The Islamic University

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Faculty of Nursing

Master of community mental health Nursing

"Effectiveness of Wellness Recovery Action Plan (WRAP) on Schizophrenic patients in Gaza strip"

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بسم الله الرحمن الرحيم

﴿يَرْفَعِ اللَّهُ الَّذِينَ آمَنُوا مِنكُمْ

وَالَّذِينَ أُوتُوا الْعِلْمَ دَرَجَاتٍ﴾

المجادلة {12}

Abstract

This study was aimed to know the effectiveness of (WRAP) wellness recovery action plan on schizophrenic patient in Gaza governorate . Total sample of (33) female patients was picked through random selection then divided into two groups, experimental and control. Age, level of education, marital status, work, residential area and income were matched to maintain neutrality. Quantitative and qualitative method through (pre post design) through international scale (Recovery assessment scale) that modified to be suitable Arabic culture, and focusing group then follow up was done after 4 months to know whether the effectiveness persistence of the program . Experimental group was conducted (WRAP) session (8-12weeks) but control group conducting usual care. Pretest conducted for both group shown there are no statistically significant differences at the level (0.05) between the mean scores of schizophrenic patients at the intervention group and schizophrenic patients at the control group regarding the dimensions of scale wellness recovery action . While for applied posttest for both group is shown that there are significant differences in patients with schizophrenic in the intervention and control groups (P-value = 0.001), and the differences were in favor of the Intervention group, for the follow up test four month later shown, the presence of statistically significant differences in the dimension scores of hope in patients with schizophrenia in degrees post-test and sequential in the Intervention group (p-value = 0.036), and the differences were for the favor of post-test, this indicates that for degree of hope may decline with members of the intervention group after the passage of time. But other domain of (WRAP) there was no statistically significant differences in the degrees of dimensions scale of wellness recovery action plan regarding (goal, Self-responsibility, Support, Knowledge and self-advocacy) between the degrees in posttest and sequential in the intervention group. (p-value < 0.05). This mean that dimensions degrees of scale of wellness recovery action plan did not show differences or a significances for members of the Intervention group after passage of time. Also Experimental had reported significant increases in their hopefulness for their own recovery , awareness of their own early warning signs of decompensating, use of wellness tools in their daily routine , awareness of their own symptom triggers, having a crisis plan in place, having a plan for dealing with symptoms, and having a social support system, and , ability to take responsibility for their own wellness .

ملخص الدراسة باللغة العربية

هدفت الدراسة الى معرفة مدى فعالية برنامج الدمج والاستشفاء لدى مرضى الفصام في مدينة غزة ولتحقيق هدف الدراسة قامت الباحثة باختيار عينة الدراسة التي تكونت من(33) مريضة تم تقسيمها الى مجموعتين احداهما ضابطة (18) مريضة, واخرى وتجريبية (15) مريضة وقد اخضعت المجموعة التجريبية للعلاج ببرنامج الدمج والاستشفاء و المكون من(12-8) جلسة استمرت لمدة ثلاث شهور بمعدل جلسة اسبوعيا, اما المجموعة الضابطة فقد خضعت للعلاج بالطريقة الاعتيادية وقد قامت الباحثة باستخدام(القياس القبلي- البعدي) الشبه التجريبي ولتحقيق الهدف تم تصميم اداتين احدهما

(recovery assessment scale) وهي استبانة عالمية قامت الباحثة بترجمة و اضافة بعض التعديلات لبعض الفقرات لملائمة البيئة والثقافة العربية, وايضا تم استخدام المجموعة البؤرية لاخذ اراء بعض المشاركين بالنسبة للبرنامج وذللك بعض الانتهاء من جلسات البرنامج للتقييم. وللإجابة على تساؤلات الدراسة والتحقق من صحة الاسئلة استخدمت الباحثة عددا من الاساليب الاحصائية تمثلت في اختبار ولكوكسون ,معامل الارتباط بيرسون , مان ويتني وعدد من الاختبارات الأخرى وتوصلت الدراسة الى النتائج التالية:

- لا توجد فروق ذات دلالة إحصائية بين المجموعتين التجريبية والضابطة في الاختبار القبلي عند مستوى دلالة (0.05>) بالنسبة لمستوى التحسن في الابعاد الخمسة في مقياس الدمج والاستشفاء.
- يوجد فروق ذات دلالة إحصائية بين المجموعتين التجريبية والضابطة في الاختبار البعدي عند مستوى دلالة = ,(p-value = 0.001) لصالح المجموعة التجريبية بالنسبة لمستوى التحسن للأبعاد الخمسة في مقياس الدمج والاستشفاء.
- توجد فروق ذات دلالة إحصائية لدى المجموعة التجريبية بين المقياس البعدي والتتبعي بالنسبة لتحسن في مستوى الأمل وكانت النتيجة لصالح الاختبار البعدي عند مستوى دلالة (p-value = 0.036)
- لا توجد فروق ذات دلالة إحصائية لدى المجموعة التجريبية في المقياس البعدي والتتبعي بالنسبة لمستوى التحسن في للأبعاد الأخرى عند مستوى دلالة (p-value < 0.05 .

DEDICATION

This thesis is dedicated to my parents who have given me the opportunity of education at the best institutions and support throughout my life. This thesis is dedicated to my Professor Mr. Youssef al jeesh who has been my guide and his philosophy. This thesis is dedicated to my husband and children who have always stood by me and dealt with all of my absence from many family occasions with a smile, to my dear daughter Mariam who never held any assistants for me, for my sons, AKram, Shade, Audi, and Sarah' God bless them. To my brothers and sisters.

I dedicate this thesis to my best friends who has always helped me and believed that I could do it. To my friends and colleagues, and specially the staff of west GAZA Psychological Clinic.

Acknowledgement

Praise be to Allah who by his grace righteous acts complete, and who with the light of his face darkness fade away, praise be to him. I thank him he allowed me to complete this work. First and foremost I offer my sincerest gratitude to my supervisor, **Dr Youssef Al-Jeesh ,** who has supported me throughout my thesis with his patience and knowledge. I attribute the level of my Master's degree to his encouragement and effort and without him this thesis, too, would not have been completed or written. One simply could not wish for a better or friendlier supervisor. **Professor Dr. Sameer Quota** has offered much advice and insight throughout my work systems. I would like to thank the members of the examination committee, Secondly I would like to express my sincere appreciation to the WHO, Islamic university for funding my entire program and specifically for financing my research. I cannot forget to thank my professor Attef Al-Aghaa for his educative design, and his patience for support me, for getting me the documents I needed for my research without which I would not have been able to write this thesis. In a special way Special thanks go to my daughter Mariam for all she has done for me that I cannot mention her, & our son's Akram, Shadi, Audi, and Sarah for supporting me throughout all my studies at University. Finally I am indebted to my many colleagues who supported me, I would like to thank west Gaza psychiatric clinic teem for supported me. I pray to Allah for their success and safety, and to open all the unlocked doors for them. Amin.

The Researcher

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Chapter One

Background

General review of study chapters

This study consists of five chapters, chapter one include, study proposal which includes, introduction, research question, justification, objectives, and demographical background. In chapter two, revision of different studies, and literature related to variables of the studies. In chapter three the researcher mentioned the methodological approach that used in completing the study in relation to sampling, design, population, data collection, analysis & ethical consideration. Chapter four includes the results of the study and finally chapter five include discussion of the results , limitation, and recommendations.

Introduction:

Mental health is a great gift we had from Allah, so we feel happy and enjoy wellbeing. Wellbeing is observed through control over behavior appraisal of reality . In work Healthy self-concept, Satisfying relationships (give and receive love), effective coping strategies, ability to deal with conflicting emotions, Live without undue fear, guilt, or anxiety, take responsibility for one's own actions ,think clearly and negotiate each developmental task but if there is severe mental illness as schizophrenia there is destruction of wellbeing.

There is no doubt that the global burden of schizophrenia chronic serious mental illness is massive. It is a result of many disabling in human welling, family, community burden.

From researcher opinion: People with schizophrenia often neglect basic hygiene and need help in with everyday activities. Because it is not as obvious that negative symptoms are part of a psychiatric illness, people with schizophrenia are often perceived as lazy and unwilling to better their lives.

In the past decade people who had sever psychiatric symptom were generally thought to be incurable difficulties do not recover and poor prognosis with progressively downhill courses and limited treatment and they be stigmatized for generation, and they have often neglect basic hygiene and need help in everyday activities . So they only treatment option that might help to relive symptom . Schizophrenia Ranks among the top 10 causes of disability in developed countries worldwide (source: The global burden of disease 1990).

The prevalence rate for schizophrenia is approximately 1.1% of the population over the age of 18 (NIMH) or, in other words, at any one time as many as 51 million. (Harvard University Press, 1996).

According to the World Health Organization (WHO), schizophrenia affects "about 7 per thousand of the adult population, mostly in the age group 15-35 years" and its high prevalence is due to "chronicity (WHO, 2010).1). They attribute chronicity to late detection and lack of treatment. WHO purports: schizophrenia affects about 24 million people worldwide, is a treatable disorder, treatment being more effective in its initial stages, more than 50% of persons with schizophrenia are not receiving appropriate care, 90% of people with untreated schizophrenia are in developing countries, care of persons with schizophrenia can be provided at community level, with active family and community involvement.

People with schizophrenia are far more likely to harm themselves than be violent toward the public . The risk of suicide is very serious in people with schizophrenia. Suicide is the number one cause of premature death among people with schizophrenia, with an estimated 10 percent to 13 percent killing themselves and approximately 40% attempting suicide at least once (and as much as 60% of males attempting suicide). Can result due to lack of treatment are the usual causes. These suicides rates can be compared to the general population, which is somewhere around 0.01%.

(Treatment Advocacy Center. www4.od.nih.gov/ofm/diseases/index.stm)

Schizophrenia, long considered the most chronic, debilitating and costly mental illness, now consumes a total of about 63 billion $ a year for direct treatment, societal and family costs. Richard` Wyatt, M.D., chief of neuropsychiatry, National Institutes of Mental Health, involves direct treatment and the rest is absorbed by other factors -- lost time from work for patients and care givers, social services and criminal justice resources.

Therefore it is essential that any intervention is appropriate cost effect and efficacious to reduce the burden. In effect, there's a two-tier system of people who get treatment and regain their lives, and others whose delayed treatment or failure to get help causes suffering and pain. Why do people often not get treatment or do so only after 10 or 20 years? It's not because of stigma. The prime reason could be that a

significant number of people with schizophrenia don' t believe they're sick, and so refuse medication.

The fact sheet offers hope: the best treatments for serious mental illness today are highly effective. Between 70 and 90 percent of individuals have significant reduction of symptom s and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.SO (WRAP) IS program and new designed facilitate the recovery and community integration of people who have had repeated symptom and relapse and become participant member of that community self-help to relive pervasive symptom and taking responsibility for their own lives and working toward meeting their own goal and dream (Copeland.,2005).

Strong national mental health recovery movement recognized that it can and do recover that there are things they can do to help themselves and feel better, can learned about these things and use them in their own lives (ralph &Corrigan., 2005).

1.1 Goal

The aims of this study to evaluate the effectiveness of wellness recovery action plan (WRAP) on schizophrenic patients in Gaza city.

1.2 Objectives of the study.

*To identify the effectiveness of WRAP on schizophrenic patients in intervention group.

*To identify the effectiveness of traditional method on schizophrenic patients in control group.

*To compare between experimental and control group regarding hope, skills, self-management and relapse symptoms.

*To provide recommendations and suggestions for the decision makers about implementation of WRAP in governmental sectors.

1.3 Research questions.

- Is there a significant difference in the degree of the wellness recovery action plan dimensions in the intervention group and the control group before implementing the program ?

- Is there a significant differences in the degree of wellness recovery action plan dimensions in the Intervention group and the control group after the implementation of the program?
- Is there a significant differences between the degrees of pre-test and post-test in degrees dimensions scale of wellness recovery action plan in the intervention group?
- Is there statistical difference between the degrees of pre-test and post-test in scale of wellness recovery action plan in the Control group ?
- Is there statistical differences between the degrees of tribal measurement and degrees of sequential measurement dimensions scale wellness recovery action plan in the intervention group ?
- Is there statistical significant differences between the degree of posttest and sequential test in degrees dimensions scale wellness recovery action plan in the intervention group?
- What are the recommendations and suggestions provided for the decision makers about implementation of WRAP ?

1.4 Justification

This is the first study was applied in Palestine and a new program also applied from the researcher opinion because the stressors that the Palestinian people were faced.

