzes and an answer key are presented in Appendix G. Each participant received a

final score based on the sum of the individual items answered correctly. Participants were not given feedback about their responses on the quizzes. Several of the treatment-related questions on the quizzes were derived from the Therapist Depression Knowledge Questionnaire developed by Simons, Padesky et al. (2010).

Examples of the questions on the quizzes are as follows:

- Factors that contribute to depression [include which of the following?]
- What is the goal of cognitive restructuring?
- According to research, structure in cognitive therapy [is important why?]

And finally, to monitor the program's consistency with training goals, after sessions 2 and 4, paraprofessionals were asked to evaluate the program on a 5-item questionnaire – Program Evaluation Form, which included items such as, "The Training Program has helped me understand the signs and symptoms of depression better now than when I started." Participants were asked to rate each of the five items on a scale where 0=strongly disagree, 1=disagree, 2=neutral, 3=agree and 4=strongly agree. Participants provided their assessment of the program's success in fulfilling the training goals set forth at the start; see Appendix H for this rating scale.

11. Statistical analysis

All data analyses were conducted using Statistical Analysis Software (SAS). Initial data cleaning was carried out to verify that all data had been entered correctly. I double entered the data by inputting it into two different files and then reviewing the files for any discrepancies between them. Preliminary descriptive analyses of the data were then conducted, including computing means and standard deviations of the scores, using measures of skewness and homoscedasticity to test whether the scores followed a normal distribution, which is required for ANCOVA. A normal distribution was in evidence at both Time 1 and Time 2.

Demographic characteristics of training and control group participants were compared by t-test for continuous variables and by chi-square test and Fisher's Exact Test for classification variables, to assess whether there were significant differences between participants at baseline. In the case of cells that contained less than 5 observations, Fisher's Exact Test was used to compare characteristics between groups. To test the direct effects of training, analysis of covariance (ANCOVA) was conducted to compare changes in training group participants' knowledge and attitude scores from assessments administered pre-training with those collected post-training, with changes in knowledge and attitudes over the same period among control participants. Level of acculturation and pre-training scores were entered in the model as covariates. Simple t-tests were then conducted to compare means within the training group pre- and post-training for both depression knowledge and attitudes.

To measure the consistency of training with learning objectives, repeated measures ANOVA was utilized to compare community leaders' evaluation scores from assessments administered after sessions 2 and 4. My power analysis indicated that to achieve statistical power of 80% for ANCOVA, with an alpha level of .05 and a medium effect size (*Cohen's f* = 0.25), a total sample size of 34 participants was required.

12. Results

Univariate analysis of variable distribution was conducted. By convention, if data are normally distributed, skewness and kurtosis both should fall within the range from +2 to –2 (Cohen, Cohen, Aiken & West, 2003). Testing for skewness and kurtosis yielded evidence of a normal distribution for all variables of interest at both Time 1 and Time 2. See Table 2 for measures of skewness and kurtosis.

Table 2. Distribution analyses

Variable	Skewness	Kurtosis
Pre-training depression knowledge	- 0.19	- 0.41
Post-training depression knowledge	- 0.23	- 0.93
Pre-training attitudes toward depression and treatment-seeking	- 0.69	1.66
Post-training attitudes toward depression and treatment-seeking	- 0.08	- 0.23

Table 3 shows the correlations among age, age entering the U.S., amount of time in the U.S., acculturation level, post-training depression knowledge and post-training attitudes toward depression and treatment-seeking. Moderate correlations were found for the following pairs: age entering the U.S. and attitudes, amount of time in the U.S. and both measures of depression knowledge and attitudes. And higher level correlations were found between the following pairs: age and acculturation and age entering the U.S. and acculturation, both of which were expected; as well as post-training depression knowledge and attitudes toward depression and treatment-seeking, which is consistent with our hypothesis that increasing knowledge through training will lead to lower levels of stigma toward depression and treatment-seeking.

Table 3. Intercorrelations between variables, (N = 37)

	1	2	3	4	5
1. Age	-	.96*	-.43*	.00	.25
2. Age entering US		-	-.48*	-.07	.31
3. Acculturation			-	.18	-.16
4. Post – Depression Knowledge				-	-.51*
5. Post – Attitudes To Depression					-

Note: *$p < .05$

Relation of Changes in Learning between Training Group and Control Group

Table 4 presents the results of ANCOVA when controlling for level of acculturation and initial knowledge of depression. There was significantly greater learning of depression knowledge from pre-training to post-training among training group participants than among control group participants ($F = 37.53$; $p < .0001$). Further, simple paired t-tests of the means of pre- and post-training knowledge of depression revealed a significant difference ($t = -11.47$, $p < .0001$) within the training group.

Table 4. Results of ANCOVA for post-training Depression Knowledge

Variable					
Post-Training Depression Knowledge	Type III Sum of Squares	df	Mean Square	*F*	*p*-value
Level of Acculturation	2.28	1	2.28	1.48	.23
Pre-Training Depression Knowledge	6.67	1	6.67	4.35	.04
Training Group	141.78	1	141.78	92.32	< .01

Relation of Changes in Attitude between Training Group and Control Group

Table 5 presents the results of ANCOVA when controlling for level of acculturation and initial attitudes. There was a significantly greater decrease in stigma as represented by negative attitudes toward depression and treatment-seeking, from pre-training to post-training among training group participants compared with control group participants ($F = 5.45$; $p = .004$). See Table 5 for results. Further, simple paired t-tests of the means of pre- and post-training attitudes toward depression and treatment-seeking among the training group showed a significant difference ($t = 4.25$; $p < .001$), with decreased negative attitudes post-training.

Table 5. Results of ANCOVA for post-training attitudes toward depression and treatment-seeking

Variable					
Post-Training Attitudes toward Depression	Type III Sum of Squares	df	Mean Square	*F*	*p*-value
Level of Acculturation	2.97	1	2.97	.20	.66
Pre-Training Attitudes toward Depression	104.40	1	104.40	7.09	.01
Training Group	131.05	1	131.05	8.90	< .01

Relation of Mid-Training and Post-Training Program Evaluations

There is no evidence to suggest greater satisfaction at the closing of training than midway through the program; with program evaluation means of 13.68 mid-training and 14.12 post-training out of 16 possible points. These means may reflect actual program satisfaction. However, given the small group context in which the evaluations were administered, participants may have considered that group leaders would see their

scores and as such, felt the need to endorse high levels of satisfaction. Further, cultural factors may have inhibited participants from expressing a negative assessment. And finally, a sense of "social desirability" may have led participants to provide positive evaluations. There was no reason to expect great changes in program satisfaction post-training compared with midway through the program. The optimal outcome would be to have reasonably high levels of satisfaction throughout, as was suggested by the findings. The results of repeated-measures ANOVA of mid-training Program Evaluation scores and post-training Program Evaluation Scores are reported in Table 6 below.

Table 6. Analysis of Program Evaluations

Variable					
Post-Training Program Evaluation	Type III Sum of Squares	df	Mean Square	*F*	*p*-value*
Time	1.68	1	1.68	.43	.52
Error (Time)	71.32	18	3.96		

Note: *$p < .05$

13. Discussion

Training refugee community leaders from Burma in the U.S. to provide CBT-based support for depression among their community members is a feasible way to expand mental health services delivery among this underserved population. In particular, evidence from this study suggests that regardless of educational level, training participants significantly increased their knowledge of depression and treatment skills.

Further, findings from this study suggest that the training program helped to decrease stigma toward depression and treatment-seeking among participants. As community and religious leaders, these individuals are in a position to influence refugees who come to them for counsel and support. As such, these trained paraprofessionals could potentially influence the level of stigma toward mental illness and treatment-seeking in the refugee community. Additionally, training leaders from within the refugee community from Burma provides the best opportunity for culturally-sensitive support by native speakers who are already in positions of trust and respect within the community.

13.1 Limitations

The primary limitation of this study was related to outcome measures, which focused on training outcomes, rather than treatment outcome scores from community members who were receiving support from trained leaders. Also, the training outcomes

utilized in this study measured knowledge and attitudes; but did not evaluate the community leaders' ability to deliver the support for which they were trained.

Further, while the sample size was large enough to achieve the required statistical power, a larger sample size would provide a richer base for analysis. Further, there were many church elders among the participants, but only two clergy members – one Buddhist and one Christian. A larger number of clergy members would allow for analyses among this group, apart from the other community leaders. And finally, extending the sample to include another refugee group would be valuable in terms of identifying elements of the training that may be especially useful for one group over another, or one culture rather than another.

13.2 Future Research

The next step in evaluating the potential for integrating community leaders into the mental health support structure for community members would be to test the effectiveness of trained community leaders in providing CBT-based support to community members with depression. One possible method would be to videotape community leaders providing CBT-based support; then code the sessions; and evaluate each leaders' performance.

A second course for future study would be a randomized controlled trial (RCT) to evaluate community members' depressive symptoms before and after receiving 12 weekly CBT-based support sessions from trained community leaders; comparing these

symptoms with those of individuals who received "usual care" by community leaders. "Usual care" in this case would refer to whatever pastors, monks, youth leaders, church elders and local community leaders would commonly do with people who came to them for support. Another option for the control condition in such a study would be to provide the community leaders with educational materials on depression. Such an RCT would allow for comparing changes in depressive from baseline to post-support visits by trained community leaders; as well as allowing for a comparison between depressive symptoms in individuals who visited trained community leaders with those of a control group.

Another avenue for future research would be to conduct the RCT described above with the addition of supervision for the trained paraprofessionals as a third group. Such supervision would be provided by a mental health professional in the larger community on a weekly basis during the course of the 12-week support sessions for community members. This RCT would require a larger sample population and would comprise three groups: 1) trained paraprofessionals with supervision, 2) trained paraprofessionals without supervision, and 3) controls providing support "as usual" or receiving educational materials. The integration of supervision into the model could potentially support relationship-building and knowledge transfer over time, and elevate the quality of support provided by paraprofessionals to community members. Further, weekly contact of these community leaders with a mental health professional could help

to reduce stigma toward treatment-seeking in the larger community, by building knowledge, familiarity and willingness to refer individuals outside the refugee community when needed.

Appendix A

Paraprofessional Provider - Demographic Questionnaire

1. Country of origin_____
2. What was your country of residence prior to coming to the U.S.A.? _____
3. How old are you? _____
4. What is your religion? (Please circle one)
    a. Christian
    b. Buddhist
    c. Muslim
    d. Other _____
5. What level of education have you completed? (Please circle one)
    a. None
    b. Primary School
    c. High School
    d. College
    e. Graduate/Professional
6. Degree/Major_____
7. What is your status as a community leader? _____
    a. Are you a church elder? _____
8. If you are affiliated with a religious institution, what is it called and where is it located? _____
9. Age upon entering U.S._____
10. Occupation prior to coming to the U.S._____
    a. Occcupation in U.S._____

11. Type of Health Care Coverage (Please circle one)
    a. None
    b. Medicaid
    c. Private insurance
    d. Work-related insurance

Appendix B

Training Program for Paraprofessionals

Cognitive-Behavioral Training

for

Community and Religious Leaders

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Table of Contents

Session 1 – Introduction, Depression and Intergenerational Conflict

INTRODUCTION by Pamela Buck

My name is Pamela Buck and I am a doctoral candidate in clinical psychology at Duke University. We would like to welcome you to the Training Program for Paraprofessionals. We thank you for coming and for your willingness to participate in this program, which is part of a study investigating the potential for training community and religious leaders in delivering cognitive-behavioral training, which we will call "CBT," for depression in community members. The long-term goal of the investigators is to discover the best way to expand the delivery of mental health services within the community. This program has been designed by researchers from Duke University in the Durham, NC. It is important that you attend all four sessions. Our first session will cover a little more material than the rest because we want to give you a broad introduction today.

We are very grateful for your participation and we would like to give each of you the opportunity to introduce yourself to the group.

[*Providers introduce themselves.*]

Our Objectives

- Train you to recognize the signs, symptoms and risk factors of depression
- Support you in educating people and profoundly changing community attitudes toward treatment-seeking for depression
- Train you to treat depression, working alongside the psychiatric community
- Discuss four significant issues related to depression:
    1. Intergenerational conflict
    2. Domestic violence
    3. Alcohol abuse and dependence
    4. Suicide

The Training Program for Paraprofessionals

How to Use this Manual

This 12-hour program is a CBT-based intervention developed to train community and religious leaders to treat depression in community members. Over the 4 three-hour sessions, you will be trained to support community members suffering with depression. Before getting into a discussion about depression and CBT, let's take a few minutes to introduce you to this manual and how best to use it. First, we want you to recognize some common codes that will be used to identify different aspects of the training.

Training Session Format: The schedule for each session mirrors the three main CBT activities:

I. Education – Depression and CBT
II. Skill-building – Depression support skills are marked with this symbol, "  "
III. Problem-Solving – Practice exercises appear in orange text boxes, such as this:

Exercise: An orange box such as this one indicates an exercise you will engage in during the training session to practice your new support skills.

CBT Assumptions: These will appear in light purple boxes such as this one throughout the manual. They will help you better understand some of the basic assumptions of CBT.

Terminology – When new terminology is first introduced, it will be in **bold** and *italics*. For example, we will refer to you as the ***provider*** and to the person you treat as the ***client***. From that point on, these words will not be bolded or italicized in the manual.

- Bullet Points include the arrow, and numerals, and signify key information we will be discussing during the four training sessions.

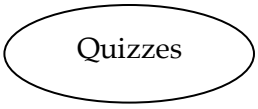
CBT Session Outline: In each training session, you will find a box similar to the one below that presents the structure you will follow with your client in each support session. Briefly, two of the components will be bolded and explained below the box at each session.