Worldwide public health problem and serious concern for mental health professional. In the face of the staggering statistics on mental health-the World Health Organization reporting 22.8% of disease attributed to a mental health disorder in 2004 (compared with 16.2 cardiovascular disease and 15.9% for cancer)'***Global Burden of Disease Report', (www. Who .int /helathinfo /global_ burden_ disease/ estimates_ country / en /index. html(2008))*** and the Results of a Household Survey in 2007 recording 17.6% of adults in England having at least 1 common mental health disorder,(Mcmanus et al.,2009). The Birmingham Mental Health Commissioning team was keen to address such a rising health problem with the WRAP approach that promotes wellness as a lifestyle and recognizing the individual as the expert on his own wellbeing. It commissioned NHS Birmingham East and North's BME Mental Health Community Development Team to roll out the WRAP as a way to disseminate within communities, a mechanism to change attitudes and aid management of mental health and wellbeing then review research on professional-based programs for helping people manage their mental illness. More over burden of care that has an impact not only on society but on the family as well. The stigma

of the illness is examined along with the prevalence and impact of medication non-adherence, rejected or ignored by so many patients. The biggest reason for relapse and continued problems are in, behaviors, suicide, legal issues, substance abuse, and financial concerns. . Schizophrenia has a profound impact on one's function in all aspects of life: self-care, family relationships, income, education, employment, housing, community, and social life .

Number of systematic studies of person suffering from schizophrenia has observed that there is often significant co-occurrence of relapsing and the worth outcome, impaired function, and personal suffering high rate of re hospitalization and over suicide.

I proposed this study to the practice psychiatry the effectiveness of WRAP among schizophrenic patient in our environment. This will assess in the formulation of treatment plan that aimed at minimizing of relapse and increasing functioning well and reducing re hospitalization, improve the clinical outcome.

1.5 Demographic context of Gaza strip

small area of Palestine, located on the south of Palestine on the coast of Mediterranean sea Gaza Strip , high crowded area where approximately 1.5 million live in 362 square kilometers, with length about 45 kilometers, and width ranging between 6-12 kilometers. It lies between Egypt Mediterranean sea and occupied Palestine. most of the population are refugees. They are distributed at five cities, eight refugee camps and about eight villages. It is divided into five governorates; the North of Gaza, Gaza city, Mid-zone, Khany-ounis, and Rafah governorate The refugees constitutes about two thirds of the total populations at Gaza strip, about half of them live at camps.(PCBS,2007) . The population under 15 year old percentage in Gaza strip is 49% and 2.5% of age 65 years and more(MOH,2006).

1.6 Community mental health center

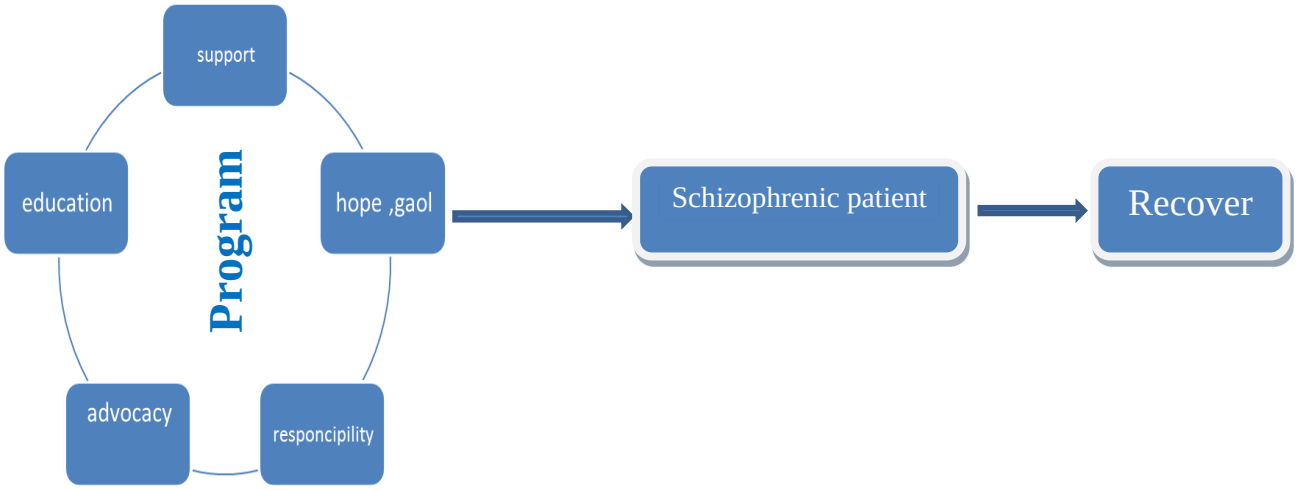
In 1995 Ministry of Health runs 6 community mental health center distributed through Gaza governorates one of them based in Rafah governorate, one in khan-younis governorate, one in mid-zone, one in Gaza city and the last one in North Gaza according MOH planning to cover mental health services and community mental health needs as psychopharmacology treatment ,counseling coeducation therapeutic session.

Chapter Two

Conceptual Frame Work & literature Review

conceptual frame work **(self-developed model)**

2.1 Definitions



Recovery Program

Theoretical definition of Recovery.

Mental health recovery is defined as a journey, of healing and transformation. from darkness into the light. A journey to take control of our problems, to take control of our lives for freedom . Freedom both from mental health problems and social exclusion we experience(Anthony, 1993). The same other add that a person with mental illness can recover even though the illness is not "cured. [Recovery] is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Operational definition of Recovery.

The Researcher defined recovery as :

Recovery is an action plan, or concepts of trust, hope, understanding, support ,spirituality & wellness• Recovery from mental illness is not like recovery from flu. It's recovery of life identity . Is self-designed plan for staying well and helping you to feel better when you do not feel well to increase personal responsibility and control over your own life and help you manage your life through the way you want wish, to increase personal empowerment, improve quality of life, and assist people in achieving their own life goals and dreams.

2.1.1 Schizophrenic patient

according DSM-1V customer or client who is diagnosed as schizophrenia by psychiatrist at least five years ago, has a file follow up continually under medication of antipsychotic drugs has stability according to GAF, and Dr who cooperate with the team.

❖ Theoretical definition of Schizophrenia.

The Researcher agree those researchers through definition of schizophrenia according to DSM-1V as Schizophrenia is characterized by profound disruption their cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self. The array of symptoms, while wide ranging, frequently includes psychotic manifestations, such as hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding fixed false personal beliefs (delusions). No single symptom is definitive for diagnosis; rather, the diagnosis encompasses a pattern of signs and symptoms, in conjunction with impaired occupational or social functioning (DSM-IV .,2000).

Schizophrenia, according to DSM-IV requires at least 1-month duration of two or more positive symptoms, unless hallucinations or delusions are especially bizarre, in which case one alone suffices for diagnosis. Negative symptoms are those that appear to reflection or diminution or loss of normal functions (Roy & Deviant, 1994; Crow, 1995; Blanchard et al., 1998). These often persist in the lives of people with schizophrenia during periods of low (or absent) positive symptoms. Negative symptoms are difficult to evaluate because they are not as grossly abnormal as positives ones and may be caused by a variety of other factors as well (e.g., as an adaptation to a persecutory delusion). However, advancements in diagnostic assessment tools are being made.

Operational definition of schizophrenia.

The Researcher defined Schizophrenia: as a chronic and severe mental disorder that is characterized by a disintegration of the process of thinking of emotional responsiveness and contact with reality. Schizophrenia causes symptoms that can interfere with many aspects of people's lives, especially their work and social life. Some symptoms make it difficult to know what's real and what's not. These symptoms have been described as being similar to dreaming when you are wide awake." Other symptoms can cause problems with motivation, concentration and experiencing enjoyment.

2.2 Schizophrenia

2.2.1 Historical back ground of schizophrenia

Some commentators argue that mental illness can only be defined within specific historical time and social context (Mulder., 1993). Ancient physicians, as early as ancient Egypt and the second millennium before Christ deemed psychosis to be a physical illness of the heart and uterus originating in the blood vessels or from "purulence, fecal matter, a poison or demons (Carlsson.,2005).

Greek physicians blamed delusions and paranoia on a lack of harmony between bodily humors of blood, phlegm, and yellow or black bile (Fabrega.,1990). From the 12th to the 14th century, town records in Europe substantiate that forceful banishment of the mentally ill was practiced as the "madman tended to be equated with paganism, demonic origins and the countryside" (Fabreg.,1990).

Early Christian saints "blessed" with voices and visions may have been, in fact, people with schizophrenia, but their experiences were considered divine rather than demonic (Heinrichs, 2003; Porter, 1987).

In the 19th century .(Macdonald., 1981). In 1967, Sir Audrey Lewis, the field of psychiatry was born, and special hospitals were created for mental patients. Summed up the ignorance of the past and the hope for the mentally ill. And gave way to more effective treatment for the mentally ill.

In 1889, German physician Emil Kraepelin coined the term dementia praecox to describe the symptoms currently associated with schizophrenia disruptions he observed in perceptual and cognitive functioning, while praecox referred to the onset of the disorder in early adulthood (Adityanjee et al., 1999).

In 1911, Swiss psychiatrist Eugene Bleuler coined the word schizophrenia to describe the disorder (Alexander & Selesnick, 1966; Maj & Sartorius, 1999). Derived from the Greek root words schizo, meaning split, and phrenic, meaning mind, the "split" refers to the split or fragmentation of the thinking the split between subjective feelings and thoughts being experienced (Walters., 2005). or to indicate a split in psychic functioning 1966). Also, Bleuler was the first to describe the positive symptoms (delusions, hallucinations, and disorganized speech or behavior) and negative symptoms (affective flattening, alogia, and volition) of the illness (Adityanjee et al., 1999).

2.2.2 Prevalence:

Worldwide, schizophrenia strikes 20 million people with an annual incidence rate of 1 to 4 per every 10,000 adults aged between 15 and 24 (Davies & Drummond, 1990). Schizophrenia is a relatively common illness and it is certainly the most common form of psychotic disorder. Schizophrenia is estimated at about ten times higher with an average lifetime prevalence of 1% (Canavan, 2000). Mean incidence of schizophrenia reported in epidemiological studies (0.07–0.17 per 1000 Average rates for men and women are similar although the mean age of onset is about 5 years greater in women (hence a lower female rate in adolescence), with a second smaller peak after the menopause. The lifetime prevalence of schizophrenia is between . 4and 1.4% (Cannon & Jones, 1996). The National Survey of Psychiatric Morbidity in the UK found a population prevalence of probable psychotic disorder of 5 per 1000in the age group 16 to 74 years (Singleton et al., 2000). Incidence and prevalence of schizophrenia varies with latitud**e** prevalence data is suspected to be higher due to potential under reporting of the disease In contrast to most previous studies that suggest a decline in the incidence of schizophrenia. Evidence of an increasing incidence of schizophrenia and in particular for males in a Palestine is due to suffer from stress, Poverty and political environment which causes illness, that may lead to lower socio-economic status .Trauma may increase vulnerability to the illness . Barriers to adaptation are decline addressed with coping strategies schizophrenia is believed to be a result of complex interactions between genetically determined biological factors and stressful environmental factors that provoke the illness Although previous studies have led to the common wisdom that schizophrenia affects new data reports that 1 out of every 100 individuals, indicate that this prevalence may be too high.

2.2.3 Diagnosis:

Diagnosis is a considerable controversy exists as whether a diagnosis of schizophrenia really represents a single underlying disorder and (Gelder et. al., 1997). agree with symptom clusters that confirm a diagnosis of schizophrenia. There are three main domains including psychotic symptoms such as certain types of auditory hallucinations (hearing voices), delusions(‘paranoia’ and ‘telepathy’) and thought disorder (incomprehensible speech)and negative symptoms such as poor self-care, reduced motivation, reduced ability to experience pleasure, a logia (reduced production of thought), affective blunting (lack of emotional expression) and reduced social functioning.

And the rare symptom of catatonia requires that at least one such diagnostic symptom from one of the three domains should be clearly present for 1 month. the diagnosis is confirmed if two of these symptoms have been present in a less clear manner over the same time frame. The diagnosis is not made in the presence of prominent mood symptoms, such as depression or mania. Diagnostic symptoms need to be present for at least 1 month It also stipulates that there should be evidence of ongoing symptoms persisting for at least 6 months.

2.2.4 Prognosis, course and recovery

Historically, many psychiatrists and other healthcare professionals have taken pessimistic view of prognosis for schizophrenia regarding it as severe intractable and often deteriorating lifelong illness. This negative view has failed to find confirmation from long-term follow-up studies, which had demonstrated considerable variations in long-term outcome. While it is estimated that around three quarters of people with schizophrenia will experience recurrent relapse and some continued disability(Nadeem et al., 2004), the findings of follow-up studies over periods of 20 to 40 years suggest that there is a moderately good long-term global outcome in over half of people with schizophrenia, with a smaller proportion having extended periods of remission of symptoms without further relapses (Gaebel&Fromman, 2000; Harrison et al., 2001; Jobe & Harrow, 2005).It should also be noted that some people who never experience complete recovery from their experiences nonetheless manage to sustain an acceptable quality of life if given adequate support and help. Treatment with antipsychotic medication, around80% will relapse within 5 years of a treated first episode, which is partly explained by discontinuation of medication (Nadeem et al., 2004; Robinson et al., 2002).

There is some evidence that early involvement in a progressive therapeutic program incorporating social and psychological interventions as well as medication might be an important factor in realizing long-term gains (de Haan et al., 2003;Harrison et al., 2001; Linszen et al., 2001). Research has also suggested that delayed access to mental health services in early schizophrenia – often referred to as the duration of untreated psychosis is associated with slower or less complete recovery and increased risk of relapse and poorer outcome in subsequent years (Bottlender et al.,2003).

2.2.5 Definition of schizophrenia:

The researcher defined schizophrenia as severe mental illness that interferes with person's ability to think clearly, manage emotions make decisions and relate to others. schizophrenic enriched bacterized by some deterioration in personal functioning. Difficulties may include memory and concentration problems, social withdrawal, unusual and uncharacteristic behavior, disturbed communication and affect, bizarre ideas and perceptual experiences, poor personal hygiene and reduced interest and motivation for day-to-day activities. During this prodromal period, people with schizophrenia often feel that their world has changed but their interpretation of this change may not be shared by others relatives and friends frequently report that the person with schizophrenia has changed 'in them selves'. These changes may well affect the person's ability to hold down a job, study, or relate to family and friends.

Also three authors agreed with the definition of Schizophrenia (Johnson ., 2006). Schizophrenia is a chronic and severe mental disorder that is characterized by a disintegration of the process of thinking of emotional responsiveness and contact with reality. (grant,2003) defined Schizophrenia as a serious brain disorder that has been described as one of the most debilitating and baffling mental illnesses known Schizophrenia is characterized by a dysfunction of the thought process affecting a person's ability to think clearly, and distinguish between what is real and what is imaginary. Schizophrenia is severe psychiatric disease, characterized by a range of dysfunctions in perception, thinking, language, behavior, affect, volition, drive and cognition (Holthausen, 2003).

2.2.6 Types of Schizophrenia

According to(DSM IV.,2000). There are five types of schizophrenia that are commonly recognized: These types are based on the type of symptoms exhibited, Schizoaffective disorder is not one of these types but is instead a different diagnosis.

- **Paranoid Schizophrenia** A person feels extremely suspicious and persecuted, or grandiose, or experiences combination of these emotions.
- **Disorganized Schizophrenia** A person is often incoherent in speech and thought but may have delusions.
- **Catatonic Schizophrenia** A person is withdrawn, mute, negative and often assumes very unusual body positions.

- **Residual Schizophrenia :** Type of Schizophrenia in which the following criteria are met :Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

- **Undifferentiated schizophrenia** : Type of Schizophrenia in which symptoms that meet Criterion are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.
- **Schizoaffective disorder.** These people have symptoms of schizophrenia as well as mood disorder such as major depression, bipolar mania, or mixed mania.

Undifferentiated Schizophrenia Conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the above subtypes, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics.

Additional information on schizophrenia.

2.2.7 Symptoms of schizophrenia

There are five types of symptoms characteristic of schizophrenia: delusions, hallucinations, disorganized speech, disorganized behavior, and the so-called "negative" symptoms. However, the signs and symptoms of schizophrenia vary dramatically from person to person, both in pattern and severity. Not every person with schizophrenia will have all symptoms, and the symptoms of schizophrenia may also change over time.

1 -Delusions

A delusion is a firmly –held idea that a person has despite clear and obvious evidence that it isn't true. Delusions are extremely common in schizophrenia, occurring in more than 90% of those who have the disorder. Often, these delusions involve illogical or bizarre ideas or fantasies. Common schizophrenic delusions include.

❖ Delusions of persecution

Belief that others, often a vague "they," are out to get him or her. These persecutory delusions often involve bizarre ideas and plots (e.g. "Martians are trying to poison me with radioactive particles delivered through my tap water").

❖ Delusions of reference

A neutral environmental event is believed to have a special and personal meaning. For example, a person with schizophrenia might believe a billboard or a person on TV is sending a message meant specifically for them.

❖ Delusions of grandeur

Belief that one is a famous or important figure, such as Jesus Christ or Napoleons. Alternately, delusions of grandeur may involve the belief that one has unusual powers that no one else has (e.g. the ability to fly).

❖ Delusions of control

Belief that one's thoughts or actions are being controlled by outside, alien forces. Common delusions of control include thought broadcasting ("My private thoughts are being transmitted to others"), thought insertion ("Someone is planting thoughts in my head"), and thought withdrawal ("The CIA is robbing me of my thoughts").

2 -Hallucinations

Hallucinations are sounds or other sensations experienced as real when they exist only in the person's mind. While hallucinations can involve any of the five senses, auditory hallucinations (e.g. hearing voices or some other sound) are most common in schizophrenia, Visual hallucinations are also relatively common. Research suggests that auditory hallucinations occur when people misinterpret their own inner self-talk as coming from an outside source.

Schizophrenic hallucinations are usually meaningful to the person experiencing them. Many times, the voices are those of someone they know. Most commonly, the voices are critical, vulgar, or abusive. Hallucinations also tend to be worse when the person is alone.

3 -Disorganized speech

Fragmented thinking is characteristic of schizophrenia. Externally, it can be observed in the way a person speaks. People with schizophrenia tend to have trouble concentrating and maintaining a train of thought. They may respond to queries with an unrelated answer, start sentences with one topic and end somewhere completely different, speak incoherently, or say illogical things.

❖ **Common signs of disorganized speech** in schizophrenia include:

Loose associations – Rapidly shifting from topic to topic, with no connection between one thought and the next.

- Neologisms – Made-up words or phrases that only have meaning to the patient.
- Perseveration – Repetition of words and statements; saying the same thing over and over.
- Clang – Meaningless use of rhyming words ("I said the bread and read the shed and fed Ned at the head").

4 -Disorganized behavior

Schizophrenia disrupts goal-directed activity, causing impairments in a person's ability to take care of him or herself, work, and interact with others. Disorganized behavior appears as:

- A decline in overall daily functioning.
- Unpredictable or inappropriate emotional responses.
- Behaviors that appear bizarre and have no purpose.
- Lack of inhibition and impulse control.

5 -Negative symptoms (absence of normal behaviors)

The so-called "negative" symptoms of schizophrenia refer to the absence of normal behaviors found in healthy individuals. Common negative symptoms of schizophrenia include Lack of emotional expression –Inexpressive face, including a flat voice, lack of eye contact, and blank or restricted facial expressions.

- Lack of interest or enthusiasm – Problems with motivation; lack of self-care.

- Seeming lack of interest in the world – Apparent unawareness of the environment; social withdrawal.
- Speech difficulties and abnormalities – Inability to carry a conversation; short and sometimes disconnected replies to questions; speaking in monotone.

(www.helpguide.org/mental/schizophrenia_symptom.htm)

2.2.8 Etiology

Two theories of etiology exist: The biological model and the environmental model. Both models will be fully addressed in this following section. Biological models of schizophrenia include the genetic model although risk ranges vary in the literature. First-degree biological relatives (parent, sibling, or offspring) of people with schizophrenia are 3% to 7% more likely to develop the disease than the general population (Jones&Cannon,1998). A higher lifetime risk of 5% to 10% exists for first-degree relatives including siblings and children (Cannon et al., 1998). Risk increases to 13% for a child with one parent with schizophrenia and swells to 35% to 40% for a child with two parents with schizophrenia (Lee, McGlashen, & Woods, 2005).It is now generally accepted that genetics participate substantially in schizophrenia etiology.

❖ Neurotransmitter Model:

The neurotransmitter model is one of the "earliest, most enduring and most influential of the modern neuron chemical theories of mental illness (Baumeister& Francis, 2002,). This model focuses on chemical transmission in the prefrontal cortex, hippocampus, and temporal lobes of the brain. It postulates "that increased dopamine receptor activity in these areas results in hallucinations and delusions" (Beebe, 2003). Dopamine dysfunction could be the primary mechanism for the elaboration of delusions and delusional perceptions (Lecrubier &Kapur,2005). Increased levels of glutamate in the prefrontal and limbic brain have been found in people with schizophrenia (Van Elst et al., 2005). Increased prefrontal glutamate concentrations have also been associated with poorer global functioning.

❖ Executive Function Model:

Executive function models endeavor to explain schizophrenia as a dysfunction in the prefrontal brain resulting in neurocognitive deficits(Suzuki et al., 2005).

These deficits affect ability in "ordering sequential behaviors', establishing goal-directed plans, maintaining task when interrupted , monitoring personal behavior, and associating knowledge with required responses (Beebe., 2003)

However, while there is a relationship between poor insight and cognitive impairment, these may not be specific to frontal lobe dysfunction (Goodman, Knoll, Isakov, & Silver, 2005) Cellular level loss or reversal of asymmetry is consistent with the hypothesis of a primary change in the relative development of areas of heteromodal association cortex in the two hemispheres (Cullen etal., 2006). As memory significantly correlates with insight (Chen et al., 2005).Structural abnormalities may impair insight development).

❖ Environmental Models:

Mid-20th century research ushered in environmental constructs of etiology based on family dynamics, ethnicity, vulnerability, and trauma. These environmental constructs will be discussed in this next section.

❖ Family Dynamics:

Frieda Fromm-Reichmann often blamed the mother-child relationship, specifically, the schizophrengoenic mother for provoking the illness (Neill.,1990). In the mid-1950s, Bateson extended this notion and proposed the Double-Bind hypothesis. Essentially, he hypothesized that an intense relationship with another person (the mother) who expresses two contradictory messages leaves the recipient of the messages (the child) unable to explain the contradiction and, therefore, is forced to withdraw from the situation, or to ignore the messages. The second message contradicts the first and is often enforced with punishment. .

A finish study of adopted out offspring of mothers with schizophrenia found that no cases of schizophrenia developed in offspring adopted into families considered healthy or only mildly disturbed, while of those offspring who were psychotic, nearly all were raised in disturbed adopted families (Tienari et al., 1987).thus providing possible evidence of the interaction between genetic factors and the environment.

(Jarvis., 2007). Conducted a review of north American literature to help clarify mechanisms underlying poverty, migration, and racial discrimination that contribute to mental illness. He found substantial scholarly neglect in this area and hypothesizes

this may be due to the rise of genetic-biological paradigms to explain mental illness. Accumulating evidence from migrant studies demonstrates that social factors play a role in the development of schizophrenia, but the mechanism by which social factors exert their influence is as yet unknown (Cantor-Graae., 2007).(Jarvis., 2007). Notes a paucity of literature on the social causes of psychosis and challenges North Americans to address these social factors. Environment can neither be discounted, nor considered solely liable as the primary factor in disease etiology.

Cultural differences do exist, yet the literature has not yet determined if race predisposes a person to the illness or if illness is a response to the social environment in which the person of race is steeped.

❖ Ethnicity:

Social forces such as class, poverty, and marginality affect culture. Social class of origin is associated with positive symptoms of schizophrenia over the early illness course (Brown, Susser, Jandorf, & Bromet, 2000).

Three paradigm shifts challenge the concept of "ethnicity". Firstly, an ethnic group in one setting is not necessarily generalizable to similar populations in other countries. Secondly, simplistic ethnic groupings or "race" based research variables have evolved toward sophisticated categories of "identity" and "cultural groups" in conjunction with assessment of socio-economic variables at the individual and community level. Finally, illness and recovery are highly subjective (Bhui& Singh, 2004).And debate continues about whether religious acceptance of psychosis plays a part in reducing the rate of diagnosis of the illness, or whether some people are mistakenly treated for a brain disease rather than a curable spiritual illness (Castillo., 2003).

Interestingly, the course of schizophrenia is significantly more benign in the developing world than in more technologically advanced countries. Themes explaining these phenomena in traditional cultures are identified as externalizing causality, thus reducing stigma and reinforcing expectations of the condition as being a temporary state, resulting in greater opportunities for social reintegration supported also by extended kinship networks (Lefley., 2000).

However, three socio-environmental variables differentiate the African-Caribbean cases from their peers and the normal control groups: unemployment, living alone, and a

long period of separation from either or both parents as a minor. In Sweden, East European, Greek, and Iranians were over-represented at a psychiatric outpatient clinic, with a corresponding under-representation of Swedish patients (Al-Saffar et al.,2004). Also Importantly, Black Africans are the immigrant group most often experiencing prejudice in North European countries.

Poverty is considered the number one contributor to mental illness in general (Desjarlais, Eisenberg, Good, &Klein an, 1995), although rather than poverty causing the illness, the illness may lead to lower socio-economic status (Maxmen & Ward, 1995) . Religion and spirituality may also play a part in the cultural aspects of the illness (Baetz, Griffin, Bowen, &Marcoux, 2004; Stanghellini, 2005). Awareness of the implications of diversity and cultural sensitivity need to be better integrated into mental health research.