CBT SESSION OUTLINE
➢ **Mood Check**
➢ Agenda Setting
➢ Previous Session Review
➢ Address Agenda
➢ New Homework
➢ Summarizing & Feedback

MAJOR HEADINGS Boxes: You will see these boxes throughout the manual indicating subsections that need your attention.

MAJOR HEADINGS

- **Skill-Building:** This symbol will help you recognize the section in the manual where you will be presented with new support skills.



At the start of sessions 2, 3 and 4, you will be quizzed on your understanding of the concepts and practices. You will be alerted to quizzes by this symbol.

✓ **Homework –** A check mark tells you that what follows is a homework assignment for you to complete for the next session. Look for these at the end of section III of each session.

NOTES – At the end of each session, you will find a blank page to write notes.

Handouts – At the end of the training session material, you will find ***Training Handouts*** and ***Treatment Handouts.*** We will go over the ***Training Handouts*** in our sessions together. We will refer to the ***CBT Activity Book of Support Handouts*** and you may use them in treating clients. You may wish to bring some of them into your sessions with clients as guides or tools.

Supplemental Reading – These materials provide additional information on the topics we cover in our training sessions together.

Conclusion – At the end of this manual, you will find a list of articles and books used to prepare these training materials. Also, you will find a ***Program Evaluation Form***, which you'll be asked to complete to let us know about your thoughts and experience as a trainee in this program.

Materials - The following materials are provided:

- Training Manual in 3-ringed binder – allowing you to remove and copy handouts
- Training Notebook – for notes and homework assignments
- Pens
- Copies of CBT Activity Book, which paraprofessionals may use with clients

Asking Questions – Please stop me any time to ask questions; either as I am going through the material or at the end of the section. Others will probably have the same question, so please raise your hand and ask. Also, you may share any ideas or comments you have. We greatly value your input and hope you will participate in all discussions.

Referrals – A *Referrals Guide* is provided for you on the last page of this manual, p. 104. It includes the names, addresses and contact information for the hospitals, rehabilitation centers, shelters and community health care centers that you will contact to help your clients.

Let's start by talking about Depression in the Community

- Expected to be the 2nd leading cause of disability worldwide by 2020; second only to heart disease
- Compromises the quality of life and functional capacity of tens of millions of people worldwide
- Great risk factor for death among the chronically ill
- Enormous social cost, especially to vulnerable populations
- High rates of depression among refugee and immigrant communities in North Carolina

Why train community and religious leaders to treat depression?

- Your community and religious leaders are trusted by the community and provide some psychological support in their current roles.

- These leaders will be culturally-sensitive support providers who deeply understand the suffering of community members.

- Stigma toward seeking help from mental health providers in the larger community leaves community members to suffer in silence.

- Lay people, meaning non-professionals, like you have been trained before to provide
  - primary care services;
  - CBT for depression;
  - psychoeducation programs promoting health and smoking cessation;
  - nutritional, stress-reduction and family planning counseling;
  - HIV/AIDS-related support and services.

I. SIGNS AND SYMPTOMS

Mental Disorder

A ***mental disorder*** is a psychological or behavioral pattern generally related to personal distress or disability; is not common within the culture; and makes it difficult for a person to carry out daily activities. It may be a combination of thinking, perceiving, feeling and behaving.

Major Depression – "Depression"

- A mood disorder involving a person's thoughts, actions, interactions with other people, body, appetite and sleep
- Can affect people of any age, race, or ethnic group
- NOT the same as a passing bad mood and is never a "normal" part of life
- ***NOT a sign of personal weakness*** or a condition that can be willed or wished away
- Without treatment, it can last for weeks, months, or years
- ***Up to 15% of people diagnosed with depression eventually commit suicide***; therefore, treatment is very important

Depression is diagnosed when five or more of the following symptoms are present for most of the day, ***nearly every day for at least 2 weeks:*** (At least one of the symptoms must be either persistent sad or "empty" feelings, or loss of interest in activities.)

- Constant sadness
- Irritability
- Hopelessness
- Trouble sleeping
- Low energy or fatigue
- Feeling worthless or guilty for no reason
- Significant weight change
- Difficulty concentrating
- Loss of interest in favorite activities
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal thoughts without a specific plan, or a suicide attempt or a specific plan for committing suicide

In much of Asia and within Asian refugee and immigrant communities in NC, it is common for individuals to report ***mainly physical symptoms***, such as the following:

- Nausea, stomach ache, headache, chronic body pains

Some people experience mild depression, while others experience severe, disabling depression. Not everyone who is depressed experiences every symptom of depression.

Some Risk Factors for Depression

- Loneliness and lack of social support
- Recent stressful life experiences
- Family history of depression
- Marital or relationship problems
- Financial strain
- Early childhood trauma or abuse
- Alcohol or drug abuse
- Unemployment or underemployment
- Health problems or chronic pain

Trauma History as Risk Factor

Refugees are at much higher risk than the general population for psychiatric disorders associated with the experience of violence, war, torture, forced migration, exile and stressful resettlement conditions. Many refugees and immigrants have experienced pre-migration trauma and stressful refugee camp experiences.

- ❖ Up to 10 times the rate of post-traumatic stress disorder (PTSD) and high rates of depression, chronic pain and other physiological symptoms.
- ❖ Pre-migration trauma and refugee camp experiences predict psychological distress 5 years and more after migration, regardless of ethnicity and length of time in the U.S.
- ❖ Over 20 years after arrival, pre-migration trauma is still associated with PTSD and major depression.

Related Issue: Intergenerational Conflict

The migration process creates cross-cultural challenges for families that can lead to or intensify already existing intergenerational conflict, setting the stage for abuse, neglect and depression.

- In Asian American youths, parent-child conflict is associated with suicidality.

- How well a refugee child has adjusted to American culture interacts with parent-child conflict to predict suicidality. Less acculturated youths are at greater risk for suicidal thoughts and behavior if they have greater parent-child conflict than adolescents who have adjusted better.

Discussion:

- What has been your experience with intergenerational conflict?

- What can you share about intergenerational conflict in your community?

Anti-depressant medications

Clients who meet the criteria for depression may receive antidepressant medication from their family doctor or mental health provider in the larger community. These medications alter brain chemistry to decrease symptoms of depression and restore a sense of psychological well-being.

Stigma

Stigma is a characteristic, behavior, or reputation that is socially undesirable. People who are stigmatized are associated with a rejected or negative image. Among refugees and immigrants from South and Southeast Asia, there is stigma toward treatment-seeking for depression. People suffering from depression often stay home and do not go to work, remaining isolated and further compounding their distress. People often have a bias against someone who is withdrawn, sad, complaining of physical discomfort and lack of motivation. This social isolation can make a person's depressive symptoms even worse, especially in those who are left alone in the U.S. or when family members have moved away to work in another area. We hope you will encourage all members of the community to reach out to people who may be withdrawn because of depression. And, we hope you will teach community members that it is acceptable to seek support for depression and other mental disorders.

II. DEPRESSION SUPPORT SKILLS

What is *Cognitive-Behavioral Therapy*?

- Cognitive Behavioral Therapy (CBT) is a **structured, problem-solving** psychological treatment.

- In CBT, you will work with your client to **set goals** for each session and longer-term goals, which may take several weeks or months to achieve.

- CBT **focuses** on WHAT and HOW a person thinks, not WHY he thinks that way. CBT is concerned with what is happening NOW and focuses on solving problems and changing behavior.

- CBT includes 3 primary activities:
    1. Education
    2. Skill-building
    3. Problem-solving

CBT Assumption: what people think about an event determines how they will feel about that event. CBT aims to ***alter the cycle of unhealthy thinking and the resulting undesirable actions.***

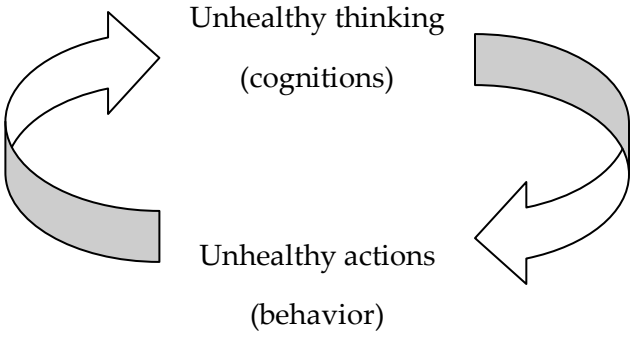


Figure 1. The cycle of unhealthy cognitions and unhealthy behavior.

CBT Assumption: People learn unhealthy thoughts and behaviors; therefore, they can also learn new skills that improve their mood and coping ability. Changing thoughts and behavior will improve mood.

Ask your client to come back at least 6 times for support. Changing thoughts and behavior can help prevent relapse; a relapse is when depression returns again after a person has begun to feel better. ***The lowest risk of relapse is for people whose initial treatment was CBT or behavior therapy.***

Two ways CBT addresses ***Depression***, which is caused by the cycle of unhealthy thoughts and behaviors:

1. ***Cognitive Aspect*** – Working with your clients to change his thoughts, beliefs, ideas, attitudes, assumptions, mental imagery and ways of directing his attention for the better.

2. ***Behavioral Aspect*** – Teaching your clients helpful behavioral strategies:
    a. Coping skills for both daily living and stressful situations
    b. Identifying healthy ways to interact with other people
    c. Planning and managing their daily schedule
    d. Taking actions and engaging in pleasurable activities
    e. Learning how to distract themselves from negative thoughts
3. One of the **key goals** you will have with your clients will be to **increase their daily level of activity** in order to improve their mood.

12-Session Individual CBT for Major Depression

3-Step Approach

Step 1: **Education**

- signs and symptoms of depression
- how CBT works
- the structure for support sessions
- common types of unhealthy thinking styles

Step 2: Skill-Building

- to identify unhealthy thoughts and beliefs
- to recognize how those ideas affect their mood, behavior and physical condition
- for example, use of the **CBT Tool: Thought Record**
    - help clients question the accuracy of such thoughts
    - guide them in replacing unhealthy thinking with healthy thinking
    - support them in making small meaningful changes in their behavior, which will lead to healthier thinking

Step 3: Problem-Solving

- teach coping skills
- suggest activities and homework for practicing healthy thinking and behavior
- for example, use of the **CBT Tool: Activity Log**
    - teach your client to schedule pleasurable experiences into their daily lives

CBT Support Session Outline

Structure in CBT is associated with better treatment outcomes. Learning to deliver this support session in 30 minutes will be valuable in treating community members in the future. Make clear choices, focusing on only one or two problems in each session. Below is your session outline, which is reprinted for your convenience as ***Support Handout #1.***

CBT Support Session Outline

➢ **Mood Check**	Start by checking on client's mood and symptoms using the Mood Scale provided in Support Handout #2
➢ **Agenda Setting**	Provider and client set an agenda for the session
➢ **Previous Session Review**	Create a bridge to the new session and review homework, discussing problems and successes
➢ **Address Agenda**	Together, address issues on the agenda
➢ **New Homework**	Together, set new homework
➢ **Summarizing & Feedback**	Provider summarizes the session and client provides feedback

CBT SESSION OUTLINE
➢ **Mood Check**
➢ **Agenda Setting**
➢ Previous Session Review
➢ Address Agenda
➢ New Homework
➢ Summarizing & Feedback

We will discuss two components of the CBT outline in each of our training sessions, starting with the Mood Check.

- **Mood Check –** You can get a good idea of how your client has been feeling since your last session by asking your client to respond to a mood chart. Please take out ***Support Handout #2 – Mood Chart***. Show this pictorial scale to your client at the beginning of each session and write down the number corresponding to their response in your support notebook. Each picture corresponds to a number from 1-5 with 1 being the poorest and 5 being the best in terms of mood. Compare your client's score to his last session. If your client's mood has changed, ask your client to comment on this change.

  For practice, we would like you to check and record your own mood each day between now and our next session using the mood check.

- **Agenda Setting –** Ask your client what problems he would like to talk about during that session, limiting the list to one or two.

Skill-Building: Reflective Listening

Description of Skill

Reflective Listening is a communication strategy involving ***two key steps***: 1) trying to understand your client's idea, then 2) offering the idea back to your client, to confirm you understood the idea correctly.

Four Reflective Listening Skills

1. **Prompting**. With as few words as possible, tell your client you want him to continue speaking, to give you more information. There are two types of "prompts": ***verbal*** and ***nonverbal***.

2. **Open-Ended Questions**. These questions focus on missing information that you want. And they are questions that **cannot** be answered with a simple, "Yes" or "No." Here are some examples of helpful Open-Ended questions:
    a. Can you tell me more about that?
    b. Why do you think that is?
    c. What does that mean to you?

3. In **Rephrasing**, you put into your own words what you think your client is saying and then reflect that back to him to check the accuracy of your understanding.

4. **Empathy Statements** are designed to both clarify and reinforce what your client is saying, but with a greater emphasis on reinforcement, which is key to motivating a person. Showing empathy for your client gives him the feeling he is understood, and also that you have some compassion for him and his situation.

Skill-Building: Re-Directing the Conversation

Description of Skill

Let's talk about another communication strategy. You will have only 30 minutes with your client. So when speaking with your client, try to get to the heart of the matter quickly and respectfully. Re-direct your client when he is straying from the main issue or talking a lot.

IMPORTANT: What is causing your client distress NOW?

You may stop him and ***re-direct him to the present,*** if necessary. You may gently interrupt him to be sure you understand his distress. You will probably have some clients who talk a lot and others who do not talk very much or ever. It may be easy to rely on the client who talks a lot.

To gently and respectfully re-direct the conversation, you may say:

- Thank you for sharing your ideas. I wish we had time to talk about that more, but since our time is limited, let's return to the problem we agreed to discuss.

- I'm going to interrupt you because you have brought up some interesting ideas we should discuss further.

- Thank you for sharing your ideas, but I'm going to interrupt you now so that I can tell you about another important topic I think will help in our conversation.