❖ Vulnerability Model:

Symptoms of schizophrenia are provoked by vulnerability to stress (Leung &Chue, 2000; Rudnick, 2001). Early theoretical models of the relationship between stress and vulnerability have held their validity. As discussed earlier in this chapter, schizoid ataxia is a model advanced by (Meehl.,1962, 1989). Where the interaction of genetically driven, conjectured neural integrative deficits with stressors leads to the occurrence of schizophrenia. Stressors may actually trigger symptoms of disease in vulnerable populations (Rabkin., 1982), as hypothesized in the "two-hit" theory of mental illness: the first hit is genetic predisposition, and the second hit is a stressful or traumatic life event that triggers the illness predisposition, (Corcoran & Malaspina, 2004).

(Canavan.,2000). Speculates that roles of nature and nurture can be conceptualized using a multi-locus model of schizophrenia, thus illustrating that one's genetic makeup creates a vulnerability to detrimental environmental influences. The greater the individual's level of vulnerability, the less stress is required to trigger the psychosis (Lee et al., 2005).

Stress and coping theories are examples of environmental adaptation models. Adaptation is a dynamic process of adjusting to changeable life conditions; Barriers to adaptation are addressed with coping strategies. Schizophrenia patients, with blunted cortical responses to psychosocial stressors, have displayed more passive and avoidant coping strategies than a control group (Jansen et al., 1999)

❖ Trauma:

In keeping with the vulnerability model, a Post-Traumatic Stress Disorder (PTSD) perspective has been documented. About 90% of people with severe mental illness have experienced at least one traumatic event and most have been multiply traumatized. Trauma exposure in this population is associated with psychotic symptoms, suicidal, hostility, anxiety, and depression (Pratt et al., 2005). PTSD symptoms are associated with greater emotional distress, PTSD is not associated with schizophrenia specific symptoms Re-experiencing symptoms of PTSD is most strongly associated with predisposition to hallucinations (Gracie et al., 2007)**.**

❖ Conclusion

Chapter Two has provided an introduction to the problem of schizophrenia from historical perspectives, along with some contextual information on the genetic, biological, and environmental formulation of etiology. Genetic factors and gene-environment interactions the liability for the disease, also examined were the contributions of ethnicity and vulnerability. Finally, this chapter has provided information on the prevalence of the illness and how it impacts on gender. It is important to explore and examine the multi-faceted and thus complicated set of aspects contributing to etiology and diagnosis in order to fully study and understand.

❖ Burden

Now provides some context of the enormous social costs of the illness that include the burden of care, stigma, social behaviors, and risks of suicide, legal issues, and financial concerns. These social costs provide the rationale for the importance of studying the phenomenon and for developing strategies to build insight in people with schizophrenia profound impact on one's function in all aspects of life: self-care, family relationships, income, education, employment, housing, community, and social life.

❖ Burden of Care

Globally, nearly 3% of the total burden of human disease is attributable to schizophrenia (Public Health Agency of Canada, 2004). It is difficult to obtain exact figures depicting the burden of care, as studies often measure and include differing factors

when citing direct and indirect costs. However, even with these variations in measurements, studies do provide a strong sense of the global burden of care inflicted by the illness. The direct costs of schizophrenia in Western countries range between which in turn account for between 7% and 12% of the gross national product (WHO., 1996). Social and family costs (Lee et al., 2005; Schizophrenia Homepage, 2004), occupy 25% of all hospital beds, Schizophrenia is the most "resource intensive mental illness, accounting for one-third of all mental illness costs" (Nursing Economics, 1999), and costs are mainly attributable to hospitalizations for the initial episodes and subsequent relapses (Thieda et al., 2003). Globally, inpatient admission is the single largest contributor to the direct costs of treating schizophrenia (Knapp et al., 2004). In specifically, indirect costs result from lost employment productivity, unemployment, and permanent withdrawal from the labored direct costs may exceed direct costs force because illness, injury, or death. Indirect costs include death resulting from mental illness and costs associated with the impact of the illness on families, caregivers, and institutions. In addition to the above costs, individual costs, such as decreased quality of life, have also been identified (Public Health Agency of Canada, 2002).

❖ Vocational :

Most people suffering from mental illness lack paid employment (Ruesch et al., 2004).

Onset of schizophrenia usually leads to disruptions in an individual's education and ability to sustain employ. Globally, it has been noted that people with schizophrenia have trouble finding and keeping paid employment. Lost productivity has been attributed to patient morbidity and mortality (Knapp et al., 2004). Furthermore, exploration of the relationship between work and quality of life reveals that subjects "without any work-like occupation have the smallest social networks with comparatively few contacts to close friends, colleagues and relatives (Ruesch et al., 2004,)Typically, as the disease strikes those in their so-called productive years, only 30% to 40% of people with schizophrenia marry and most have limited social contacts (Public Health Agency of Canada, 2004).

❖ Family Costs of the Illness

Families of those suffering with the illness. By default, de-institutionalization of the mentally ill has often left the responsibility for their care to their families usually middle-aged or older parents (Milliken., 2001). And most often the mothers . This "informal care" (Gutierrez-Maldonado et al.,2005) .Places a heavy burden on families Schizophrenia causes disruptions to normal family functioning often due to the stigma attached to schizophrenia, which negatively impacts on the patient's ability to acquire housing, employment, and social support (Dickey & Azeni,1996). In addition, families are concerned about medication non-adherence (Coldham, Addington., 2002; Dickey &Azeni, 1996). The financial costs that accompany legal difficulties, and substance abuse by those with the illness. Finally, families frequently face the difficult decision of having their family member involuntarily committed to hospital (Crisanti, 2000)

❖ Caregiving

As a result of their illness, people with schizophrenia have difficulty maintaining satisfactory, stable independent housing and close interpersonal relationships with people (Browne & Courney., 2005). The World Health Organization (1996) reported that while difficult to quantify, estimates of the extent of family burden of those caring for a relative with schizophrenia range from 30% to 80% of families. Five-country European study indicated that the typical family, on average, spent six to nine hours a week providing support for their relative with schizophrenia. The United States, the mean hours spent by family members in care giving activities was 67 hours per month (Franks, 1990). These cultural differences in care giving may be related to legislation, centrality of the family, availability of mental health services, stigma, and external help-seeking beliefs (Kung, 2000). Families Helping Families, the(Schizophrenia Society of Canada ,2002,) offers a sad litany of how schizophrenia affects families: sorrow, anxiety, fear, shame, guilt, isolation, bitterness, ambivalence, anger, jealousy, depression, denial, and blame, pathological focus on the illness, marital discord, divorce, and desire to move away, sleeplessness, weight loss, social withdrawal, and search for explanations, increased substance abuse, and concern for the future. (Milliken., 2001). Also lists powerlessness, isolation, repressed anger, fatigue, and grief. Additional costs imposed on caregivers include: household expenditures, travel costs, and lost earnings (taking time off work or stopping work altogether to care for their relative) (Knapp et.al., 2004). The typical family

of a mentally ill person is often in chaos. Parents look frantically for answers that often can't be found; siblings flee. Hope turns to despair, and some families are destroyed no matter how hard they try to survive. (Schizophrenia Society of Canada, 2002).

❖ Stigma

The stigmatization of mental illness further complicates the difficulties and grief suffered by people with the illness and their families found that half of the families of recently hospitalized schizophrenia patients concealed hospitalization, and one patient's husband blocked his wife's hospitalization in denial of her illness. Despite empirical evidence that contradicts theories such as " schizophrenogenic mother, the double bind theory and marital skew and schism covert blame by society still falls on families and mothers of people with schizophrenia, who are often the main caregivers This blame leads to therapeutic misalliance with the physician, which creates conflict and mistrust, contributing to poor outcomes (Canavan., 2000).

❖ Medication:

The difficulty of predicting how an individual with schizophrenia will respond to medication is a desperate problem (Fleischhacker & Widschwendter, 2006). And this problem overlaps with the problem of medication non-adherence. Medication non-adherence so are as high as 70% to 80% among non-adhering patients tend to be younger, have shorter durations of illness, have an episodic course of illness, report side effects less frequently, make incorrect attributions to current positive symptoms more frequently, and have a more negative subjective response to medication. Interestingly, key relatives of non-adherent patients are most often employed, and therefore, less able to provide support. Some patients refuse to take medication, due perhaps to lack of insight, unpleasant side effects, an overly complicated medication regime, or the patient's preference for the benevolent voices in his or her head. Approximately 50% of outpatients and 20% of inpatients fail to take prescribed medication (Agawam, Sharma, Kishore Kumar, & Lowe, 1998).

Forty percent stop taking their medication within the first year following diagnosis, and by the two-year mark, the rate has climbed to 75% (WHO, 1996). (Tamminga., 2003). Dubbed antipsychotic medication as "mechanistic insight "and the phrase refers to the leverage that antipsychotic medication has over a lack of insight.

Without this leverage, the lack of insight is a major factor in relapse and hospitalization and is likely to be the most difficult problem associated with the illness (Coldham et al., 2002; Yen et al., 2005). Often, families are first to feel the brunt of the effect of their loved one's no adherence to medication.

❖ Behaviors :

Families often find their ill loved one's behavior to be embarrassing or bewildering. These feelings may arise from observing people with schizophrenia who look or dress "funny", talk to themselves (Barker, Lavender, & Morant, 2001) or engage in bizarre conduct like being naked in public . They may also be hostile (Barker et al., 2001) have poor hygiene and no longer respond to normal social cues. Family distress is often related to patients' apathy, inactivity, or failure to comply with social duties rather than with more psychotic or behavioral symptoms (WHO, 1996). However, the burden is closely linked to the extent of symptomatic behaviors of their family member with the illness. Families are more distressed by patient disorganization rather than negative symptoms in first episode psychosis (Adding ton et al., 2003). Cultural differences also exist (Salleh.,1994). Found that 41% of Malaysian families perceived hostility, violence, and disruption of family activities as the main sources of stress.

❖ Suicide :

Suicide is another chief concern for families (Torrey., 2001). Estimates that 10% of all patients with schizophrenia kill themselves, most commonly in the first five years of developing the illness (Healy et al.,2006). Suggest these estimates may be low given that as possible causes for the increase in suicide rates their findings point to increasing suicide rates for patients with schizophrenia. Their review suggests de-institutionalization and use/non-use of antipsychotic medication Suicide attempts are one of the best indicators of the risk of committing suicide (Rascon et al., 2004). Risk factors for people with schizophrenia include: previous suicide attempts, depression, hopelessness, substance abuse, male gender, and a young age (Kaneda, 2006). Incidence of suicide, the percentage of deaths from suicide was found to be significantly higher in males than females, but studies on suicide rates need refining to include differentiation of subtype of schizophrenia, age, inpatient versus outpatient, ethnic group, social class, education, marital status, and treatment (Lester, 2006). The profile of the schizophrenia patient most

likely to commit suicide is: young, male, white, has never married, has good pre-morbid function, has post-psychotic depression, and has a history of substance abuse and suicide attempts. Those at highest risk "have a remitting and lapsing course" and "poor response to medication", are "socially isolated, hopeless about the future, and have a gross discrepancy between their earlier achievements and their current level of function" (Torrey, 2001.,).

❖ Legal Issues :

Legal issues are a worry for families (Roesch& Golding, 1985; Teplin, 1984). Those suffering from a mental illness are more likely to be incarcerated than the general public.

While the crime rate for people with severe mental illness is higher than that of the general population (Swift., 2000). The lifetime prevalence of psychotic disorders was found to be as high as 29.3% among inmates in security units. In alcohol and drug treatment centers, this rate was 25.3% (Mandal., 2002). Offences committed by mental patients range from shoplifting, mischief, such as willful damage to property (Martin's Annual Criminal Code, 2004) and "dine and dash", to more serious crimes such as assault, arson, or murder (Health Canada.,1990). People with schizophrenia are more likely to be convicted of an offence involving violence (Wallace, Mullen, & Burgess, 2004).

❖ Financial Concerns

Finally, money is often poorly managed by mentally ill people, and the cost of subsidization is frequently foisted upon family members. Commonly living on a disability pension, people with the illness may spend all or most of their income on impulse purchases or bestow it upon friends, family members or strangers (Health Canada, 1999). Families are heavily burdened when supporting a loved one with schizophrenia yet paradoxically, the family plays a key role in stabilization of their family member with the illness (Kuipers, 2006; Rosenfarb, Bellack, Aziz, & Sayers, 2004).

❖ Conclusion

This Chapter has provided the rationale for the study and outlined the burden of care that impacts not only on society, but on the family as well. The stigma of the illness was examined along with the prevalence and impact of medication non-adherence,

behaviors, suicide, legal issues, and financial concerns, Finally. This chapter made a clear statement of the real problem and the practicality to better understand impact development.

’’To recover, you need to be in the driving seat. Other people can help you along your journey. But you need to be at the wheel! And make choices about where you want to go’’

2.3 Recovery:

The searcher opinion : Many of the skills required to manage their lives and their emotional distress can be acquired once people begin to believe in their own capacity to recover and to develop self-belief. Self-managed care may include a range of strategies including holistic remedies, spirituality, physical exercise, creativity and medication. We could see how to protect ourselves better and begin a kind of practice of natural protection. I am talking about the ordinary things people tend to do when they have a good life. I mean some of the things you may take for granted – like being kind to yourself, getting enough rest, some exercise , eating nutritious food, having little treats, having fun. These things is a kind of many of the skills required to manage their lives and their emotional distress can be acquired once people begin to believe in their own capacity to recover and to develop self-belief. Self-managed care may include a range of strategies including holistic remedies, spirituality, physical exercise, creativity and medication.