III. EXERCISES – USE OF SUPPORT SKILLS

Exercise: ***Reflective Listening Skills***

May I have a volunteer to do an exercise with me? The volunteer will share a real and serious problem. Reflective Listening is for working through serious not simple problems. For example, use Reflective Listening when your clients mention a dilemma regarding family members, finances, or how to handle a significant loss for example.

***

Now we are going to split the group up into pairs to for a role-playing exercise. Please move your chairs so you are sitting in pairs. I am going to ask one person to share a problem and the other to practice his Reflective Listening skills. The goal of the exercise is to **identify the heart of the problem** and **obtain confirmation that you are correct**. I will come around to help each pair, as needed.

***

Let's come back together as a group and discuss the exercise. I would like to hear about your experience with this exercise?

Over our next three sessions together, we will continue to practice ***Reflective Listening*** together and eventually, you will use this skill with your clients. Thank you all for participating in these exercises. The best way to learn your new support skills is for each of you to have a chance to practice them. We encourage you to practice your support skills with each other between training sessions.

✓ **Session 1 – Homework Summary**

- ✓ **Homework 1** - Do your **Mood Check** each day until we meet again. Write down the date, time and the number corresponding to your mood in your notebooks.
- ✓ **Homework 2 -** Practice **Reflective Listening** with a friend, as we have today.
- ✓ **Homework 3 - Re-read** the Session 1 material.

* * *

Please feel free to come up and speak with me if you have any questions. We thank you for participating in this session and we look forward to working with each of you over the next 3 sessions of this training program.

NOTES

Session 2 – Depression and Domestic Violence

Homework Review: How did it go? Did you do your daily **Mood Check**? What did you discover? And how did your **Reflective Listening** assignment go? Did you have any difficulties, any questions?

QUIZ 5-item multiple choice quiz on the material presented in Sessions 1

Related Issue: Domestic Violence

In this program, we are training you to use support skills to address depression and we will consider several related issues that may contribute to depression in the community. There are cycles of social problems leading to depression, which in turn leads to higher incidences of the social problem. Intergenerational conflict, excessive drinking and domestic violence are examples of this circular effect. We will talk about all three of these problems in our training program. In this session, we will address domestic violence, which is violence or physical abuse toward your spouse; commonly men being violent against women. In a 2011 focus group carried out by the Orange County Health Department with members of the community from Burma, domestic violence was identified as a significant social and mental health problem. Today, we are going to discuss domestic violence and how you might use your support skills to address this problem with community members. You may be able to improve the overall quality of life for those affected by domestic violence, which includes men, women and children of all ages.

Teach CBT skills to address Domestic Violence

Teach ***empowerment techniques and steps toward financial independence***

Cognitive Change

- Give women a safe place to
  - Say out loud what is happening in their homes
  - *Identify* and *examine* their thoughts about themselves and the violence; these skills are taught in this session
  - Choose a new way of thinking and acting in relation to the violence
  - Ask for help from community resources for domestic violence
- Teach ***Assertiveness Skills*** to empower women stand up for themselves; these skills will be taught in Session 4

Behavioral Change – Help empower women to engage in

- Self-Care – become aware of their needs and plan self-care into daily life
  - Sleep, medical care, nutritional needs, childcare
- Actions to achieve Financial Independence
  - Use *Assertiveness Skills* to ask for help, to ask for what you want
  - Use *Activity Log* and *Planning Skills* to make a plan and carrying it out, asking for help when needed; skills taught in Session 3
  - Set Goals for job-training, job-seeking and job improvement
  - Role-play use of *Self-Care* and *Assertiveness Skills* in the workplace
  - Review childcare needs related to employment

Teach Respect for Women and Problem-Solving Skills

Cognitive Change

- Identify attitudes toward women by examining Automatic Thoughts, taught in this session
- Use Cognitive Restructuring to encourage Respect for self and women; Cognitive Restructuring is also taught in this session

Behavioral Change

- Use Problem-Solving Skills, which we will teach you in this session
  - to resolve problems in the home
  - to address problems at work
- Use *Activity Log* and *Planning Skills* taught in Sessions 3
  - To get a job or change jobs
  - To manage finances
  - Share responsibilities related to home and family

If your client is being hurt by someone, REFER the person to a community resource; see p. 104.

If your client is hurting someone, REFER the person to a community resource or Call 911; see p. 104.

A *Referrals Guide* is provided for you on the last page of this manual. It includes the names, addresses and contact information for the hospitals, rehabilitation centers, shelters and community health care centers that you will contact to help your clients.

Remember, no matter what risk factors are present, *cutting out daily activities is a common pathway to depression*. And, self-critical thinking along with reducing daily activities often work together to maintain depression. Through CBT, you will help your clients change their negative thinking and increase their daily activities to improve their mood.

I. SIGNS AND SYMPTOMS

Depression and Anxiety

People you treat for depression may also experience anxiety - an unpleasant emotion brought on by fearful thoughts about future events, thoughts about past events, or negative thinking about the self. ***Depression and anxiety may stem from the same biological vulnerability***. Instead of being separate categories, depression and anxiety may be dimensions of distress and functional impairment, with many people moving back and forth along the spectrum across their lifetime.

Depression and anxiety may exist on a continuum:

Depression Anxiety

Stigma

Many people with depression and anxiety often withdraw from work, social and family relations. They often feel shame and guilt for not being as productive and sociable as they once were. They avoid social situations and withdraw even from their closest relatives. As they avoid people, places or things they dread, they may find it harder to encounter these things and may feel even greater anxiety. Encourage them to confide in their family and friends and allow others to help them.

We hope you will teach community members that while people with anxiety and depression may appear withdrawn, anti-social or even odd to them at times, it would be helpful to reach out to them, offer assistance and even spend time with them. Otherwise the person may become increasingly more isolated and less accepted in the community. If you speak with community members who are having trouble getting through the day, support them in visiting a psychiatrist or their family doctor in addition to treating them yourself.

CBT SESSION OUTLINE
➢ Mood Check ➢ Agenda Setting ➢ **Previous Session Review** ➢ **Address Agenda** ➢ New Homework ➢ Summarizing & Feedback

Remember, ***structure in CBT is associated with better treatment outcomes.***

- **Previous Session Review –** BRIEFLY, make a bridge between the previous session and this week's session by asking:
  - What was important to you from our last session?
  - What did you learn from the homework?
  - What went well? What did not go so well?
  - How can you put into practice what you learned?

- **Address Agenda -** Prioritize and discuss the problem or problems your client puts on the agenda. However, first ask if there are any other pressing problems or issues.
  - Tell your client you may only get to one or two items on the list in that session.
  - Guide your client in assessing the accuracy of his thoughts about the difficult situation
  - Use and teach **problem-solving skills**
  - Help your client plan actions or activities that may help address the problem

The First CBT Session

Now we are going to discuss what to do in the first support session. Ask your client:

- What brought you here to talk with me and how are you feeling now?
- What are your expectations for how I can help you?

Ask about daily functioning:

- What do you do on a typical day?
- How often do you see family and friends?
- How are your relationships with others?

1st Session Objectives

- Establish a strong working relationship
- Develop a shared understanding of the problem
- Educate your client about depression, how CBT works and what sessions will be like
- Agree on goals with your client
- Ask your client to come back for at least 6 sessions
- Instill HOPE in your client

Use your **Reflective Listening Skills** to clarify and confirm your client's problems.

Goals for Support Sessions

To instill hope, set specific goals together with your client in the first session. When your client is actively involved in setting goals, he is likely to be more motivated, do what is suggested in CBT and complete support sessions. Here are some ways to think about goals:

- **Short-term goals** – realistic changes that can be made today, tomorrow and next week. Start with these as **they provide the best chance of success to your client.** Together, focus on these over the next few sessions.
- **Medium-term goals** – changes in thoughts and behaviors to be made over the next few weeks. They build on the short-term goals.
- **Long-term goals** – where your client wants to be in 6 months or a year; possibly goals to work toward for weeks or even months. They build on the short and medium-term goals.

Ask pointed questions, such as,

- "How would you like things to be different?"
- "What do you want your life to look like?"

Choosing the areas to try to change first is important. *Tell your client to think specifically about the following:*

- Changes he would like to make at work, at home, in his relationships with family, friends and others
- Symptoms he would like to decrease or eliminate, such as drinking too much alcohol
- Areas that would improve his life: including spiritual, intellectual, cultural
- Identifying and changing extreme and unhelpful thoughts
- Improving problem-solving skills
- Assertiveness and other changes in relationships
- Increasing exercise and overcoming inactivity
- Overcoming physical problems such as pain or difficulties
- Using prescription medications appropriately and effectively

Help your client form very concrete behavioral goals, such as,

- "I would like to get a job,"
- "I would like to be able to concentrate better,"
- "I would like to go back to school,"
- "I would like to be able to manage my finances better,"
- "I would like to be more assertive."

Clear Focus

Help your client evaluate his goals and decide which ones he could work at on his own and which ones he wants to work on with you. Remember, focus on a **single problem area to start.**

In Session

- ***Support Handout #3*** is a summary of actions for the first support session.
- ***Support Handout #4, Main Targets for Change*** may help you summarize your client's problems and classify them as short, medium and long-term goals.
- Work toward achieving goals at every session.
- You may take a few notes on what your client says during or after the session.
- You may keep your handouts with you during support sessions.
- You may use or copy material from your CBT Activity Book for clients.
- Keep sessions at the same time each week, if possible.

II. DEPRESSION SUPPORT SKILLS

Practice Healthy Thinking and Behavior in 3 Steps:

Step 1 - Identify negative automatic thoughts

Step 2 - Replace them with healthy thoughts

Step 3 - Practice healthy thinking and behavior

To understand Step 1, **What are *Automatic Thoughts***?

- occur spontaneously in response to a given situation
- occur effortlessly, more or less all the time
- usually unnoticed because people are so used to them
- often reveal a person's perspective
- may be irrational, detrimental or destructive to a person's well-being
- influence emotions, behaviors and physiological responses to a situation

Skill-Building: Identifying *Automatic Thoughts*

Description of Skill

Identifying automatic thoughts is easiest when your client shows medium or high levels of emotion. When you see your client's feelings change, talk about the thoughts and images associated with the change or increase in emotion. Ask your client,

- What was going through your mind just then?

If the person is describing a difficult situation and you notice his feelings change, ask:

- What did this situation mean to you?
- Or, were you thinking of what might happen next or were you remembering something that happened before?

Also, help your client recall negative automatic thoughts that come up when facing problems in daily life, when you are not there.

When your client has negative feelings or is physically uncomfortable, he may make mistakes in his thinking and react to situations in unhelpful or regrettable ways. Please take out ***Training Handout #1 – Unhealthy Thinking Styles – Common Patterns*** and we will go through some of these patterns.

CBT Assumption: Clients **practice** monitoring automatic thoughts outside the support session. As with any new skill, learning to monitor automatic thoughts takes practice.

Skill-Building: Examining Automatic Thoughts

Description of Skill

After identifying automatic thoughts, you and your client will examine them to see what they tell you about his thinking on a particular situation. Then work to challenge any unhealthy thoughts and replace them with more accurate, beneficial, constructive thoughts and beliefs; this process is called ***Cognitive Restructuring***. ***The goal of cognitive restructuring is to replace unhealthy thoughts with helpful ones.***

CBT Tool: ***Thought Record***

The Thought Record is a tool you will use to help your client identify unhealthy thoughts and replace them with healthy thoughts and behaviors. Below is an example of a Thought Record.

Thoughts	Feeling/Action	Consequences
I feel hopeless and fatigued.	I have stopped trying to exercise.	I feel even more fatigued.
I am unsuccessful at everything.	I feel depressed because of my unsuccessful life, and wonder how I am going to get through the rest of the day.	I have stopped trying to make things better. I feel isolated and sad.

How to Fill out the Thought Record

- 1st column, write your **Thoughts** about a distressing situation.
- 2nd column, write the **Feelings/Actions** that result from your **Thoughts.**
- 3rd column, write in any of the three types of **Consequences** you experience:

    1. **Feelings** – such as sadness, fear, anger, rage
    2. **Behaviors -** unhelpful or harmful behaviors.
    3. **Physical Symptoms -** For example, after arguing with a friend, your client may find himself flushed, hot, or shaking. Physical symptoms can be caused or worsened by stress.

Daily Practice – Thought Record

Instructions

- 1st column, write your **Thoughts** about a distressing situation.
- 2nd column, write the **Feelings/Actions** that result from your **Thoughts.**
- 3rd column, write any of the three **Consequences** you experience: feelings, behaviors, physical symptoms.

Thoughts	Feeling/Action	Consequences

Teach your client

How to use ***Support Handout #5 – Daily Practice – Thought Record,*** included in your CBT Activity Book. You will introduce this tool in the second session with your clients and ask them to complete one Thought Record each day.

Practice

As a part of your training, we would like you to complete at least one of these forms each day. As with all skills, the more you practice, the more comfortable you will be using your CBT support skills with your clients.

Now, let's go through two ways a person may react when a friend does not return his phone call.

Thoughts	Feeling/Action	Consequence
Example 1 I must have done something to upset them. I am such a horrible person.	Withdraw from family and friends	Anxious, upset, depressed
Example 2 They're probably just really busy and haven't had time to get back to me yet.	Go about daily activities peacefully	Content, neutral

Two people may have very different reactions to the same situation based on how they ***interpret*** and ***evaluate*** the situation according to their thoughts and beliefs. Choosing to believe that his friend is busy and simply has not called back yet, allows a person to feel content or neutral. Help your client try on new, positive interpretations of situations.

Key to Change

Explain to your client that it is not the event that is upsetting; it is his negative or unhelpful beliefs about the event that upset him.