You may take for granted – like being kind to yourself, getting enough rest, some exercise, eating nutritious food, having little treats, having fun. What is extraordinary is that for many of us with a mental illness, seeing the importance of these things is a kind of revelation. They are something we have to learn how to do, and then do almost self-consciously until they become second nature so(W RAP) this is most scientific base that achieve these objective life . (Roberts &Wolfson,2004). Perhaps the most useful differentiation between cure and recovery is between the ideas of ‘recovery of the disorder in the person and the recovery of the person with or without the disorder recovery action plane help patient to manage their self that define as self-management is something we all do . It is whatever we do to make the most of our lives by coping with our difficulties and making the most of what we have applied specifically to people with a schizophrenia diagnosis It includes the ways we cope with, manage, minimize the ways of the condition

limits our lives, as well as what we do to thrive, feel happy and fulfilled to make the most of our lives despite the condition.(Martyn, 2002).

2.3.1 Mental Health Evaluation& Component

Community Mental Health Centers usually provide wide range of services which might be helpful to you?

The researcher shows that the needs of people with psychiatric symptoms differ from one person to another. Mental health centers often offer a variety of services to meet each person's needs.

I may have already used some of the following services to dealing with patient and may be interested in trying others. By to follow up I will see which services might be helpful to them? But most of them sometime are not available. In our region specially as developing country more over adding Israeli occupation might be increase the severability of situation. So these services must or must not help as we see. I Should tic assign as we shown.

- ✓ Case Management

  *Medicare.

  *It usually covers inpatient and outpatient bills as possible.

- ✓ Medicaid

If you have a low income (or no income) and have mental health problems that interfere in working full-time, you may be eligible for Medicaid, which is called Medicaid health insurance "Medical Assistance. In some states they usually cover inpatient and outpatient bills, and medication costs Depend on your work history and financial need. You may be eligible for Public Assistance & welfare programs.

- ✓ Individual therapy
- ✓ Group therapy

  *Social skills training

  *Family psych education and other family services

  *Support groups

* Recreational Therapy (R.T)

* Employment services

*financial benefits

Benefit programs are established to help members of our community when they are having financial difficulties.

- ✓ Case manager or social worker will also know of any recent changes in benefit programs.

*Become aware of your legal rights.

It's important to educate yourself about the laws against discrimination.

To combat stigma, it is important to know your legal rights and where to seek help if your rights have been violated. To fight stigma, you might decide to correct misinformation in other without disclosing personal experience.

It is important to fight self-stigma and educate yourself about mental disorders because it can make you feel discouraged and cause you to lose hope in your recovery.

Stigma refers to negative opinions and attitudes about mental illness.

- ✓ Social Security or affair.

*financial resources

- ✓ Supplemental Security Income

Public assistance" temporary assistance for family needs" or "welfare programs." If you have a low income and have mental health problems that interfere in working full-time programs to assist with the purchase of food, such as food stamps many states and communities help with housing costs.

2.3.2 Components of a Community Support System:

Three components are realistic and achievable. Next we talk about each component in more detail. Recovery means regaining mental health and achieving a better quality of life, Recovery is not just about medication or other therapies which deal directly with symptoms. These can be very important, especially for those who have experienced

serious mental illness, but mental health is built on much broader foundations. For any one individual the biggest step to recovery of mental health may be finding a great place to live, getting a job, establishing a good relationship with their family, meeting new friends or identifying a professional who can help them work through their problems. Usually there are a set of different things which are important to an individual's recovery.

People with serious mental illness will usually need support in order to make progress towards recovery. Some people have a higher level of need and require a lot of support – for example, people who have lived in hospital for some time – but this does not exclude them from achieving recovery.(www.hafal.org)

1. Commitment to Progress is the first component essential to recovery:

Recovery depends on actively taking steps to improve life. It is vital to agree and act upon a step-by-step, goal-focused plan. Too often planning concentrates on assessment: steps that need to be taken to achieve goal . A good plan needs to hold its focus on long-term goals but include the intermediary, less intimidating steps which allow person to take action.

2. Empowerment and self-management:

Empowerment and self-management together form the second essential component for recovery. Empowerment means exercising rights and responsibilities in making choices about life. Self-management means taking the actions required to lead a life based on those choices . Most people with a serious mental illness already exercise a significant amount of choice about their lives and take much of the action required to achieve recovery. For example, many people manage the administration of their medication.

3. "Whole Person Approach":

(Sometimes called a 'holistic' approach). This means addressing all key aspects of life which together contribute to well-being. By setting goals in all areas of life people can approach recovery more comprehensively. What the Whole Person Approach offers is methodical way of doing this. The Recovery Program encourages you to take a "Whole Person" approach, the following components of a Community Support Program. Whole Person Approach leads to far greater progress towards recovery. For example, some

symptoms such as negative thoughts and passivity are not only addressed by looking at direct medical or psychological treatments . They can be relieved by focusing on areas such as housing, social life or education. That's because our state of mind and mental health is affected by the way we live.(www.hafal.org© Hafal 2009)

2.3.3 These components are essential resources in recovery:

Treatment and support, Family and friends, Peer support, Meaningful work Income support, Community mobility, Community groups and organizations Protection and advocacy, Psychiatric rehabilitation, Leisure and recreation, Education, Housing and Health care Overcoming or managing the disease and living in a physically and emotionally healthy way. Start with the basics - medication, meals, sleep and exercise. Establishing routines for these basic health tasks are essential for recovery of function. The recovery as a multi-dimensional concept. Hope is the anchor point upon which recovery is based. Demonstrating respect for the consumer supports his or her hopefulness and nurtures the person's self-esteem. When people convey trust in the consumer, it strengthens the consumer's confidence and motivation to assume increased responsibility for taking control of one's own life. The eight factors listed are important antecedents for Recovery Hope Competence Respect Trust Understanding Wellness Choice Spirituality.

2.3.4 Introduction

Everyone has a past that involves situations which were good or bad. Whenever something happens that reminds me of one of the experiences, it triggers memories of that time. I react to the current situation the way I reacted to the original ones. (I may not even be aware of the original event.) Triggers can be internal (self-thoughts or emotions) or external (situations, events or what people do or say). In order to cope with triggers the person may abuse substances, have rages, withdraw from others, feel nervous or anxious, feel suspicious, or hear voices**. It is important to be able to identify my specific triggers in order to develop coping strategies to avoid relapsing. And Serious Mental illnesses that disrupt people's ability to carry out essential aspects of daily life such as self-care and household management.** Mental illnesses may also prevent people from forming stable relationships. This often results in pushing away caregivers, family and friends who may be the force keeping that person from becoming homeless and neglected. As a result of these factors and the stresses of living with a mental disorder in addition Poor mental

health may also affect physical health due to neglect taking the necessary precautions against disease. When combined with inadequate hygiene due to homelessness, this may lead to physical problems such as respiratory infections and skin diseases, also Some mentally ill people are drug abuse due to misused which can lead not only to addictions . All these bad impact lead to unemployment and difficult to obtain residential stability . So we should do hard to save mentally ill patients because they are human. This is can be achieve by recovery action plane beside the medication.

Recovery has only recently become a word used in relation to the experience of psychiatric symptoms. Those who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives, that the medications, if they (health care professionals) can find the right ones or the right combination, may help, and that they will always have to take the medications. Many of us have even been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness. Only by medication the patient can manage their illness but not for ever specially most of them are psychotic and need help from us so . There are new developing program as self-guidance, manage their life and keeping functioning well developing by Mary Copeland .She has previse experience with psychotic disease she has been learning that relaxation and stress reduction techniques and fun activities can help reduce the symptoms. She could have been learning that she would probably feel a lot better life without so hectic and chaotic, she spent more time with people who affirmed and validated her and that support from other people who have experienced these symptoms helps a lot. She was never told that she could learn how to relieve, reduce and even get rid of troubling feelings and perceptions. Perhaps if the patient had learned these things they would not have spent weeks, months and years experiencing extreme psychotic mood swings while doctors searched diligently to find effective medications.

Now the times have changed. Who have experienced these symptoms even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. I should learn the patient how we farebeating good parents. How to be warm relationships with our partners, parents, siblings, friends and colleagues. And climbing mountains, planting gardens, painting pictures, writing books, making quilts,

and creating positive change in the world. And it is only with this vision and belief for all people that we can bring hope for every one by assessing them to reach goal . Sometimes our health care professionals are reluctant to assist patient in this journey--afraid that they are setting their selves up for failure. But more and more of them are providing the patient with valuable assistance and support like me . I was talking about educating the people they work with, about providing temporary assistance and support for as long as is necessary during the hard times, about working with people to take responsibility for their own wellness, to explore with them the many options available to address their symptoms and issues and then send them on their way back to their loved ones and into the community.

SO People who experience psychiatric symptoms are no longer feel that they are sentenced to a life of chronic illness that interferes with their ability to work toward and reach their goals Instead, by using self-help skills and strategies that complement other treatment scenarios they are achieving levels of wellness, stability and recovery they always hoped were possible. This recovery information is being networked across the country by Mary Ellen and an ever-growing number of recovery educators, through self-help publications, seminars, workshops, presentations, support groups and the internet.

2.3.5 Recovery action plane

The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings" (Deegan, 1996). The simple fact that this statement was made in a recent publication indicates the extent of the belief that people with mental illness which do not recover will always remain a burden on society and must be "taken care of" rather than encouraged to become independent contributing members of society. It also indicates the extent of the need for the systematic and extensive study of how people become well and how they stay well in spite of, and perhaps because of, the barriers they face. In the early 1980's, the term recovery seldom appeared in articles or concept papers. For example, Houghton's(1982). Personal account was titled "Maintaining Mental Health in a Turbulent World," and Leete's (1989) was called "How I Perceive and Manage My Illness. Although it is a study of how consumers view their struggle and how they define wellbeing in the late 1980's and early 1990's, the word recovery was introduced in consumer writing by Deegan (1988) in "Recovery: "Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the1990's. I would like to suggest that the decade of the **1990** also be known as the

"**Decade of Recovery."** I believe that by more widespread use of our existing techniques and settings, grounded as they are in our current community support and rehabilitation philosophy, many more people with psychiatric disabilities can recover than currently do.

Mary Ellen Copeland is an author, educator and mental health recovery advocate who have also experienced mental illness. She specializes in the successful self-management of psychiatric symptoms. Her work is based on her intensive nationwide studies of thousands of people who have psychiatric symptoms and on her own personal struggle with manic depression - rising from total incapacitation to enjoying a rich and rewarding life.

The Wellness Recovery Action Plan (WRAP) was developed by Mary Ellen Copeland in 1997 with group of people who were having a hard time with severe and troubling symptoms and behaviors to the point they spent much time in hospital and day treatment programs. They spent several days working together to formulate this plan, and it has been used by hundreds of people since its inception. WRAP is a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility and improve quality of life. The self-designed plan teaches you how to keep yourself well to identify and monitor your symptoms and to use simple, safe, personal skills, supports, and strategies to relieve these symptoms. WRAP can be used along with any other treatment scenario that you have chosen for yourself. (Copeland.,2002)

The researcher thinks that recovery defined as, like prevention and cure, must take its rightful place as our vision in this decade. For example People with severe physical disabilities, such as spinal cord injury, or flue ,spinal cord injury can recover even though the spinal cord has not. Likewise, people with severe psychiatric disabilities can recover even though they still may experience symptom exacerbations.

2.3.6 Definition of recovery

Another definition of recovery . Recovery is an ongoing process of growth, discovery, and change" The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability The aspiration is to live, work, and love in a community in which one makes a significant contribution" (Deegan, 1988) person with mental illness can recover even though the illness is not cured [Recovery] is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness (Anthony, 1993). Also having

some hope is crucial to recovery; none of us would strive if we believed it a futile effort. I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned eachother (Leete, 1989). It involves hope, courage, adaptation, coping, self-esteem, and confidence, a sense of control or free will (Blanch et al., 1993).

Other researcher disagree with opinion for recovery . It has long been assumed that people with severe mental illness do not recover, leading to low expectations which have been seen to erode hope and collude with chronicity (Harrison and Mason, 1993).

(Stocks., 1995).“Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. At times our course is erratic and we falter, slide back, regroup and start again.