CBT Assumption: In CBT, we focus on WHAT and HOW a person thinks, not WHY he thinks that way. This includes how your client's thoughts, ideas, feelings, attitudes and behaviors affect his daily life.

Teach your Client

- The way he talks to himself can influence how he gets through the day.
- Saying negative things to himself about himself and his world can make depression worse and interfere with getting through the day, creating a vicious cycle.

To Challenge Unhealthy Thoughts, ask your client:

- Is there any evidence for this belief?
- What is the evidence against this?
- What is the worst that can happen if you give up this belief?
- What is the best that can happen?

As thoughts are challenged, they are no longer able to cause the same level of distress. For example, if your client says, "Everyone hates me", help him examine this thought. Ask him whether it is really true that no one loves him. You may ask him to list the people who love or like him and then point out that his thinking he is unlovable is mistaken and is not helpful.

If your client is having difficulty thinking about something other than his negative thoughts, suggest he try to distract himself from those thoughts. Please take out ***Training Handout #2 – Distraction Techniques*** and we'll go through these strategies together.

Depression often keeps people from caring for their health, seeking medical attention and complying with prescribed treatments. Let's go through some Thought Records, starting with the unhealthy thinking and behavior and then looking at healthier thoughts and behavior below.

Unhealthy Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
I am sure I will become ill.	Hopelessness, sadness. I will not get my check-up or take my medicine; there is no point.	Greater risk of illness
Because I am uneducated, I don't know anything about health	Little confidence and self-esteem; no effort to learn about health or make use of resources	Greater risk of poor health
Only doctors can find health problems.	Ignoring my symptoms or signs of health problems.	Greater risk of developing major health problems

Change Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
I can take charge of my health	Trying to do positive things for my health, such as getting my check-ups	Protection against potentially fatal illnesses
Anyone can learn about health	Actively trying to learn about and practice good health behaviors, such as exercise	Better health
I am responsible for taking care of my health and getting help. I can help the doctors help me.	Looking out for early signs of health problems and actively seeking help	Decreased risk of health problems

(Rahman et al., 2008)

In Session 3, we will talk about behavioral techniques that may help reduce unhealthy thinking and depressive symptoms and increase daily activities.

Skill-Building: Problem-Solving Skills

Description of Skill

Everyone faces problems in life. The ability to cope with problems is one of the factors determining psychological well-being. Often, people with depression have poor problem-solving skills and many attempt to handle conflict by avoiding the problem. Problem-solving can provide many possible responses to a difficult situation. And it increases the likelihood of choosing the best option.

Good Problem-Solving depends on

- Realizing that you are able to cope with problems
- Recognizing problems when they occur
- Not acting impulsively to solve problems

Steps in Problem Solving

1. Define the problem - be specific and consider all aspects of problem
2. Come up with many possible solutions
   a. Be non-judgmental
   b. Be willing to combine or change your ideas
3. Your solution
   a. *Will it resolve the problem?*
   b. *Can it be done?*

4. Try out your solution
   a. Did it work?
      i. If yes, stop
      ii. If not, try again or try another solution

Problem Solving with Clients

- Help guide your client through problem-solving in session
- Use **role play** to show your client what you would do
- Give suggestions as to possible solutions
- Reinforce your client often, letting him know you support his good ideas

People with depression often experience tiredness and worry over carrying out daily chores. Let's go through a Thought Record which shows the use of problem-solving skills used to cope with daily stress at home.

Thoughts	Feeling/Action	Consequences
Unhealthy thinking and behavior:		
Ran out of time to prepare evening meal for the family. I'm useless! Why I am not coping?	Don't even try. Just fall asleep watching TV on the couch.	upset, frustrated; disorganized
Change unhealthy thinking and behavior:		
Worried about preparing dinner for the family	I can cook the soup and let my daughter do the rest.	Less stress; sense of accomplishment, motivated to do more the next day
Feeling exhausted mid-day and worried about how to manage the rest of the day.	I will stay calm and do what I really need to today and leave the other chores for when I am feeling better.	optimistic, in-control, confident; re-planning schedule to complete necessary tasks only

Unhealthy Thinking Styles

Explain to your clients that we often make common thinking mistakes when we are uncomfortable in a particular situation or when we are experiencing negative feelings and sensations. Please take out ***Training Handout*** #1 which presents various unhealthy thinking styles and how they may show up in your client's thinking. Let's go through these together.

Automatic Thoughts, Intermediate Beliefs, Core Beliefs

Unhelpful beliefs typically fall into three categories:

1. **Core beliefs** – a person's most central ideas about the self and the world. When someone is depressed, his core beliefs are negative and unrealistic, and they lead him to mainly negative and unrealistic thoughts. If his core belief is, "It's terrible to be unloved," his intermediate belief might be, "I must please everyone" because, "If I please everyone, then people will love me." Core beliefs influence the development of intermediate beliefs.
2. **Intermediate beliefs** – attitudes, rules and assumptions that can influence how your client looks at a situation and the automatic thoughts he has.
3. **Automatic thoughts –** the actual thoughts about a situation or images that people experience moving through their minds.

Primarily, you and your clients will focus on identifying and modifying automatic thoughts. Later you may address intermediate and core beliefs.

BEHAVIORAL CHANGE

The **behavioral aspect of CBT** involves replacing the unhealthy behaviors that are contributing to depression with healthier behaviors and training your clients in needed skills. Remember, stopping daily activities is a common pathway to depression. Through CBT, you can help your client increase his daily activities and improve his mood. Increasing enjoyable activities is especially helpful.

To decrease depressive symptoms

- role-playing to practice new behaviors in session
- engage in exercise, hobbies and social activities
- encourage socialization or exercise for clients who are withdrawn
- assertiveness and other skills training

Breaking down a large task into small manageable parts can help your client:

- take control of negative thoughts and fears associated with tasks
- decrease avoidance and anxiety
- experience more success, improving mood and increasing the desire and confidence to try new things
- see how the parts of the problem are connected and how they affect him

III. EXERCISES – USE OF SUPPORT SKILLS

Exercise #1: First CBT Session

Please get into pairs for a role-playing exercise. Decide who will be the provider and client first.

Providers, with your Support Handout #3 or your own notes, please take your client through his first support session from start to finish in 30 minutes.

Clients, we will hand you a piece of paper describing your current distress.

***

[After 30 minutes] Please switch roles now. We will do the same now, with providers taking clients through a 30 minute 1st session.

***

[After exercise] Let's come together and talk about your experience as the provider.

- Were you able to get through everything you needed in 30 minutes?
- What worked well?
- What was challenging?
- Did you find out why your client came to his support session and what his current distress is?

To the client:

- How did you feel about the relationship between you and the provider?
- Were you comfortable?

Supplemental Information Related to Exercise #1

For the Trainer Only

Some pairs of trainees will have the same issue. Write the following issues on separate pieces of paper and give them to the "clients":

- Your spouse died 6 months ago and you spend all day on the couch every day
- You have to move from your son's home to your daughter's because your son is moving to Florida; you are fearful about your move for many reasons
- Your teenage children are making more of your decisions and handling more of your affairs because they speak English well; you are having trouble speaking up for yourself
- You have not been feeling well but you are afraid to go to the doctor for a check-up, even though you know it is important
- You drink alcohol every day and your daughter told you he thinks it is a problem
- You spend all your time alone until your adult son and his wife come home from work; you have not seen your friends for months and feel isolated and lonely

Exercise #2: Choosing Supportive Goals

Get into pairs for a role-playing exercise. You will each take turns being the provider and the client.

As the provider, ask your partner – the client, what he would like to address in support sessions. Use the prompt questions and write down your client's goals for his support sessions – short, medium and long-term.

As the client, you can use some actual goals you may have. Or, you may make them up.

Short-term goals:

Medium-term goals:

Long-term goals:

Ask your partner, the client, for confirmation that these are the goals he wants to address.

Exercise #3: Identifying and Examining Automatic Thoughts

Practice Using the Thought Record

Let's get into pairs for a role-playing exercise. We will take turns being the provider and the client who needs help. Decide which of you will be the provider first.

As the provider, you will explain to your client the purpose of the Thought Record first. Then, explain to your client how to use the Thought Record:

- 1st column, write your **Thoughts** about a distressing situation.
- 2nd column, write the **Feelings/Actions** that result from your **Thoughts.**
- 3rd column, write in the **Consequences** you experience: feelings, behaviors, physical symptoms.

(A blank copy of the Thought Record is provided on the next page for your use.)

Providers, ask your client for a distressing situation and their feelings about it. Guide them in filling out the Thought Record.

As the client, please tell your provider about a distressing situation, which you may use as an example in filling out the Thought Record. You may make this up.

Take 10 minutes to complete this exercise and then we will switch roles. Time is limited so be brief and clear.

* * *

Discussion – Do we have a pair that is willing to tell us about your experience?

- What was the distressing situation?
- What automatic thoughts did you analyze and what information was revealed?
- What did you put in your columns?
- As the provider, what did you discover?
- Clients, do you have any comments?

Through these exercises, we want to get you into action using your support skills. As always, please ask questions at any time.

- ✓ **Homework #1:** Please keep a **journal of your daily automatic thoughts** during this training program. You may notice that there are certain times of the day when you are more prone to strong emotions and/or physical reactions, such as feeling depressed, worn-out, tired, moody or irritable. You may observe that during these times you may think in a more negative, unhelpful way than you do at other times of the day when you are feeling less depressed, tired, or irritable. Keeping a journal will help you better understand its purpose and value before you begin working with your client.

  In support sessions, you will ask your client to keep a diary so that he can identify how he reacts to certain events. This will help your client identify patterns of thoughts, emotions, physical feelings and actions, and see if they are unrealistic or unhelpful.
- ✓ **Homework #2:** In order to teach your clients, we would like each of you to practice using the **Thought Record**. We also recommend you ask your clients to do this on a daily basis for at least the first week during your support sessions. At our next session, please be prepared to share what you observed and recorded in your Thought Record. Make copies of the Thought Record provided as ***Support Handout #5***.
- ✓ **Homework #3** – Write down your own **goals** – short, medium and long-term.
- ✓ **Homework #4 –** With a fellow trainee, practice using your **Problem-Solving Skills**. Take turns being the provider and the client who has a significant problem. Use your **Reflective Listening Skills** to get clear about your client's problem. As the provider, work with your client to come up with 3 possible solutions to his problem. Reverse roles so each of you has the opportunity to be the provider. As the provider, write down the problem and the 3 strategies you developed with your client. Be prepared to share about your experience at our next session.

✓ **Homework #5** – Do something enjoyable and come back and tell the group what you did. This could be a walk in a beautiful garden, reading an enjoyable book; talking with a friend.

✓ **Homework #6 – Re-read** Session 2 material.

✓ **Session 2 – Homework Summary**

1. Practice keeping a **Journal of Automatic Thoughts**
2. Complete one **Thought Record** per day
3. Your **Goals** – short, medium and long-term
4. Practice using **Problem-Solving Skills** with a fellow trainee
5. Do something **enjoyable**
6. **Re-read** Session 2 material

Quiz

Remember that we will have a quiz at the start of next session. The quiz will cover the material presented in Sessions 2. Please read through the materials again to help you prepare for the quiz.

* * *

Thank you for your participation in today's session. We look forward to seeing you next time.

NOTES

Session 3 – Depression and Alcohol Dependence

Homework Review: How did it go? Did you do your daily **Thought Records**? Did you keep your daily **Automatic Thoughts Journal**? Did you do something enjoyable this week? What did you do? Who would like to share the 3 strategies they came up with in the **Problem-Solving** assignment? Did you have any challenges with these assignments? Any questions?

QUIZ 5-item multiple choice quiz on the material presented in Sessions 2.

Today we are going to start out by talking about alcohol abuse and dependence, which are significant problems among the community and are both related to depression. Approximately 20% of monthly admissions at one district networking hospital are related to alcohol abuse/harmful use. The rate of problem drinking in the same area may be as high as 50%. Alcohol abuse and dependence often occur along with other mental disorders, often covering up the presence of the other disorder; including depression. People with depression may get progressively worse if they are drinking too much alcohol. Many people attempt to medicate their depression with alcohol. However, ***alcohol acts as a "depressant" on the central nervous system.*** Excessive drinking can worsen the course of mental disorders such as depression and other chronic illnesses, such as cancer, HIV/AIDS and heart disease. Alcohol use is a factor in many local suicides and contributes to the growing number of vehicle and motorcycle accidents. We will start by discussing alcohol abuse and dependence.

I. SIGNS AND SYMPTOMS

Alcohol Abuse and *Alcohol Dependence*

Because excessive drinking is so prevalent among the community members and it tends to worsen the course of depression, we are going to review the signs and symptoms of ***alcohol abuse*** and ***alcohol dependence*** to help you recognize and care for people who have these problems along with depression.

Difference between *alcohol abuse* and *alcohol dependence*

In alcohol abuse, a person can still set limits on their drinking, unlike in alcohol dependence.

The path from *alcohol abuse* to *alcohol dependence*

- Alcohol abuse is a major risk factor for alcohol dependence
- Not all alcohol abusers become alcohol dependent
- **Physical dependence on alcohol** is the key difference from alcohol abuse
- Risk of alcohol dependence is greatest in a binge or daily drinker
- May develop **suddenly** in response to a stressful change - a death, retirement, or another loss
- May develop ***gradually as a person's tolerance to alcohol increases***

Signs and symptoms of *alcohol dependence*

- Most severe form of problem drinking
- Reliance on alcohol to function or feeling physically compelled to drink
- Loss of control over one's drinking
- Wanting to quit drinking, but unable to do so
- Giving up other activities because of alcohol
- Alcohol takes up a lot of energy and focus
- Drinking even though it is clearly causing problems
- Most common in men, but also present in women

***Tolerance*: The 1st Major Warning Sign**

Tolerance means that over time, a person needs more and more alcohol to feel the same effects he used to feel with smaller amounts. Ask your client:

- Do you have to drink a lot more than you used to in order to feel an effect?
- Can you drink more than other people without getting drunk?

***Withdrawal*: The 2nd Major Warning Sign**

Drinking to relieve or avoid withdrawal symptoms is an important sign of alcohol dependence. When a person drinks heavily, the body gets used to the alcohol and experiences withdrawal symptoms if it is taken away. *Ask your client:*

- Do you need a drink to steady the shakes in the morning?

***Alcohol withdrawal* symptoms include:**

- Anxiety or jumpiness
- Shakiness or trembling
- Sweating
- Nausea and vomiting
- Insomnia
- Depression
- Irritability
- Fatigue
- Loss of appetite
- Headache

In severe cases, ***withdrawal*** from alcohol can also involve hallucinations, confusion, seizures, fever, and agitation; which can be dangerous. If a person has these symptoms, he should be brought to the hospital for treatment.

Effects of Chronic Alcohol Use

- Intoxication
- Hallucinations and tremors
- Dementia
- Confusion, speech problems, loss of muscle coordination

Making a Referral

Alcohol abuse and dependence are problems that affect many people in the community. Often clients will not be entirely honest with you about how much they are drinking. You may use ***Training Handout #3 – Symptoms of Alcohol Use Disorder*** to clarify the person's use of alcohol and the effects on his life. It will also help you assess who may need psychiatric help and who may simply want to return to you for ongoing support. A *Referrals Guide* is provided for you on the last page of this manual, p. 104. It includes the names, addresses and contact information for the hospitals, rehabilitation centers, shelters and community health care centers that you will contact to help your clients.

Support Sessions

People with drinking problems need to change behaviors and social habits to stay away from drinking. You can help your client set short, medium and long-term goals to target these changes, practice new behaviors and create new routines that help him stay away from drinking and improve his mood. Be aware that it will be difficult for a person to stay away from drinking if he still feels depressed after he stops drinking. Over time, it may become obvious to the person and to you that he is having a problem decreasing his use, or he may become injured. In this case, refer him to the psychiatric professionals at the local hospital or at the rehabilitation facility; see the Referrals Guide on p. 104 of this manual. At the same time, you may continue to work with that person.

Stigma

Social stigma toward treatment-seeking for alcohol use disorders may be strong enough to keep people from admitting they have a problem or ever seeking help. With the high problem-drinking rate among community members, we encourage you to speak openly to individuals, families and even school children about:

- Dangers of excessive drinking
- Importance of seeking help to address stressful life situations
- Need for treatment when moving from alcohol abuse to ***alcohol dependence***

CBT Session Outline
➢ Mood Check ➢ Agenda Setting ➢ Previous Session Review ➢ Address Agenda ➢ **New Homework** ➢ **Summarizing & Feedback**

- **New Homework –** Work with your client to develop a specific action plan for how, between sessions, he will **put into practice** what was learned in the session. The assignment will provide the opportunity to:
  - test and practice the new skills
  - practice new healthy ways of thinking and behaving
  - be exposed to situations he fears little by little
- **Summarizing –** You and your client will summarize the important points of the session and how the client can use what was learned over the coming week. Have your client write them down.
- **Feedback –** Ask your client:
  - What was helpful about the session and what was not?
  - Did I understand you correctly?
  - Is there anything you want to do differently in the next session?
- **Closing the session –** confirm the date and time of your next session and wish your client well.

Suggestions for the Provider

- Show genuine interest in your client. Your ***curiosity as the support provider*** is the factor most likely to increase your client's involvement in CBT sessions. Also, **client ratings of their *relationship with their CBT providers* are higher in CBT than in many other therapies**.
- ***Structure in CBT is linked to better treatment outcomes***. Follow the session outline and teach your client about the support session structure and he will know what to expect.
- Emphasize to your client that he will take an *active* part in support sessions, both in session and between sessions through the homework. Tell him it is important to bring the therapy session into his daily life. Ask your client to come to see you for at least 6 sessions.
- Explain to your client how CBT will help them feel better. As he becomes aware of how thoughts and behaviors affect their mood, he can feel happier and more hopeful even if his difficult circumstances do not change. Depression can be managed. Tell your client:
  - CBT focuses directly on daily life and offers a practical approach to help him feel better.
  - If you can think in helpful ways, you will begin to feel better.
  - Often people with depression are not doing anything they enjoy. Through CBT, you will teach your clients ways to bring enjoyable activities back into lives.

Help clients prevent a relapse

Tell clients that if the depressive symptoms return even though they are using all their tools, they can ask their doctor about further treatment before the depression becomes disabling. Ask your client,

- What will you do if they feel yourself becoming depressed again?

Behavioral Techniques

The ***behavioral techniques*** outlined below are simple strategies you can teach your clients to help them manage feelings of distress, negative thinking, fatigue, or other symptoms. These techniques may also help increase your client's daily activities, an important way to improve his mood, particularly when they are enjoyable activities.

Skill-Building: Activity Scheduling & Planning

Description of Skill

You may help your clients plan their daily and weekly schedule during the course of his support sessions to help them manage their daily activities, decrease negative thoughts, control their level of fatigue, and in general, feel less depressed and more in control of their lives.

Let's review ***CBT Activity Book – Support Handouts #6***. ***Support Handout #6*** provides steps for planning a manageable schedule. Go through the steps with your clients during session.

Skill-Building: Good Sleep Practice

Good Sleep Rules	Check if Yes
1. I don't go to bed until I am drowsy.	
2. I get up at about the same time every morning.	
3. I don't take long naps during the day.	
4. I don't drink caffeine later than 6 hours before bedtime.	
5. My sleep environment is comfortable – mattress, pillow, temperature, light, noise.	
6. I exercise and spend some time relaxing every day.	

Source: Rahman et al., 2008

Go over the Good Sleep Rules with your client in session. Ask your client to fill in the Good Sleep Record, which appears in your CBT Activity Book, every morning. Review your client's Good Sleep Record in session.

Good Sleep Record	Daily Monitoring						
My thoughts disturbed my sleep last night							
I tried to replace unhealthy thought with healthy ones							
I tried to follow the six rules of sleeping well							

Source: Rahman et al., 2008

People with depression often report fatigue, stress, body aches, anxiety and sleep disturbance. Let's go through a Thought Record related to these depressive symptoms.

Unhealthy Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
I am too tired to think clearly or get things done.	Fatigue; giving up and not trying	Increased stress
I am very worried all the time.	Anxiety; unable to relax or sleep	High level of anxiety and fatigue
I feel so much stress I cannot sleep well.	Anxiety, worrying, and tossing and turning at night	High stress and tension causing physical aches and pains
I have will always have physical aches and pains.	I must be ill and there is nothing I can do about it.	Cycle of stress and inaction leads to health problems.

Change Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
If I take care of myself, I will feel less tired.	Hope; trying to improve health, such as daily exercise	Cycle of inactivity broken; better health
I can postpone my worrying until tomorrow. There's nothing I can do about it now.	Less anxiety; greater efforts to relax	Relaxation and rest; better health
I can relax even if I'm unable to sleep.	Less anxiety; engaging in more relaxing activities	Cycle of anxiety and sleeplessness is broken
My aches and pains are from stress and being overtired.	Rest and relaxation will help decrease physical aches and pains. I am not sick.	Better health

(Rahman et al., 2008)

Isolation, loneliness and avoiding others make depressive symptoms worse. Let's go through some Thought Records related to sharing problems with others.

Unhealthy Thinking		
Thoughts	**Feeling/Action**	**Consequences**
Noone understands my problems.	It's useless talking about problems with others	Not sharing problems, distancing from others, losing support
I don't want to stir up conflict by discussing my problems.	Keeping feelings inside	Increased stress and tension leading to poor health
I will always be disappointed by others.	Avoiding people	Losing support
I should take care of my sick spouse by myself; it's my job.	Discouraging others who want to help	Increased stress

Change Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
Perhaps I can make more of an effort to be understood.	I should try harder to explain what bothers me.	While not everyone will understand, some will, and will support me.
I will share my problems with a trusted friend and ask for advice.	Talk with someone I trust about my problems	Stress from problems is reduced by sharing; less isolated
There is some good in almost everyone.	I should talk to people I like without a lot of expectations.	Maintain social support
Help from others is good for my family and me.	Staying open to receiving help	Involving others helps relieve stress

(Rahman et al., 2008)

CBT Tool: Activity Log

The **Activity Log** is an effective tool for recording the activities a client chooses for the coming week and the frequency with which he does the activity. Here is an example of a client's Activity Log for one week.

Type of Activity	How Often?	Daily						
Go to support session	*Twice weekly*							
Fill in Thought Record	*Once daily*							
Go for a walk	*Once daily*							

Help your client fill in columns 1 and 2 in session and explain to him that he will put an "x" or check mark in the boxes representing the days of the week. Tell him this is where he will record his homework assignments. A copy of the Activity Log is provided in as ***CBT Activity Book – Support Handout*** #7.

The Activity Log would be a great tool to use when looking for a job, for example. Your client could record actions such as make list of possible jobs, pick up job applications, fill out applications, bring in applications; see Activity Log below.

Type of Activity	How Often?	Daily						
Make list of possible jobs	*Tues*							
Pick up job applications	*Tues, Wed, Thur.*							
Fill out applications	*Fri, Sat, Sun*							
Bring in applications	*Mon, Tues*							

III. EXERCISES - USE OF SUPPORT SKILLS

Exercise #1: Teaching Clients about Depression, CBT and the Structure of CBT Sessions

Please get into pairs for a role-playing exercise. You will take turns being the provider and client. We will act as if it is the first CBT session. As the provider, educate your client BRIEFLY about the following:

- What is depression?
- What is CBT?
- What is the structure of the CBT session? – What can your client expect?

Please keep your explanations very brief and clear. After this 10 minute exercise, we will switch roles.

***

Let's come together and talk about how it went.

- Were you able to teach your client about each of the three important points in a simple, clear way?
- Do you have any comments or questions?

Exercise #2: Teach Client to use the Activity Log

Get into pairs for this role-playing exercise. Decide which of you will be the provider first. We will switch roles after this 10 minute exercise.

We have included a copy of the Activity Log on the next page for your convenience.

As the provider, teach your client how to fill out the Activity Log, including activity, frequency and daily monitoring. Be brief and clear in your instructions.

* * *

Discussion:

- Does anyone have any questions?
- Did you have any difficulty being brief and clear?
- Did you have any challenges with this exercise?

Exercise #3: Problem-Solving with your Client

Please pair up with someone you have not worked with before. Decide which will be the provider and the client first in this role-playing exercise. After this 15 minute exercise, we will switch roles.

As the client, share with your provider a significant problem.
As the provider, use your **Reflective Listening Skills** to get clear about your client's problem. Work with your client to come up with 3 possible solutions to his problem.
Also, as the provider, write down the problem and the 3 strategies you developed with your client.

* * *

Discussion:

- What problem did your client present?
- Did you use **Reflective Listening Skills** to clarify and confirm your understanding of the problem?
- What three solutions did you come up with together?
- What skills would these solutions require? – Activity Scheduling & Planning, etc.

Exercise #2 – Blank Activity Log

Type of Activity	How Often?	Daily						

Type of Activity	How Often?	Daily						

REVIEW – SIGNS AND SYMPTOMS

Let's review the signs and symptoms, risk factors and support skills we have covered in this program. Please raise your hand and share what you know about the following:

- **Major Depression** (p. 8-9)
- **Alcohol Dependence** (p.48-49)
- **Suicide – Risk and Protective Factors** (p. 66 and Training Handout # 4)

Now let's review the support skills we have covered. Please participate by raising your hand and sharing what you know about each of the following.

- **Cognitive-Behavioral Therapy (CBT)** (p. 12-13)
- **Reflective Listening** (p. 17)
- **Automatic Thoughts** (p. 29-31)
- **Cognitive Restructuring** (p. 31)

Discussion: Do you have any questions on the material we have reviewed today?

- ✓ **Homework #1 –** Complete one **Thought Record** per day.
- ✓ **Homework #2 –** Assess your own "**Good Sleep**" by reviewing the list. When using this with your clients, remember they may have many distractions at home.
- ✓ **Homework #3 – Re-read** Session 3 material.

Let's fill in your Activity Log with your homework assignments to get you started.

Activity	**Daily Monitoring**						
1. Complete one **Thought Record** per day							
2. Assess your sleep habits using the **Good Sleep** List							
3. Re-read session 4 material							

✓ **Session 3 – Homework Summary**

1. Complete one **Thought Record** per day
2. Assess your sleep habits using the **Good Sleep** List
3. **Re-read** session 3 material

* * *

We will close the next session with your final Assessment of Knowledge, which will test your knowledge of the concepts, signs and symptoms, risk factors and support skills you have learned through this training program. **To prepare, please read through your manual again**. All material on the assessment is covered in the manual.

* * *

Thank you for participating in today's session. We look forward to seeing you next time.

NOTES

Session 4 – Depression and Suicide, Review & Final

Homework Review: How did it go? How are you doing with your daily **Thought Records**? Did you discover anything about your **sleep patterns**? Did you have any challenges, any questions or difficulties?

QUIZ 5-item multiple choice quiz on the material presented in Sessions 3.

Up to 15% of people diagnosed with depression eventually commit suicide. Therefore, treatment is very important. Among some South Asian refugees in the U.S., the suicide rate is over three times higher than the general population. Hanging has been the most common method among them recorded in recent years. The most often reported settlement difficulties are language difficulties, concern over family back home, separation from family and loss of cultural and religious traditions. In this session, we will discuss several risk factors and protective factors for suicide. As community leaders, you may help prevent distress as you recognize the risk factors in people. You can help people change unhealthy thoughts and then support them in taking actions that will improve their situation and decrease their distress.