But other was differ view Recovery includes personal empowerment and a spirituality philosophy, which gives meaning to life. It is accomplished one step at a time. It is deeply personal, and can be done only by the individual who is recovering (Beale &Lambric, 1995). The same authors also identified two phases through which patients go toward their recovery from a psychotic episode: (1) convalescence–getting over the experience of the psychotic episode–and (2) rebuilding–putting one’s life back together, making plans for a new life and beginning an identity shift to being an “ex-mental patient (DeMasi& colleagues, 1996). Defined the recovery from another hand developed a model based on their review of the literature that explains recovery in terms of three areas of well-being: health (both physical and mental health), psychological (self-esteem, hope, coping and confidence) and social (economic and interpersonal quality of life). Otherwise Recovery is possible through a combination of supports needed to (re)establish a major social role and the self-management skills needed to take control of the major decisions affecting one’s life. This combination of social supports and self-management helps the person regain membership in society and regain the sense of being a whole person (Fisher & Ahern, 1999,).

A recovery paradigm is each person’s unique experience of his road to recovery. My recovery paradigm included my re-connection which included the following four key ingredients: connection, safety, hope, and acknowledgment of my spiritual

Self-Surveys of 71 consumers in Ohio and 180 in Maine were used to rate ten items of importance in their recovery (Ralph, 2000a). The top four responses were:

- The ability to have hope,,,,,! Trusting my own thoughts,,
- Enjoying the environment……! Feeling alert and alive

(Smith 2000). Interviewed 10 volunteers from a consumer operated service, and found the following major themes:! Right kinds of medication! A group of supportive people

- Meaningful activities! A sense of control and independence
- A strong determination to maintain recovery
- A positive outlook on the present! Optimism about the future

"Recovery is a journey as much as a destination.. It is different for everyone. For some people with mental illness recovery is a road they travel on once or twice to a destination that is easy to find. For others recovery is more like a maze with an elusive destination, a maze that takes a lifetime to navigate".

N.Z. Mental Health Commission Recovery Competencies (2001)

(Roberts, 2004). Points out that this definition implies that a person with mental illness can recover even though the illness is not cured and that the process of recovery can proceed in the presence of continuing symptoms and disability.

In my opinion I defined recovery, like prevention and cure, must take its rightful place as our vision in this decade, for example People with severe physical disabilities, such as spinal cord injury, can recover even though the spinal cord has not. Likewise, people with severe psychiatric disabilities can recover even though they still may experience symptom exacerbations. "Recovery from mental illness is not like recovery from the flu. It's recovering your life and your identity . Recovery for me is having good relationships and feeling connected. It's being able to enjoy my life . Being more independent is an important part of my recovery process.

2.3.7 Goals

To teach participants recovery, self-management skills and strategies for dealing with psychiatric symptoms so as to:

- Promote higher levels of wellness, stability and quality of life
- Decrease the need for costly, invasive therapies
- Decrease the incidence of severe symptoms
- Decrease traumatic life events caused by severe symptoms
- Increase understanding of these illnesses and decrease stigma
- Raise participants' level of hope and encourage their actively working toward wellness, as outlined in the model developed by Mary Ellen Copeland in coordination with other people who have experienced psychiatric symptoms, health care professionals and several related organizations.
- Increase participants' sense of personal responsibility and empowerment

2.3.8 Objectives

- Hope, Personal Responsibility, Self-Advocacy, Education, Support
- Accessing good health care and managing medications
- Self-monitoring using WRAP: A Wellness Recovery Action Plan (an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness)
- Changing negative thought Patterns to Positive
- Building A Lifestyle That Promotes Wellness
- Expected Long Term Outcomes From a Recovery/Self-Management Focus
- A shift of focus in mental health care from symptom control to prevention and recovery.
- Significant reduction in the need for costly mental health and emergency services as people who experience psychiatric symptoms effectively take responsibility for their own wellness and stability, manage and reduce their symptoms using a variety of self-help techniques, and effectively reach out for and use the support of a network of family members, friends and health care professionals.
- Increased ability to meet life and vocational goals, significant life enhancement and gains in self-esteem and self-confidence as people become contributing members of the community ,uncomfortable and distressing feelings and behaviors and identify your best course of action. WRAP planning also includes Crisis

Planning (an Advance Directive) that lets others know how you want them to respond when you cannot make decisions, take care of yourself or keep yourself safe and a Post Crisis plan to guide you through the often difficult time when you are healing from a crisis.(www.wrapandrecoverybooks.com)

2.3.9 Key elements of WRAP:

- Wellness Toolbox
- Daily Maintenance Plan
- Identifying Triggers and an Action Plan
- Identifying Early Warning Signs and an Action Plan
- Identifying When Things Are Breaking Down and an Action Plan
- Crisis Planning
- Post Crisis Planning.(www.mentalhealthrecovery.com)

2.3.10 Dimensions of recovery

- **Internal factors:** factors that are within the consumer, such as awareness of the toll the illness has taken, recognition of the need to change, insight about how change can begin and determination to recover. Recovery refers both to internal conditions the attitudes, experiences and process of change of individuals. Internal conditions include hope, healing, empowerment, and connection . Self-managed care: an extension of the internal factors in which consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face;
- **External factors**: include interconnectedness with others; the supports provided by family, friends and professionals and having people who believe that they can cope with and recover from their mental illness; and external conditions include human rights, a positive culture of healing, and recovery-oriented services. Empowerment: a combination of internal and external factors–where the internal strength is combined with interconnectedness to provide the self-help, advocacy, and caring about what happens to ourselves and to others" (Ralph, 2000).

2.3.11 The key facets of a recovery scenario

1. **Hope**: There is a vision of hope that includes no limits. That even when someone says to us, "you can't do that because you've had or have those symptoms, dear!". We know it's not true only when we feel and believe that we are fragile and out of control that we find it hard to move ahead. Those who experience psychiatric symptoms can and do get well . We don't need dire predictions about the course of our symptoms--something which no one else, regardless of their credentials can ever know. We need assistance, encouragement and support as we work to relieve these symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of. Too many people have internalized the messages that there is no hope that they are simply victims to their illness. We feel valued we can offer as well as receive our self-definitions are expanded. We try out behaviors with each other, find ways in which we can take positive risks and find that we have more self-knowledge and more to offer than we were led to believe.
2. **Responsibility:** It's up to each individual to take responsibility for their own wellness. There is no one else who can do this for us. When our perspective changes from reaching out to be saved to one in which we work to heal ourselves and our relationships, the pace of our recovery increases dramatically.
3. **Education**: Education is a process that must accompany us on this journey. We search for sources of information that will help us to figure out what will work for us and the steps we need to take in our own behalf. Many of us would like health care professionals to play a key role in this educational process--directing us to helpful resources, setting up educational workshops and seminars, working with us to understand information and helping us to find a course that resonates with our wishes and beliefs.
4. **Supports**: Mutual relationship and supports is a necessary component of the journey to wellness. The nationwide focus on peer support is a result of the recognition of the role of support in working toward recovery. Throughout New Hampshire, peer support centers are providing a safe community where people can go even when their symptoms are most severe and feel safe and secure of feeling out of control and pathologies, peers support one another in moving through and

beyond difficult situations and help each other learn how crisis can be an opportunity for growth and change.

5. **Advocate**: Each of us must advocate for ourselves to get what we want, need and deserve. Often people who have experienced psychiatric symptoms have the mistaken belief that we have lost our rights as an individual. As a result, our rights are often violated, and these violations are consistently overlooked. Self-advocacy becomes much easier as we repair our self-esteem so damaged by years of chronic instability--and come to understand that we are often as intelligent as anyone else, and always as worthwhile and unique with special gifts to offer the world--and that we deserve all the very best that life has to offer. It is also much easier if we are supported by health care professionals, family members and supporters as we reach out to get our personal needs met All people grow through taking positive risks. We need to support people in building their own crisis and treatment plans, accessing information around medication side effects, refusing any treatment, (particularly those treatments that are potentially hazardous), choosing their own relationships and spiritual practices, being treated with dignity. (Maryellen Copeland,2000).

2.3.12 The role of medication in the recovery scenario.

The researcher not dismissing the importance of maintenance medication and any other treatment options ; but I am saying that the WRAP program is designed by you in practical, day-to-day terms and holds the key to getting and staying well. It does not necessarily replace traditional treatments and can be used as a compliment to any other treatment options you have chosen in developing your own WRAP . You'll identify the wellness tools that will most benefit you and will learn how to use these tools when needed every day or when you have particular feelings or experiences. From the other hand . Researcher shows that many people feel that medications can be helpful in slowing down the most difficult symptoms. While in the past, medications have been seen as the only rational option for reducing psychiatric symptoms. In the recovery scenario, medications are one of many options and choices for reducing symptoms. Others include the recovery skills, strategies and techniques. Though medications are certainly a choice, I believe that medication compliance as the primary goal is not appropriate. People who experience psychiatric symptoms have a hard time dealing with the side effects of medications designed to reduce these symptoms-- side effects like obesity, lack of sexual function, dry mouth, constipation, extreme lethargy and fatigue. In addition, they fear

the long term side effects of the medications those who experience these symptoms. Know that many of the medications we are taking have been on the market for a short time--so short that no one really knows the long term side effects. As tar dive's Dyskinesia was not recognized as a side effect of narcoleptic medication for many years. Irreversible and destructive side effects. They fear that they are at risk of similar irreversible and destructive side effects. We want to be respected by health care professionals for having these fears and for choosing not to use medications that are compromising the quality of our lives. And during people who have shared similar experiences get together, they begin to talk about their concerns about medications, and alternatives that have been helpful. But many physicians, on the other hand, worry that people who come to them blame the medication for the illness and they fear that stopping the medication which worsen symptoms they will be threatened with involuntary hospitalization . They will lead out of control symptoms, in a recovery based environment more effort needs to be spent focusing on choice and self-responsibility around behavior. If the complaint is that medications control behavior and thoughts while extinguishing all pleasurable, motivational kinds of feelings, is a need to develop a way we talk about symptoms so that each of us has many choices and options for dealing with them.

More clinicians working in a recovery-based environment will enjoy the positive reinforcement of successful experiences in working with people who are growing, changing and moving on with their lives. The recovery focus and the increased wellness of more of us will give healthcare professionals more time to spend with those who experience the most severe and persistent symptoms, giving them the intense support they need to achieve the highest levels of wellness possible. In addition, health care professionals will find that instead of providing direct care for people who experience psychiatric symptoms, they will be educating, assisting and learning from them as they make decisions and take positive action in their own behalf. These caregivers will find themselves in the rewarding position of accompanying those of us who experience psychiatric symptoms as we grow, learning and change. Wellness is for each of us on an individual basis and explores how to address and relieve those symptoms which prevent us from leading full and rich lives. Also benefits of a recovery vision include: Cost effectiveness. As we learn safe ways to interventions and therapies we will live and work interdependently in the community, supporting ourselves and our family members reduce and eliminate our symptoms . There will be less need for costly, invasive interventions

and therapies we will live and work interdependently in the community, supporting ourselves and our family members reduced need for hospitalization as we learn to manage our symptoms using normal activities and supports. We can do more and more things we want to do without lives, and work toward and meet our life goals and dreams. As we normalize people's feelings and symptoms, we build a more accepting, diverse culture

Literature Review

literature Review

Introduction

In this part the researcher will view literature reviews; the studies that concern the effectiveness of recovery action plan on schizophrenic patients:

2.4 Previous studies

- **The purpose of this study was to test the efficacy of a peer-led, mental illness education intervention called Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES)**

Method: Subjects were recruited from outpatient community mental health settings in eight Tennessee communities. Using a single-blind, randomized controlled trial design, 428 individuals with serious mental illness (SMI) were interviewed at baseline and assigned to BRIDGES or to services as usual wait list control condition. Two-and-one-half hour classes were taught once a week for 8 weeks by peers who were certified BRIDGES instructors.

Subjects were followed-up at immediate post-intervention and 6-months later. The primary outcome was self-perceived recovery, measured by the Recovery Assessment Scale (RAS). A secondary outcome was hopefulness as assessed by the State Hope Scale (SHS). An exploratory hypothesis examined the impact of depressive symptoms on both recovery outcomes.

Results: Eighty six percent of participants were followed up. On average, participants attended five sessions. Intent-to-treat analysis using mixed-effects random regression found that, compared to controls, intervention participants reported: 1) significantly greater improvement in total RAS scores as well as subscales measuring personal confidence and tolerable symptoms; and 2) significantly greater improvement in hopefulness as assessed by the agency subscale of the SHS. While study subjects with high levels of depressive symptoms had significantly poorer outcomes. Outcomes were superior for BRIDGES participants regardless of depressive symptoms Conclusions: Peer-led mental illness education improves participants' self-perceived recovery and hopefulness over time, even controlling for severity of depressive symptoms.(Schizophrenia Res. 2012).

❖ **This study conducted by Cooke et al., (2011) .**

The purpose of this study was to determine the efficacy of a peer-led illness self-management intervention called Wellness Recovery Action Planning (WRAP) by comparing it with usual care.

Sample A total of 519 adults with severe and persistent mental illness were recruited from outpatient community mental health settings in 6 Ohio communities and randomly assigned to the 8-week intervention or a wait-list control condition. Outcomes were assessed at end of treatment and at 6-month follow -up using an intent-to-treat mixed-effects random regression analysis. Compared to controls at immediate post intervention and at 6-month follow-up, WRAP participants reported: tools were used Brief Symptom Inventory Global Symptom, Hope Scale, World Health Organization Quality ,and BREF environment subscale.