IMPORTANT: If you think a person is in danger of hurting himself or someone else, bring him to the hospital Emergency Room or simply call 911.

I. RISK & PROTECTIVE FACTORS

Suicidal thoughts and behavior may be increased by other behaviors, such as excessive drinking, conflict in the home and social isolation, each of which could also be identified as targets for change. ***Training Handout #4*** is a summary of the *Risk and Protective Factors for Suicide*. Let's take it out and go through the handout together.

If a client shares he has suicidal thoughts,

- How would you know that someone may be planning to commit suicide?
- What would you do if you suspected this was a person's intention?
- Currently, what do you do when someone talks about wanting to commit suicide?

IMPORTANT – *If your client,*
has suicidal thoughts, talks about death or suicide, has developed ***signs of suicide risk*** *(see* ***Training Handout #4****),*

- Ask the person if he is thinking of hurting himself or someone else and if he has a *plan* to do so.
- **GET HELP IMMEDIATELY** if he plans to harm himself or someone else,
  - Bring the person to the Emergency Room at the hospital
  - Or, call 911 if you are not able to take the person to the hospital

A *Referrals Guide* is provided for you on the last page of this manual, p. 104. It includes the names, addresses and contact information for the hospitals, rehabilitation centers, shelters and community health care centers that you will contact to help your clients.

For future reference, we have provided ***Supplemental Readings #1*** and **#2**, which may help you support people with suicidal thinking and/or behavior. **IMPORTANT**: Remember, if you think someone is of danger to himself or others, bring him immediately to the Emergency Room at the local hospital and/or call 911.

Stigma

Because of social stigma toward suicide in the community, many people may be ashamed to share their despair. You may be the only person a suicidal individual confides in, the only person trusted with the truth. Therefore, we want to strengthen your ability to recognize and respond to suicidal behavior. Also, we hope you will encourage family members to talk with you and to get help for their loved one.

Questions for Discussion:

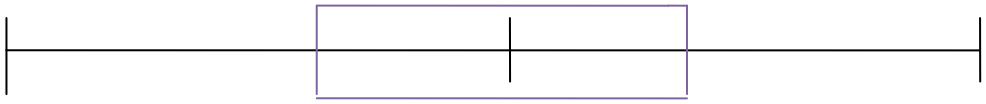
- What are your thoughts on how we can best help address stigma related to treatment-seeking for depression?
- Considering your role as community leader, how can you influence the reduction of stigma in your communities?
- What can you say in conversations with individuals? With school children? With parents?
- Do you have any questions about how to address this issue?

II. DEPRESSION SUPPORT SKILLS

Skill-Building: Assertiveness Skills

Description of Skill

Assertiveness means confidently expressing your feelings, needs and opinions, while respecting those of others; it directly affects interpersonal relations. Your client's Thought Records may reveal his need to learn **Assertive Skills**.



Passive **Assertive** **Aggressive**

At the far left of the diagram, "passive" means valuing yourself less than others; and not expressing yourself and your needs. At the far right, "aggressive" means disrespecting the rights, feelings and needs of others; and having a confrontational style in handling conflict. Being assertive is the range within the rectangle at the center.

To teach Assertiveness Skills to your client as follows:

- say "Yes" when you want to, and say "No" when you mean "No"; instead of agreeing to do something just to satisfy someone else or because he feels intimidated. Teach your client he is allowed to say, "No." Tell him to keep the conversation clear and simple and not apologize for saying, "No."
- repeat his point over and over again in a calm and firm voice until it is clear to others
- decide on and maintain clear boundaries and be comfortable and confident defending your position, even if it creates conflict
- negotiate if you want something different from someone else and listen to others
- communicate his thoughts and feelings calmly without attacking another person

Encourage your client to practice being assertive with a friend or in front of a mirror by:

- facing the other person, or himself, and trying to stay calm
- speaking clearly and firmly
- showing that he is listening

PRACTICE HEALTHY THINKING AND BEHAVIOR

People with depression often report feelings of hopelessness, helplessness and despair. Let's go through some Thought Records related to these factors.

Unhealthy Thinking		
Thoughts	**Feeling/Action**	**Consequences**
I have so many problems.	Noone can help me so there's no reason to try.	Greater stress and anxiety
I must have a serious illness because I'm always tired.	I can't afford expensive medical care, so it's hopeless.	Doing nothing and not paying attention to health
I wouldn't have health problems if I had more money.	No effort to make use of available resources.	Greater risk of illness

Change Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
I can focus on the positive and what I'm able to do.	I can try to make good changes for myself and my family.	Less stress and depression
Exhaustion is usually caused by overwork, poor nutrition and inactivity.	I could feel more energetic by doing even small activities	Good nutrition, rest and exercise
Anyone can make an effort to stay healthy.	Making the best use of available resources	Better health

(Rahman et al., 2008)

With depression, people often report guilt associated with not fulfilling their family role and responsibilities and also putting others' needs before their own. Let's go through some Thought Records related to these factors.

Unhealthy Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
My physical health isn't important; it's my family's health that matters.	Cannot care for others if I am in poor health	My family's health, both physical and psychological is affected.
I have never been a good spouse or parent.	Blaming oneself for everything.	Looking after family feels unrewarding
Noone will be affected by my tension and anxiety.	No effort to decrease stress.	Family's health and happiness are negatively impacted by my depression and anxiety.

Change Thinking and Behavior		
Thoughts	**Feeling/Action**	**Consequences**
I can give full attention to my family if I'm healthy.	More time and energy for spending time with others and having fun.	My family and I are happier and healthier.
Most of the time I take good care of my family. This is just a passing feeling.	Thinking clearly when facing difficulties	Improved problem-solving and family relations.
Even though I have problems, I can try to lessen my stress and anxiety.	Addressing problems and decreasing stress by relaxing and doing physical exercise.	Improved mental and physical health

(Rahman et al., 2008)

Using Strategies for Change

The table below suggests ways you, as providers, can help your clients change unhealthy thinking and behaviors and begin to feel better. Let's go through it together.

Problem	Strategy for Change (Sessions 1-4)
I feel terrible. I have problems with upsetting negative thoughts that keep running through my mind.	*Identify and then begin to change specific examples of these thoughts (S1)*
I have money problems. I have problems with practical problem-solving.	*Teach practical problem-solving skills (S2) and apply them to the specific problems caused by the lack of money*
I do nothing. I have stopped doing enjoyable things.	*Identify the vicious cycle of reduced activity and help your client plan a step-by-step increase in a specific enjoyable activity to start (S3)*
I have bad relationships. I keep saying, "Yes," when I mean, "No."	*Teach assertiveness skills (S4) and how to apply them in relationships – at first with specific people and addressing specific topics*

Help your client identify the current unhealthy thinking or behavior and encourage him to ask,

- What skills can I use?
- What actions can I take?

IMPORTANCE OF PRACTICING HEALTHY THINKING AND BEHAVIOR

Remind your clients that although we cannot always change a particular situation or event, such as losing a loved one, he CAN manage and take control of his own thoughts. And as a result, he can feel better or less distressed about situations in his life.

It takes PRACTICE. To learn a new skill, it is essential to practice between sessions by doing the homework. No single assignment will cure depression, but **practicing** will help improve your client's learn negative mood.

- Praise your client for doing the homework
- Your client should take credit for practicing CBT skills

Tell your client he is feeling better because he is practicing his new skills. If your client believes that he has improved only because of his relationship with you, he may not have the confidence to practice the skills on his own.

Let your client know homework is important by casually asking as he arrives,

- How did your homework go?

Help solve any problems and answer any questions; problem-solving is an important in CBT. Most clients will do the homework. When a client consistently does not, identify this problem as early as possible.

If your client is not doing his homework, ask:

- Is it a matter of time, reading ability, forgetfulness, or having other responsibilities?
- We want you to start feeling better and we know how important homework is. Can I help you figure out what is getting in the way so you can do the homework and start feeling better?

Identify thoughts that lead to not practicing, such as:

- It doesn't matter what I do, nothing will change.
- I don't feel like doing my practice.

Ask your client:

- Are you sure that what you do won't help change the way you feel?
- Do you think you have a better chance of improving your mood if you keep doing what you have done in the past, or if you try using the skills that have helped others?

It takes PRACTICE to learn to use the Thought Record.

The more your client practices, the easier it will be to change his thoughts and feelings. We recommend that you ask your client to complete at least one Thought Record per day during support sessions. This will give him practice in identifying his unhelpful thoughts, in recognizing how they are related to negative consequences, and most importantly, in changing those thoughts so he has fewer depressive symptoms and an improved mood. Again, blank copies of the Thought Record are included in ***CBT Activity Book - Support Handout #5***.

If your client is not making progress with CBT

CBT has helped many people with depression, but it may not work for everyone. If your client does not appear to be feeling better after meeting with you 6 times, suggest your client talk with his family doctor about his depression.

By "not feeling better," we mean,

- consistently low mood, low scores on the Mood Scale with no improvement
- his mood is getting worse
- reports of other depressive symptoms or increased risk for alcohol or drug use

If a person has been depressed for a long time, he or she may continue to report low mood and not recognize that there has been improvement. Your judgment of your client's progress is important.

SUPPORT SESSION TIPS

Now, we will talk about some additional support session tips and do some final exercises. And then, for the remainder of the session, you will complete your final assessments.

Strike the right balance

Let your clients know practice is important but tell them to come to session whether they have completed their homework or not.

Avoid Applying CBT Lessons Too Broadly

Help your client avoid over-generalizing or thinking that CBT will solve all their problems. CBT can help a person get over depression, but it will not turn someone into a different person.

Feeling Guilty for Letting Oneself Be Depressed

Excessive guilt is a symptom of depression. When depressed, clients may use CBT concepts to blame themselves. Point this out early so clients can stop doing this.

Trying to Be Perfect

A client may conclude he can be perfect if he applies the principles of CBT. Tell your client that he will not succeed at everything every time and that this is alright.

Just Thinking "Happy Thoughts" is NOT enough

Tell clients that you understand their problems are real. CBT teaches that some ways of thinking and acting improve daily mood and quality of life.

Enjoyable Activities

III. EXERCISES – USE OF SUPPORT SKILLS

People who are depressed often are not doing anything they enjoy. Through CBT, teach your clients ways to bring enjoyable activities back into lives.

Exercise #1: Teach Assertiveness Skills to your Client

Please get into pairs for a role-playing exercise. Decide who will be the provider first. We will switch roles after completing this 10 minute exercise.

As the client, tell your provider an area in which you are having difficulty speaking up for yourself (being passive) or being excessively confrontational and angry (being aggressive).

As the provider, address your client's concerns and teach him **Assertiveness Skills** to address his problem.

* * *

Discussion - Let's come together and talk about your experience.

- What was the problem behavior you addressed?
- How did you go about teaching **Assertiveness Skills** in 10 minutes?

Exercise #2: CBT Session

Choose a new partner for this role-playing exercise and decide who will be the provider first. Be sure to work with someone you have not worked with before.

With your Support Session Outline in hand, take your client through an entire support session from start to finish in 30 minutes. We will give the clients a piece of paper with a problem or problems written on it that he wants to address in the session. Again, you may use your handouts if need be. Remember your time constraint.

***

[After 30 minutes] Let's switch roles now. We will provide clients with their information on a piece of paper.

***

[After 30 minutes] Let's talk about your experience as providers.

- Were you able to get through the CBT outline in 30 minutes?
- What worked well?
- What was challenging?

As the client,

- How did you feel about your relationship with the provider?
- Were you comfortable?

Final Group Exercise: What Would You Do?

Please raise your hand and tell us what you would do in the situations below. Think about:

- What skills would you need to use?
- What behavioral strategies would you suggest?
- What homework would you assign?

Help me answer the 3 questions above for each of the following situations:

1. Your client arrives very upset about an argument with his daughter.
2. Your client reports spending all day long in front of the TV most days.
3. Your client says he is unable to sleep at night and then is unable to do anything during the day.
4. Your client feels overwhelmed by his household responsibilities and his childcare responsibilities.
5. Your client indicates he gets very nervous in public and is finding it difficult to go to the market.
6. Your client indicates his spouse has complained about his frequent drinking
7. Your client says he is hopeless and considering ending his life

CLOSING REMARKS TO PROVIDERS

- **Inspire hope in your clients**
  - Congratulate clients on the progress they have made
  - Remind them that in the future they can turn back to the CBT tools in their activity books
  - CBT can be applied to any situation when your client feels overwhelmed or distressed
  - Encourage your client to practice what he has learned in support sessions over time. Tell him that with practice, the CBT skills will become natural for him.
  - Tell your client you hope that he will find these techniques valuable, and wish him every success in the future.

- As we close now, does anyone have any remaining questions or comments?

- After completion of the final assessment, we will soon hold a Closing Ceremony for all of you. We will be in touch with you as to the time and location.

- We are very grateful for your participation in this program. We hope that you will be able to use the skills you learned here to improve the quality of life for community members who seek your support.

* * *

Congratulations on completing the Training Program for Paraprofessionals!

II. FINAL ASSESSMENTS AND CLOSING

Please read each question and each of the possible responses. Select the best answer from among the choices provided. You may turn in your final assessment and leave when you are finished.

* * *

Congratulations on completing the Training Program for Paraprofessionals.

We thank you again for participating in our program!

NOTES

Training Handout #1

Unhealthy Thinking Styles – Common Patterns

We often make common thinking errors when we are uncomfortable in a particular situation or when we are experiencing unpleasant or negative feelings and sensations. Some common patterns of unhealthy thinking styles include:

Unhealthy Thinking Style	Typical Thoughts
Blaming myself If things go wrong, it is always my fault	If my spouse becomes sick, it is always my fault. I am not a good spouse.
Not giving myself credit If things go well, it's luck or because of someone else	It's only luck when my spouse and I are healthy.
Gloomy view of future Believing or predicting that bad things are going to happen	Nothing can stop me from getting sick this year. I will always be depressed.
Mind-reading Negative view of how others see you	I often think that others think badly of me
Thinking in extremes If it can't be perfect, there's no point trying	I am uneducated, so I will never be a capable person.
Not believing in my abilities	I can never achieve this task
Giving up before trying	I am no good at this

Source: Rahman et al., 2008

Training Handout #2

Distraction Techniques

Distraction techniques can help your clients take their minds off of their negative thoughts. Teach your clients these distraction techniques, which also appear in your CBT Activity Book:

- **Imagining a Pleasant Image/Scene**

  Tell your client to try to visualize a peaceful, relaxing scene: Where he would like to go? Who he would like to go with? How he would like to get there? What he would like to do there? How much time he would like to spend in his 'dream' place?

- **Listening to relaxing or enjoyable music or watch favorite movies**

  To relax, distract or lift his mood.

- **Take a short walk**

  Pay close attention to the sights, smells, sounds and characteristics of things in his garden or neighborhood; such as colors, shape and size of neighboring buildings.

- **Visualizing a red "STOP" Signal**

  Ask your client to imagine a red traffic light stop signal in his mind when he feels overwhelmed or upset by negative thoughts and feelings, including fatigue. Follow the stop signal image by saying to himself, "stop thinking these negative unhelpful thoughts" or "stop dwelling on the negative."

Training Handout #3

Symptoms of Alcohol Use Disorder

(National Institute on Alcohol Abuse and Alcoholism)

Alcohol use disorders are medical conditions that can be diagnosed when a client's drinking causes distress or harm. See if you recognize any of these symptoms in yourself. In the past year, have you (check below):

- ☐ had times when you ended up drinking **more, or longer,** than you intended?
- ☐ more than once wanted to **cut down or stop** drinking, or tried to, but couldn't?
- ☐ more than once gotten into situations while or after drinking that **increased your chances of getting hurt** (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
- ☐ had to drink **much more** than you once did to **get the effect** you want? Or found that your **usual number** of drinks had **much less effect** than before?
- ☐ continued to drink even though it was making you feel **depressed or anxious** or adding to **another health problem**? Or after having had a **memory blackout**?
- ☐ spent a **lot of time** drinking? Or being sick or getting over other aftereffects?
- ☐ continued to drink even though it was causing **trouble** with your **family** or **friends**?
- ☐ found that drinking—or being sick from drinking—often **interfered with**

taking care of your **home** or **family**? Or caused **job** troubles? Or **school** problems?

☐ **given up** or **cut back** on **activities** that were important or interesting to you, or gave you pleasure, in order to drink?

☐ more than once gotten **arrested,** been held at a police station, or had other **legal problems** because of your drinking?

☐ found that when the effects of alcohol were wearing off, you had **withdrawal symptoms,** such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

Training Handout #4

Risk and Protective Factors for Suicide

(Suicide Prevention Resource Center, Education Development Center, Newton, MA, USA)

Some of the most important risk and protective factors are outlined below.

Risk Factors for Suicide

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Socialcultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior

- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Protective Factors for Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

CBT Activity Book – Support Handout #1

CBT Support Session Outline

Provider No. _____	Session No._____
Participant No. _____	Date _____

➢ **Mood Check**	Start by checking on client's mood and symptoms using the Mood Scale provided in Support Handout #2
➢ **Agenda Setting**	Provider and client set an agenda for the session
➢ **Previous Session Review**	Create a bridge to the new session and review homework, discussing problems and successes
➢ **Address Agenda**	Together, address issues on the agenda
➢ **New Homework**	Together, set new homework
➢ **Summarizing & Feedback**	Provider summarizes the session and client provides feedback

CBT Activity Book – Support Handout #2 - Mood Chart

	Very Well
	Well
	Neutral
	Poorly
	Very Poorly

CBT Activity Book – Support Session Handout #2 (Continued)

Mood Chart with Numerical Scores

	Very Well = 5
	Well = 4
	Neutral = 3
	Poorly = 2
	Very Poorly = 1

CBT Activity Book – Support Handout #3

First CBT Session

Questions to Ask, Actions to Take

Ask your client,

- Please tell me what brought you to me and how you are feeling now?
- How are you getting along in your daily life?
    - What do you do on a typical day?
    - How often do you see family and friends?
    - How do you function in your relationships?
- What are your expectations for how I might help you?

Mood Chart

Ask your client about his current mood using your **Quick Mood Chart**. Show your client how to use the mood chart, which is provided in your CBT Activity Book. Ask your client to record his mood daily in his Activity Log and share this with you in session.

1st Session Objectives

- Develop a shared understanding of the problem
- Establish a strong working relationship
- Educate your client about depression, how CBT works and what sessions will be like
- Agree on Support Session Goals with your client
- Instill HOPE in your client

CBT Activity Book – Support Handout #4

Main Targets for Change

Summarize Problems into Clear Targets for Change		**Short, Medium or Long-term**
Problem-Solving		
Assertiveness or other changes in relationships		
Identifying and changing extreme and unhelpful thoughts		
Overcoming reduced activity or unhelpful behaviors	*ie, drinking too much alcohol*	
Overcoming physical problems	*ie, sleep or pain problems*	
Using prescribed medications correctly		

CBT Activity Book – Support Handout #5
Daily Practice – Thought Record

Instructions

- 1st column, write your **Thoughts** about a distressing situation.
- 2nd column, write the **Feelings/Actions** that result from your **Thoughts.**
- 3rd column, write the **Consequences** you experience: feelings, behaviors, physical symptoms.

Thoughts	Feeling/Action	Consequences
Unhealthy thinking and behavior:		
Ran out of time to prepare evening meal for the family. I'm useless! Why I am not coping?	Don't even try. Just fall asleep watching TV on the couch.	Upset, frustrated; disorganized
Change unhealthy thinking and behavior:		
Worried about preparing dinner for the family	I can cook the soup and let my daughter do the rest.	Less stress; sense of accomplishment, motivated to do more the next day
Feeling exhausted mid-day and worried about how to manage the rest of the day.	I will stay calm and do what I really need to today and leave the other chores for when I am feeling better.	optimistic, in-control, confident; re-planning schedule to complete necessary tasks only
Unhealthy thinking and behavior:		
I feel anxious and fearful sharing my problems	I don't discuss my problems with anyone	greater stress and anxiety; avoiding people more
Change unhealthy thinking and behavior:		
I can discuss my feelings with a few trusted friends or family	Trying to share problems with others	less stress and more feeling connected to others; less isolated and alone

Daily Practice – Thought Record

Instructions

- 1st column, write your **Thoughts** about a distressing situation.
- 2nd column, write the **Feelings/Actions** that result from your **Thoughts.**
- 3rd column, write any of the three **Consequences** you experience: feelings, behaviors, physical symptoms.

Thoughts	Feeling/Action	Consequences

CBT Activity Book – Support Handout #6
Steps for Planning a Manageable Schedule

1. Write down your weekly depression support sessions. Your provider will try to keep your sessions at a regular time. You will also find that your session will take on average 30 minutes. When planning your day, allow extra time for traveling to and from your provider.
2. Plan on eating 3 daily meals.
3. Plan to rest and relax for at least 15 to 30 minutes each day.
4. Do at least one 30-minute daily physical/recreational activity you enjoy; such as walking, gardening, or other exercise.
5. Write down on a blank sheet of paper all the activities you would like to complete during the day; including your work and regular home activities and chores such as preparing dinner, laundry, ironing, caring for children and other family members.
    a. Number each activity in terms of how important it is to you. If there is something you have to do that day, label it #1, followed by the next essential task you would like to accomplish. Example 1= support session, 2 = pick up grandchild from school, 3 = prepare dinner, etc.
    b. Write down each activity in your weekly planner, making sure to allow yourself enough time to accomplish each task.
    c. If you cannot do all the activities you would like in one day, put off your less important activities (those you rated 5 or 6) to another day when you are less busy.

It is important to maintain healthy, balanced routine. Be sure to make time daily for relaxation and exercise. Set realistic goals for what you can and cannot accomplish in a day. Set yourself up for success and fulfillment.

CBT Activity Book – Support Handout #7

Activity Log

Please write your activity in the first column and how often you will do the activity in the second column. Then, check off each day you do the activity under days 1 – 7.

Type of Activity	How Often?	Daily						
Go to support session	*Twice weekly*							
Mood Check	*Once daily*							
Fill in Thought Record	*Once daily*							
Go for a walk	*Once daily*							

Type of Activity	How Often?	Daily						

Type of Activity	How Often?	Daily						

Type of Activity	How Often?	Daily						

Supplemental Reading #1
Six Interviewing Strategies Relevant to Suicide Risk Assessment

The information below is a very brief summary of material found in The Practical Art of Suicide Assessment by Dr. Shawn Shea (1999).

These interviewing techniques place emphasis on the use of forced-choice rather than open-ended questions. Dr. Shea asserts that concrete, specific, factual information gives the clinician a database from which conclusions about suicide risk can be drawn. Even though the client's opinions and impressions are often misleading, Dr. Shea advocates opinion-questions that may identify cognitive distortions. Listed below are Dr. Shea's six major techniques:

1. **Behavioral Incident**

Questions recreate behavior in the form of a running verbal videotape. Instead of asking, "Why didn't you kill yourself?" Ask the client: "How many times have you gone to the barn with the intent to kill yourself? "How many minutes did you look down from the top floor? "How many inches were you from the edge?"

2. Shame Attenuation

Questions give credit to the client's motives and point of view as a strategy to find out what actually happened. Rather than asking, "What complaints does your husband have?" Ask, "In what way does your husband make life difficult for you?"

3. Symptom Amplification

This strategy assumes behaviors occurred and thus uses overestimation so that the client will provide a true estimate of activity. Don't ask "Have you been thinking of suicide?" Overestimate by asking "How many hours have you spent thinking of suicide this week?" "Twenty or thirty?"

4. Gentle Assumption

Behavior is assumed. Instead of "Have you thought about how your death would affect your children?" it is better to ask, "You likely have thought about your children?" "In what ways did you think your death would affect your children?"

5. Denial of the Specific

This technique might be renamed "Denial of Possibilities." If a gentle assumption question such as "In what way did you think your death would affect your children?" fails to produce meaningful data, the client may be more open to consider specific behaviors that are presented as possibilities. "Have you ever thought of how your death might affect your children?"

6. Normalization

This approach gives permission for the client to feel or act in certain ways because it is normal to do so under similar circumstances. "Many people who have lost their wife feel life just isn't worth living. Do you feel that way?"

Review prepared by David J. Knesper, M.D. on March 7, 2003. See the complete lecture at http://www.depressioncenter.org/suicide_assessment/index.htm

Supplemental Reading #2
Assessment and Management of Individuals at Risk for Suicide

(University of North Carolina at Chapel Hill, Clinical Core Competencies Curriculum)

Below is a common framework for learning about and gaining skill in working with individuals at risk for suicide. This is a set of core competencies, based on current empirical evidence and expert opinion.

A. Working with Individuals at Risk for Suicide: Attitudes and Approach

1. Manage your reactions to suicide

a. Become aware of your own emotional reactions, attitudes and beliefs related to suicide

b. Understand the impact of your emotional reactions, attitudes and beliefs on your client

c. Tolerate and regulate your emotional reactions to suicide

d. Obtain professional assistance from psychiatric professionals

2. **Reconcile the difference (and potential conflict) between your goal to prevent suicide and your client's goal to eliminate psychological pain through suicidal behavior**

a. Understand that suicidal thinking and behavior "makes sense" to your client when viewed in the context of his or her history, vulnerabilities and circumstances

b. Accept that your client may be suicidal and validate the depth of your client's strong feelings and desire to be free of pain

c. Understand the functional or useful purpose of suicidality to your client

d. Understand that most suicidal individuals suffer from a state of mental pain or anguish and a loss of self-respect
e. Maintain a nonjudgmental and supportive stance
f. Voice authentic concern and true desire to help your client
g. View each client as an individual with his or her own unique set of issues and circumstances, and as someone you are seeking to understand thoroughly within their family and community context; rather than as a stereotypic "suicidal client."

3. **Maintain a collaborative, non-adversarial stance**
    a. Listen thoroughly to attain a shared understanding of your client's suicidality and goals
    b. Communicate that helping to achieve resolution of your client's problem(s) is most important
    c. Create an atmosphere in which your client feels safe sharing information about his or her suicidal thoughts, behaviors and plans
    d. Share what you know about the suicidal state of mind
    e. Honestly express to your client why it is important that the person continue to live
    f. Work with your client and do not abandon him or her
    g. Be empathic to the suicidal wish
4. **Make a realistic assessment of your ability and time to assess and care for a suicidal person**

B. **Understanding Suicide**

1. Be familiar with suicide-related statistics

2. Demonstrate an understanding of risk and protective factors (earlier handout)
    a. Ask your client questions about suicide-related risk and protective factors during assessment
    b. Consider risk and protective factors when formulating risk
    c. Incorporate modifiable risk and protective factors into treatment and services planning
    d. Consider risk and protective factors when managing suicidal clients

C. **Collecting Accurate Assessment Information**

1. Integrate a risk assessment for suicidality early on in the meeting, regardless of the setting in which the interview occurs, and continue to collect assessment information on an ongoing basis
2. Ask about risk and protective factors
3. Ask about suicide ideation, behavior and plans
4. Ask about warning signs of imminent risk of suicide

D. Developing a Plan of Action

1. Collaboratively develop an emergency plan that assures safety and conveys the message that your client's safety is not negotiable
2. Coordinate and work collaboratively with psychiatric professionals to get help for your client

E. Managing Care

1. Follow your clients closely including taking reasonable steps to be proactive
    a. Motivate and support your clients in getting them to a psychiatric professional at the hospital

b. Engage in collaborative problem-solving with the client to address barriers in adhering to the plan and to revise the plan as necessary

c. Assure that your client, family, significant others, and other care providers are following through on agreed upon actions

d. Follow-up with all suicidal clients

2. Follow principles of crisis management

a. Take a problem-solving approach

b. Maintain a matter-of-fact demeanor

c. Perceive crises as opportunities for growth

d. Know that crises are short-lived

e. Neither punish nor reinforce suicidal behavior

F. Documenting

1. Write down information you collected from your client and give it to the psychiatric professionals

Conclusion
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Referrals Guide

Domestic Violence

- In **Chapel Hill**, call Compass Center for Women and Families 24-hour Crisis Line at (919) 929-7122. Located at 207 Wilson Street, Chapel Hill, NC 27516

Alcohol Abuse/Dependence

- In **Chapel Hill**, bring the person to the Emergency Room at the hospital – UNC Health Care, 101 Manning Drive, Chapel Hill, NC 27514, Phone: (919) 966-4131.