Result:(1) significantly greater reduction over time in Brief Symptom Inventory Global Symptom Severity and Positive Symptom Total, (2) significantly greater improvement over time in hopefulness as assessed by the Hope Scale total score and subscale for goal directed hopefulness, and (3) enhanced improvement over time in QOL as assessed by the World Health Organization Quality of Life-BREF environment subscale. These results indicate that peer-delivered mental illness self-management training reduces psychiatric symptoms, enhances participants' hopefulness, and improves their QOL over time. This confirms the importance of peer-led wellness management interventions, such as WRAP as part of a group of evidence-based recovery-oriented services.

❖ **This study conducted by Jessica et al.,(2011)**

The main aim of this study to evaluate successful illness self-management for people with serious mental illnesses is the ability to advocate for themselves in health and rehabilitation settings.

This study reports findings from a randomized controlled trial comparing for patient self-advocacy among intervention group who received a peer-led mental illness self-management intervention called Wellness Recovery Action Planning (WRAP) and control group those who received usual care. Outcomes were self-reported engagement in self-advocacy with service providers, and the relationship between patient self-advocacy

and other key recovery outcomes. In a multivariable analysis, at immediate post-intervention and 6-month follow-up, WRAP participants were significantly more likely than controls to report engaging in self-advocacy with their service providers. Higher self-advocacy also was associated with greater hopefulness, better environmental quality of life, and fewer psychiatric symptoms among the intervention group.

- **This study conducted by Starnino et al., (2010)**

The aim of this preliminary study was to examine the impact of participation in an illness self-management recovery program (Wellness Recovery Action Planning-WRAP) on the ability of individuals with severe mental illnesses to achieve key recovery related outcomes.

Sample: A total of 30 participants from three mental health centers were followed immediately before and after engaging in a 12-week WRAP program.

Result: Three paired sample t-tests were conducted to determine the effectiveness of WRAP on hope, recovery orientation, and level of symptoms. A significant positive time effect was found for hope and recovery orientation. Participants showed improvement in symptoms, but the change was slightly below statistical significance.

- **The purpose of this analysis: To evaluate the two of statewide initiatives in Vermont and Minnesota in which self-management outcomes of Medication and Psychosocial Treatments among mental illness**.

using Wellness Recovery Action Planning (WRAP).Total sample 381 participants (no)147 in Vermont and 234 in Minnesota) Pre-post comparisons survey instrument that assessed three dimensions of self-management: 1) attitudes, such as hope for recovery and responsibility for one's own wellness; 2) knowledge, regarding topics such as early warning signs of decompensating and symptom triggers; and 3) skills, such as identification of a social support network and use of wellness tools.

Results: Significant positive changes in self-management attitudes, skills and behaviors were observed on 76% of items completed by Vermont participants (13 of 17 survey items), and 85% of items completed by Minnesota participants (11 of 13 items). In both states, participants reported significant increases in: 1) their hopefulness for their own recovery; 2) awareness of their own early warning signs of decompensating; 3)

use of wellness tools in their daily routine; 4) awareness of their own symptom triggers; 5) having a crisis plan in place; 6) having a plan for dealing with symptoms; 7) having a social support system; and 8) ability to take responsibility for their own wellness.(Psychiatric Rehabilitation Journal, Vole 34(2), 2010, 113-120)

- **(Cook et al., 2009)The main Objective. Of This study: To examine changes in psychosocial outcomes among participants in what is called Wellness Recovery Action Planning.**

Sample. Eighty individuals with severe mental illness at 5 Ohio sites completed telephone interviews at study baseline and one month following the intervention Paired t-tests of pre- and post-intervention scores. (WRAP). An 8- week, peer-led, mental illness self-management intervention.

Results. Revealed significant improvement in self-reported symptoms, recovery, hopefulness, self-advocacy, and physical health; empowerment decreased significantly and no significant changes were observed in social support. Those attending six or more sessions showed greater improvement than those attending fewer classes.

- **The primary purpose of this study : was to evaluate the statewide implementation of the illness management and recovery program, a curriculum-based intervention for adults with severe mental illnesses.**

Sample assessed for 324 consumers with severe mental illness. Using knowledge gained from the National Evidence-Based Practices Project, the mental health center of Indiana assisted seven community mental health centers with implementation of the illness management and recovery program. Implementation was conducted by trainers, who provided in-depth skills training, ongoing monitoring and supervision, and consultation as needed. At six and 12 months, the tool assessed by use of the Illness Management and Recovery Fidelity Scale Hope Scale and the Satisfaction With Services Scale, respectively.

Result:The illness management and recovery program was successfully implemented at six of seven sites; five sites achieved high fidelity by 12 months and the sixth by 24 months. Self-reports of consumers and clinicians indicated significant changes in illness self-management. Consumers reported increased hope but no changes in satisfaction with service . Psychiatry Serv. 2009 Apr;60(4):483-90. doi: 10.1176/appi.ps.60.4.483.

- **Hunan et al., (2005-2007)**

The aim of the study evaluated this combination of therapies with early-stage schizophrenia treated from Jan. 1, 2005, through Oct. 31, 2007..A Total sample1,268 patients of 633 were randomly assigned to receive pharmacotherapy plus a psychosocial intervention involving 48 one-hour group sessions. The other 635 patients received medication alone. The intervention included four evidence-based practices: psych education (instruction for families and caregivers about mental illness), family intervention (teaching coping and socializing skills), skills training and cognitive behavioral therapy.

Result :The risk of relapse was lower among patients in the combination group, occurring in 14.6 percent of patients in that group and 22.5 percent of patients in the medication-only group. The combined treatment group also exhibited greater improvements in insight, social functioning, activities of daily living and on four domains of quality of life, and a significantly higher proportion of them were employed or received education. There were no significant differences in either frequency or type of adverse events between the groups. “"

- **This study evaluated the effectiveness of the Illness Management and Recovery program implemented in a group format**.

A sample of 210 persons with a severe mental illness receiving treatment at rehabilitation centers in the community in Israel were randomly assigned to either the Illness Management and Recovery program compared with those receiving treatment as usual . The Illness Management and Recovery Scale (client and clinician versions) and measures of coping and social support were administered to participants before and after the intervention.

Results: Participants in the Illness Management and Recovery program showed significant improvement in knowledge about their illness and progress toward their personal goals compared with those receiving treatment as usual. Clinician ratings also indicated significant improvement in overall outcome for clients in the Illness Management and Recovery program compared with those who received treatment as usual. Significant improvement in coping was found in both groups, and no change in social support was found for either group. PSYCHIATRIC SERVICES volume: 58 ,2007

❖ **This study conducted by Copeland .,(2005).**

The aim of this study examined the effects of WRAP participation on psychiatric symptoms, hope, and recovery outcomes for people with severe and persistent mental illness

Quasi-experimental study, with an experimental comparison groups (n=58) and control group (n=56) experimental was conducted. WRAP sessions (8-12 week) at five community mental health centers in a Midwestern state. Scale that use : The Modified Colorado Symptom Index, the State Hope Scale, and the Recovery Markers Questionnaire (RMQ) were employed at the first and last WRAP sessions, as well as six months following the intervention. Repeated measures analysis of covariance and planned comparisons before and after the intervention were conducted

Result conducted by researcher I s Findings revealed statistically significant group intervention effects for symptoms and hope, but not for RMQ. Planned comparisons showed statistically significant improvements for the experimental group in psychiatric symptoms and hope after the intervention, while non-significant changes occurred in the comparison group.

❖ **This study conducted by (Buffington, 2003).**

The aim of this study is to examine the results of 42 WRAP cycles between 2002 and 2003. A total of 305 mental health consumers participated, and 234 of these completed pre-tests and post-tests for a 77% response rate Two-tailed tests of differences in proportions revealed that following the training,.

Result: significantly greater percentages of participants self-reported having hope for recovery, taking responsibility for their own wellness, having a support system in place, managing their medications well, having a list of things to do every day, being aware of their symptom triggers, awareness of their early warning signs of psychosis, having a plan to deal with prodromal symptoms, having developed a crisis plan, having a lifestyle that promotes recovery and finding it easy to engage in recovery promoting activities. Of the 234 respondents, 140 or 44% responded to a follow-up survey posttest conducted 90 days after the end of WRAP training. All of these respondents (100%) reported feeling more hopeful about their recovery and 93% (n=130) said they had encouraged other consumers to participate in WRAP training .

❖ **This study conducted by (Bullock &colleagues.,(2000).**

This study is to evaluate The Consumer Leadership Education Program (LEP)that prepares mental health consumers for leadership positions on community agency boards and committees . The intervention was a 16-week psych educational program The LEP was designed in a participatory process with a. sample 10 mental health consumers, tool using the Recovery Attitude Questionnaire scale information from consumer interviews, and focus groups in addition, qualitative as well as quantitative data were gathered to assist in understanding the change processes. Evaluation of the LEP, used wait-list groups as control groups and conducted pre post- and six-month follow-up assessments. Comparison with control groups, trainees.

Result: showed significant improvement on measures of consumer-rated symptoms, self-efficacy, empowerment and community living skills. Training participants reported significant improvement in their (1) ability to control negative and social symptoms of illness, social relationships, (3) personal care and vocational skills and (4) personal power. There was also a trend toward improvement in overall attitude about recovery.

2.4.1 This Summarizing in previous study

Several studies of peer-led recovery education interventions for this group suggest that they increase participants' knowledge of the causes and treatment of mental illness, enhance feelings of empowerment, and improve quality of life , managing symptom . A single group, 80 individual , pre-post evaluation of a 8 week WRAP program &1-month following intervention curriculum of advocacy, recovery, taught by trained peer instructors found significant improvement positive impacts on hopefulness & no significant change were observed in social support but improve in self-report symptom , empowerment, and opportunities of recovery (cook etal.,2009). Otherwise A one-group 519, six month pre-post evaluation of a 8 -week,-focused recovery education intervention called peer led illness self-management mental illness. WRAP Recovery action plan (cook etal.,2011). Found significant greater reduction symptom severity, greater improvement over time in hopefulness & QOL found that compared to controls, intervention participants showed significant improvement in empowerment, hopefulness, and personal recovery**.** Moreover among other participants with SMI (Jessicatal.,2011). A randomized controlled trial evaluated successful illness self-management in ability to advocate for them self-education program' case control design by comparing usual care . Pre- posttest 6 month follow up WRAP participant were significant more likely than control group report engaging self-advocacy with greater hopefulness bitter QOL fewer psychiatric . Furthermore, recovery among 30 find visuals with schizophrenia 12week intervention pre post study applied to examine the impact of participant in WRAP on ability of individual with SMI to achieve key recovery related outcome(starnino etal .,2010). Found that significant positive time effect was found for hope and recovery orientation improvement in symptom but the change was slightly below significant statisticians. Also Studies of 334 consumer with SMI participant in relation focused recovery intervention using knowledge consultation and providing training at six of seven site , 5 site achieve high fidelity by 12 month and sixth by 24 month self-report of consumer indicate significant change in illness self-management report increase in hope but no change in satisfaction with serves(Psychiatry Serv. 2009).

(Buffington.,2003) . Different result from other colleagues, was beautiful and ideal study because there was more explanation and more important outcome examined multiple domain and aspects of (WRAP). First: long period of WRAP cycle of 42 sessions 305

participant response rate of attendance were 234 pre posttest. Found Significant greater percentages of participant self-report having hope for recovery take responsibility having support system, managing their medication, having a list of thing to do every days, having aware of symptom and trigger more aware of early warning sign, having a plan to deal with symptom and having developed crisis plan developed a life style that promote activities . Also evaluate self-management outcome of medication and psychosocial treatment on mental illness among 381 patient pre posttest used assess three domain hope, responsibility ,knowledge skill training participant reported significant increase in their hopefulness for own their recovery , awareness in own early warning signs by using wellness tool having a crisis plane, having social support system , ability to take responsibility.(Psychiatric Rehabilitation Journal, 2010). (Hunanet al.,2005-2007). Evaluated combination of therapies with early stage of schizophrenia sample of 1268 patient case control design first group has medication only , second group have combination therapy pharmacotherapy plus psychosocial treatment with 48 hour session. This is differs approach by using psych education family intervention ,skill training , cognitive behavior therapy combination treatment found exhibited greater improvement in insight , social function activity of daily living , QOL significant higher proportion of them were employed and received education , replace was lower among patient combination therapy group about14.6% but 22% on medical only group. There is no significant in their frequency or type of adverse event between the group .recovery for interpretation

2.4.2 These different outcome related to.

Regional variations in WRAP implementation and outcomes. Caveat concerns the design of the study using a wait-list control condition. Differ methodology selection in hospital outpatient community based institutional residential area, differ tools and variation in sample numbers, variation in duration of program vary in program duration might have revealed different findings than those attained at the end of the different time week , months. Years.