- OR, **Call Freedom House Recovery Center** at (919) 942-2803, which is located at 104 New Stateside Drive, Chapel Hill, NC 27516

Suicidal Behavior

If you consider a person may harm himself or another person,

- In **Chapel Hill,** call 911 or bring the person to the Emergency Room at the hospital – UNC Health Care, 101 Manning Drive, Chapel Hill, NC 27514. Phone: (919) 966-4131

Appendix C

Paraprofessionals - Assessment of Depression Knowledge

Signs, Symptoms and Support

1. Major depression is diagnosed when 5 or more symptoms of depression are present for most of the day, nearly every day
    a. for at least 1 year
    b. for at least 6 months
    c. for at least 2 months
    d. for at least 2 weeks
2. Physical symptoms of depression include
    a. Difficulty concentrating
    b. Nausea, stomach ache, headache, chronic body pains
    c. Hopelessness
    d. Loss of interest in activities
3. Which of the following is a sign of suicide risk?
    a. Frequent complaining
    b. Nervousness and forgetfulness
    c. Self-destructive behaviors, such as injuring oneself
    d. Visiting a mental health professional

4. Reflective listening is a communication strategy that includes the following:
    a. Two steps: seeking to understand the speaker's idea and confirming you have understood the idea by offering it back to the speaker
    b. Finding out as much as you can about the speaker's personal history
    c. Mindfulness meditation
    d. Investigating a person's willingness to change
5. Cognitive-behavioral therapy is which of the following:
    a. A family-focused treatment
    b. Based on understanding one's childhood
    c. Mainly focused on interpersonal relations
    d. A way of altering the cycle of unhealthy thoughts and behavior
6. Following the completion of treatment, the lowest risk of relapse – depression returning after treatment, is when the initial treatment was:
    a. Medication (once the best combination is found)
    b. Medication plus cognitive-behavioral therapy
    c. Behavior therapy or cognitive-behavioral therapy
    d. Cognitive-behavioral therapy, interpersonal therapy, and medication have equivalent relapse prevention outcomes

7. You can best identify automatic thoughts in cognitive therapy when

    a. Emotion is present at medium or high levels.

    b. Emotion is reduced so the client can be rational.

    c. The client has average or better intelligence.

    d. The client knows how to fill out a thought record.

8. According to research, structure in cognitive therapy:

    a. Is only helpful if the client likes structure.

    b. Reduces therapy alliance ratings.

    c. Is more important early in therapy than later in therapy.

    d. Is linked to better treatment outcomes.

9. Which of the following is most likely to help clients engage more in CBT sessions?

    a. Lower session fees

    b. Medication

    c. Therapist curiosity

    d. Homework assignments

10. Research shows that client ratings of how well he connects or gets along with the provider,

    a. Are poorer in CBT but these do not affect therapy outcome.

    b. Are higher in CBT than in many other therapies.

    c. Are not relevant to CBT outcomes.

    d. Are more relevant to outcome in CBT than in other therapies.

Note: Items 5 – 10 are taken from the Therapist Depression Knowledge Questionnaire, (Simons et al, 2010).

Key – Assessment of Depression	
1. D 2. B 3. C 4. A 5. D	6. C 7. A 8. D 9. C 10. B

Appendix D

Paraprofessionals - Assessment of Attitudes Toward Depression

A. Please read the following statement: 'John is depressed and took a Tylenol overdose last month to try to hurt himself.'

   Please underline the answer that best reflects your views:

1. I think this would damage John's career.
   a. Strongly agree^{+2}/Agree^{+1}/Neutral^{0}/Disagree^{-1}/Strongly disagree^{-2}/Don't know^{0}
2. I would be comfortable about inviting John to my home for dinner.
   a. Strongly agree^{-2}/Agree^{-1}/Neutral^{0}/Disagree^{+1}/Strongly disagree^{+2}/Don't know^{0}
3. How likely do you think it would be for John's wife to leave him?
   a. Very likely^{+2}/Quite likely^{+1}/Neutral^{0}/Unlikely^{-1}/Very unlikely^{-2}/Don't know^{0}
4. It is best for John to take care of his personal problems and not share them with a mental health professional.
   a. Strongly agree^{+2}/Agree^{+1}/Neutral^{0}/Disagree^{-1}/Strongly disagree^{-2}/Don't know^{0}

5. John and his family will be embarrassed if John speaks with the doctor about his sadness.

   a. Strongly agree^{+2}/Agree^{+1}/Neutral^{0}/Disagree^{-1}/Strongly disagree^{-2}/Don't know^{0}

Note: Section B.1-5 was adapted from the Attitudes to Mental Illness Questionnaire (Luty, Fekadu, Umoh & Gallagher, 2006).

B. Please read each statement and circle the answer that best reflects your viewpoint.

1. Depression is a way that weak people confront life's problems.

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

2. I am comfortable addressing the problems of people with depression.

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

3. Depression reflects a personality characteristic in the person that is not easy to change.

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

4. Depression will go away without the help of doctors and mental health professionals.

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

5. Depressed people should share their personal problems with their family only.

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Note: Section C. 1-5 was adapted from the Attitudes About Depression Questionnaire (Levav et al., 2005).

Appendix E

A Short Acculturation Scale for Burmese-Speaking Refugees: English Version
INSTRUCTIONS: Please circle the number that corresponds to your best answer to each question.

1. In general, what language(s) do you read and speak?

Only Burmese language(s)*	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

2. What language(s) did you use as a child?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

3. What language(s) do you speak at home?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

4. In which language(s) do you usually think?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

5. What language(s) do you usually speak with your friends?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5
Other_____	

6. In what language(s) are the TV programs you usually watch?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5

7. In what language(s) are the radio programs you usually listen to?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5

8. In general, in what languages(s) are the movies, TV, and radio programs you *prefer* to watch and listen to?

Only Burmese language(s)	1
More Burmese language(s) than English	2
Both equally	3
More English than Burmese language(s)	4
Only English	5

9. Your close friends are:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

10. You prefer going to social gatherings/parties at which the people are:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

11. The persons you visit or who visit you are:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

12. If you could choose your children's friends, you would want them to be:

All Burmese	1
More Burmese than Americans	2
About half and half	3
More Americans than Burmese	4
All Americans	5

*Burmese language(s)—refer(s) to Burmese or other dialects spoken by people from Burma (Myanmar). Adapted from "A Short Acculturation Scale for Filipino Americans," which was adapted by Dela Cruz, F.A., Padilla, G.V. & Agustin, E.O., 2000, from "A Short Acculturation Scale for Hispanics," by G.Marin, F. Sabogal, B. V. Marin, R. Otero-Sabogal, and E. J. & Perez-Stable, 1987, Hispanic Journal of Behavioral Sciences, 9, pp. 201-203.

Appendix F

A Short Acculturation Scale for Karen-Speaking Refugees: English Version
INSTRUCTIONS: Please circle the number that corresponds to your best answer to each question.

1. In general, what language(s) do you read and speak?

Only Karen language(s)*	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5
Other_____	

2. What language(s) did you use as a child?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5
Other_____	

3. What language(s) do you speak at home?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5
Other_____	

4. In which language(s) do you usually think?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5
Other_____	

5. What language(s) do you usually speak with your friends?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5
Other_____	

6. In what language(s) are the TV programs you usually watch?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5

7. In what language(s) are the radio programs you usually listen to?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5

8. In general, in what languages(s) are the movies, TV, and radio programs you *prefer* to watch and listen to?

Only Karen language(s)	1
More Karen language(s) than English	2
Both equally	3
More English than Karen language(s)	4
Only English	5

9. Your close friends are:

All Karen	1
More Karen than Americans	2
About half and half	3
More Americans than Karen	4
All Americans	5

10. You prefer going to social gatherings/parties at which the people are:

All Karen	1
More Karen than Americans	2
About half and half	3
More Americans than Karen	4
All Americans	5

11. The persons you visit or who visit you are:

All Karen	1
More Karen than Americans	2
About half and half	3
More Americans than Karen	4
All Americans	5

12. If you could choose your children's friends, you would want them to be:

All Karen	1
More Karen than Americans	2
About half and half	3
More Americans than Karen	4
All Americans	5

*Karen language(s)—refer(s) to Karen or other dialects spoken by Karen people from Burma (Myanmar). Adapted from "A Short Acculturation Scale for Filipino Americans," which was adapted by Dela Cruz, F.A., Padilla, G.V. & Agustin, E.O., 2000, from "A Short Acculturation Scale for Hispanics," by G.Marin, F. Sabogal, B. V. Marin, R. Otero-Sabogal, and E. J. & Perez-Stable, 1987, Hispanic Journal of Behavioral Sciences, 9, pp. 201-203.

Appendix G

Paraprofessionals – Training Program Quizzes

Quiz 1 of 3

1. Major depression is diagnosed when 5 or more symptoms of depression are present for most of the day, nearly every day
    a. for at least 1 year
    b. for at least 6 months
    c. for at least 2 months
    d. for at least 2 weeks
2. Physical symptoms of depression include
    a. Nausea, stomach ache, headache, chronic body pains
    b. Hopelessness
    c. Loss of interest in favorite activities
    d. Difficulty concentrating
3. Reflective listening is a communication strategy that includes the following:
    a. Finding out as much as you can about the speaker's personal history
    b. Two steps: seeking to understand the speaker's idea and confirming you have understood the idea by offering it back to the speaker
    c. Mindfulness meditation
    d. Investigating a person's willingness to change

4. Cognitive-behavioral therapy is which of the following:
    a. A family-focused treatment
    b. Based on understanding one's childhood
    c. Mainly focused on interpersonal relations
    d. A way of altering the cycle of unhealthy thoughts and behavior
5. Following the completion of treatment, the lowest risk of relapse – depression returning after treatment, is when the initial treatment was:
    a. Medication (once the best combination is found)
    b. Medication plus cognitive-behavioral therapy
    c. Behavior therapy or cognitive-behavioral therapy
    d. Cognitive-behavioral therapy, interpersonal therapy, and medication have equivalent relapse prevention outcomes

Quiz 2 of 3

1. Many researchers and clinicians believe depression and anxiety
    a. stem from the same biological vulnerability
    b. are distinctly different categories of distress and impairment
    c. are unrelated disorders
    d. appear to be related, but are not
2. Many people with depression
    a. are violent
    b. often withdraw from work, social and family relations
    c. work harder than other people
    d. focus only on the positive
3. Risk factors that may lead to depression include
    a. weak character
    b. exercise
    c. history of trauma or abuse
    d. spending a lot of time socializing

4. What is the goal of cognitive restructuring?

    a. To understand one's childhood

    b. To replace unhealthy thoughts with helpful ones

    c. To replace hallucinations with helpful actions

    d. To increase healthy behaviors

5. According to research, structure in cognitive therapy:

    a. Is only helpful if the client likes structure.

    b. Reduces therapy alliance ratings.

    c. Is more important early in therapy than later in therapy.

    d. Is linked to better treatment outcomes.

Quiz 3 of 3

1. Alcohol is considered a

    a. stimulant

    b. hallucinogen

    c. opiate

    d. depressant

2. How may alcohol abuse develop into alcohol dependence?

    a. it does not

    b. gradually as a person's tolerance to alcohol increases

    c. by using drugs along with alcohol

    d. through physical illness

3. You may help women suffering with domestic violence by

    a. teaching assertiveness skills and encouraging financial independence

    b. ignoring the problem

    c. suggesting they not to talk about it

    d. trying to change the subject

4. Which of the following is most likely to help clients engage more in CBT sessions?
    a. Lower session fees
    b. Medication
    c. Therapist curiosity
    d. Homework assignments
5. Research shows that client ratings of how well he connects or gets along with the provider,
    a. Are poorer in CBT but these do not affect therapy outcome.
    b. Are higher in CBT than in many other therapies.
    c. Are not relevant to CBT outcomes.
    d. Are more relevant to outcome in CBT than in other therapies.

Answer Key – Quizzes 1-3		
Quiz 1	Quiz 2	Quiz 3
1. D 2. A 3. B 4. D 5. C	1. A 2. B 3. C 4. B 5. D	1. D 2. B 3. A 4. C 5. B

Appendix H

Paraprofessional Questionnaire - Assessment of Training Program

Program Evaluation Form

Please circle the response that best describes your experience as a participant in this Training Program.

1. The Training Program has helped me understand the signs and symptoms of depression better now than when I started this program?

0	1	2	3	4
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

2. The new support skills were well explained to me.

0	1	2	3	4
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

3. The Program has given me the knowledge and skills to be a more valuable and helpful to community members.

0	1	2	3	4
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

4. The program has helped me feel better prepared and confident to treat individuals with depression and support their families.

0	1	2	3	4
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

5. What recommendations do you have for making the program more helpful?

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Biography

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