2.4.3 conclusion

Welling recovery action plane (WRAP) proved that a scientific base practice Education program about mental illness self-management is fundamental for promoting recovery from serious mental illness (SMI). Growing out of the recent focus on patient-centered care as a means of enhancing health care quality self-management education provides people

with the knowledge, skills, and supports their need to live independently, self-direct their care, led self-management programs controlling severity of symptom, offer the additional advantage of providing role models for wellness and instilling hope for recovery more recent is the development of education programs created and taught by peers who are also recovering from SMI .

2.4.4 Comment on the previous studies

The researcher will discuss previous studies of the effectiveness of led self-management program (WRAP) on patient out come with key concept of recovery and another independent variables with severe mental illness as schizophrenic patient ; the first one is tools used in these studies, the second is samples of the studies, and the third about the results of the previous studies, as the following:

2.4.5 Tools of the previous studies

Most of previous studies are followed one strategies for self-management &-education program to improve mental health .This was showed in focused program (WRAP). But other author's used another approach as showed in study of tooth et al., (1997) program was ,person constructive theory .And leader ship education program in study of Bullock & colleagues (2000).Illness management and recovery program.

2.4.6 Tools that used

Majority of previous studies were used quantitative as well as qualitative data questioners included different internationals tools, and focusing group also used the most common international tools that used in the previous studies were questioner as hope scale to evaluation hope for recovery, WHOQOL scale to evaluate daily living and social relation and friend relative. But additional tools were used as recovery marker questionnaire(RMQ) , modified Colorado symptom index scale to determine severity of symptom . These tools showed in study of Copeland.,(2005). Another famous international tool which used in the studies was Brief symptom inventory global symptom scale to assess level of symptom. This was shown in studies of cook etal.,(2011). Also some of the previous studies used other scales to evaluate the attitudes about recovery from mental ill that was attitudes questionnaire and other form that appears in interviewing by focusing group. This study is for ,**Bollock &** colleagues (2000). In addition to the previous scales most of the studies used questionnaires about socio-demographic characteristics and schizophrenic related variables such as age of onset, duration of the disease, marital status residential

aria, level of education, economic statues.in spite of few studies , sample and age of subject not clear.

2.4.7 Study design.

The majority of studies used experimental design case control design study pre posttest one group as shown in study of (cook etal.,2009). and other study use to compare between two groups as shown in(cook etal.,2011). Posttest only was applied but conducted comparison case control . and used post posttest by six month follow up to evaluate more outcome result case control shown in study. (Copeland ., 2005).

2.4.8 Sample of the previous studies

the study samples were ranged between 10 members Bullock& colleagues (2000) ,starninoet al., (2010) to 30 person, cook et al .,(2009).80 participant and tooth et al .,(1997)60 subject were sheared in the study.

However, the medium samples shown in the study of Copeland .(2005) as shown 114 persons & other study the participant were 305 patient Buffington(2003) & in the study Cook et al., (2011) subject were519.

While some studies have large samples as studies of (Hunan et al.,2005-2007) total sample was 1268 participant .And other studies sample was not clear as shown in studies of Jessica et al.,(2011).

2.4.9 Researcher comment

From researcher opinion in spite of good improvement in some aspect of life and good management . The Illness Management and Recovery program research on WRAP and other peer-led programs can point us to the active ingredients in this type of intervention, and thereby inform the development of new ways for peers to promote self-determination and social participation also was effective in increasing clients' knowledge of their illness and helping them make progress toward personal goals .Managing symptom creates plane for triggers and crisis this is very beautiful aspect and scientific approach that make patient with severe mental ill feeling more alive and more humanistic as others. According to the European society they live with complete welling and advanced health, recreational life, all aspect of their life is preserved supplies. But according to our environment may be more differ from other culture. Insufficient in major dimensions that support a life in recovery's living in a physically and emotionally healthy way" a job, school, volunteerism, family caretaking or creative endeavors, the independence,

income and resources, have to participate in society. Community' means relationships and social networks that provide support, friendship, love and hope. "All these resources are non-available in our society . Because we are occupied from Israeli occupation and our situation fluctuated from time to time , we faced stressors every days . Bad economic status, crowded aria, decrease in social affair Medicaid , increase of rate of unemployment so mild ratio of patient functions socially, but may still display some clinical signs. This is with patient who have living highly level with all aspect of life. There is multiple factors that play certain role in delayed of level of recovery researcher **say that** with so sorry &I hope of my God and wishes my end result be more optimized believe that may be succeed by some aspect of recovery that is support systems because we are living in extending family close relative with others. This is our Islamic attitudes and our religious and another aspect spiritual side Spirituality it includes feeling more connected to one's self, to other people, to our community, and to God, Nature, or Life in general and close relation with our G od this had a certain and important role for reaching recovery road & Empower. We should motivate people to work toward their personal recovery and wellness moving toward their life goals and living the lives they want to live Doing enjoyable, cheerful, fun and creative things that helps you to be more open to the possibilities of life and helps you feel more hopeful about your future!

Chapter Three

Methodology

Introductions

This chapter deals with the research procedures followed by the researcher to answer the study questions and test it's hypothesis and then talk about the research methodology used in the study, a description of the population, the research sample, the method selected, the statement of building study tool, extract sincerity, reliability, consistency of internal and Intervention design and control variables, also contains chapter on how to implement and conduct of the study, and statistical treatment used in the data analysis.

3.1 Study design

Qusi experimental ,pre & post design used in this study to know related different effectiveness of recovery between two group. WRAP participant with usual care and comparing with control group with usual care only.

3.2 Data Collection

Data about the impact of the Recovery and WRAP facilitation programs were collected using pre and post course questionnaires. Questionnaires were completed by participants prior to starting the education program (pre-course) and immediately after completion (post-course).A follow-up in the form of a series of focus group interviews with a sample of the participants of the last day of program was also held. The information gathered in these questionnaires revolves around opinions on and knowledge of Recovery from mental health problems opinion on all aspect of dealing with recovery. In the post-course questionnaire there was an added section on facilitation skills, perceived utility of the course and an overall satisfaction rating.

3.3 Population

1) All chronic females schizophrenic patients in west Gaza city who are receiving treatment from west Gaza clinic in Gaza city, and numbered (100).

3.4 Sample and sampling

The study sample consisted of two samples :case group & control group.

- **Pilot Study:** where the measure was applied to 10 patients of schizophrenia patients in (a) for the purpose of ensuring the validity of the research and study tool used to calculate the validity and reliability.

By convenience sample according my criteria and GAF scale stability 50, mild deterioration in function is clear and other inclusions criteria. The sample was thirty three person by numerate these file and randomly selection I have fifteen person for intervention. They are illegible for program intervention and the other subject for control group.

The number of patient that applicable for my criteria were (33) according to file number randomly selection. Fifteen patient for intervention group and eighteen patient for control group have all criteria to participant for my program, and sample Matches with age, gender, disease, living area. We should assess and evaluate the degree of progressing effectiveness of recovery action plane before and after programs They have criteria as female age 18-45years diagnosed schizophrenia has file continually follow up, adherent for medication, were eligible, willing to participate, and available for the 3-month study period Of the 15 experimental subjects. Total of 33 individual.

❖ **Demographic characteristic:**

• Age groups for patients with schizophrenia for the type of group (Intervention , control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the intervention group for age groups (Chi-Square = 0.12, P-value = 0.942), and this indicates that there is homogeneity in the two groups for age groups(less than 20 years old, less than 30 years, 30 years and over), and can be seen from the following table (1):

Table (1) age groups for patients with schizophrenia in the control group and the Intervention group

Age		KIND		Total
		Experimental	Control	
less than 20 years	N	2	2	4
	%	13.3%	11.1%	12.1%
less than 30 years	N	3	3	6
	%	20.0%	16.7%	18.2%
30 and more	N	10	13	23
	%	66.7%	72.2%	69.7%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square= 0.12, P-value>0.05)

• Status of schizophrenic patients for the type of group (Intervention, control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the Intervention group for the social situation (Chi-Square = 5.32, P-value =0.150), and this indicates that there is homogeneity in the two groups with regard to case (Married, single, divorced, widowed), is illustrated by the following table (2)

Table (2) marital Status of schizophrenia patients in the control group and the Intervention group

Martial statues		KIND		Total
		intervention	Control	
Married	N	3	1	4
	%	20.0%	5.0%	11.4%
Single	N	4	9	13
	%	26.7%	45.0%	37.1%
Divorced	N	7	5	12
	%	46.7%	25.0%	34.3%
Widow	N	1	3	4
	%	6.7%	25.0%	17.1%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square= 5.32, P-value>0.05)

• Function for patients with schizophrenia for the type of group (Intervention, control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the Intervention group for function (Chi-Square = 1.23, P-value = 0.455), and this indicates that there is homogeneity in the two groups for the function (working, not working), and evidenced by the following table ():

Table (3) employment for patients with schizophrenia in the control group and the Intervention group

Work		KIND		Total
		Intervention	Control	
Employed	N	1	0	1
	%	6.7%	0.0%	3.0%
Unemployed	N	14	18	32
	%	93.3%	100.0%	97.0%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square= 1.23, P-value>0.05)

• Monthly income for schizophrenia patients for the type of group (Intervention, control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the Intervention group for monthly income (Chi-Square = 2.71, P-value = 0.25), and this indicates that there is homogeneity in the two groups for income Monthly (500 shekels, 1000 NIS 2000 NIS), is illustrated by the following table:

Table (4) monthly income of schizophrenia patients in the control group and the Intervention group

Income		KIND		Total
		Intervention	Control	
500 nis	N	6	3	9
	%	40.0%	15.8%	26.5%
1000 nis	N	6	12	18
	%	40.0%	63.2%	52.9%
2000 nis	N	3	3	6
	%	20.0%	21.1%	20.6%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square= 2.71, P-value>0.05)

Educational level of patients with schizophrenia for the type of group (Intervention, control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the Intervention group for educational level (Chi-Square = 4.78, P-value = 0.443), and this indicates that there is homogeneity in the two groups for the level education (illiteracy, primary, preparatory, secondary, diploma, university), is illustrated by the following table(5):

Table (5) the educational level of schizophrenic patients in the control group and the Intervention group

Educational level		KIND		Total
		Intervention	control	
Illiterate	N	1	3	4
	%	6.7%	16.7%	12.1%
Primary	N	4	7	11
	%	26.7%	38.9%	33.3%
Prep	N	5	5	10
	%	33.3%	27.8%	30.3%
Secondary	N	2	0	2
	%	13.3%	0.0%	6.1%
Diploma	N	3	2	5
	%	20.0%	11.1%	15.2%
University	N	0	1	1
	%	0.0%	5.6%	3.0%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square=4.78, P-value>0.05)

• The housing area for patients with schizophrenia for the type of group (experimental, control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the Intervention group for the residential area (Chi-Square = 0.27, P-value = 0.481), And this indicates that there is homogeneity in the two groups for the area housing (city, camp), is illustrated by the following table:

Table (6) housing area for patients with schizophrenia in the control group and the Intervention group

Area		KIND		Total
		Intervention	Control	
City	N	13	16	29
	%	86.7%	80.0%	82.9%
Camp	N	2	2	6
	%	13.3%	20.0%	17.1%
Total	N	15	18	33
	%	100.0%	100.0%	100.0%

(Chi-square= 0.27, P-value>0.05)

3.5 Control Condition

Study participants in the control group were placed on a waiting list guaranteeing them the opportunity to receive the12-week WRAP class after each person in the cohort completed their final interview. While on the waiting list ,control group participants received all of their usual services, including psychotropic medications and medication management, individual and group outpatient therapy, residential services, treatment, and inpatient care. Because no other WRAP classes were taught at any of the sites throughout the study period, we were able to maintain the integrity of the no treatment condition.

All participants in intervention group should provide written informed consent to participate using procedures approved by the director of mental health Institutional Review Board. The study was registered at Islamic University & Ministry of Health. There are no known conflicts of interest for any author and all authors certify responsibility. The initial sample size was 15 adults. Female in the experimental condition and 35 in the control condition for a total of 35 individuals who were eligible.

3.6 Sitting

I selected my sample from six main communities of mental health center in Gaza City by convenience sample will be west Gaza clinic.

Study started from March -2012 to march -2013

3.7 I instruments of the study

Qualitative & quantitative data that includes two evaluation techniques one of this is focusing group, other was pre and posttest, one time T1 prior 2week from starting

WRAP program. Then after three months of ending program immediately focusing group inter viewing, after that time T2 after ending the interviewing, time T3 four month post T2.Test .

Researcher used two instruments .**recovery assessment that international scale**, The primary outcome was self-perceived recovery from SMI measured by the Recovery Assessment Scale (RAS) (Giffort et al., 1995). Comprised of 41 items rated on a 5-point scale from "strongly agree" to "strongly disagree," the RAS conceptualizes recovery along with multiple components. In addition to a total score, subscales measure personal confidence, willingness to ask for help, goal orientation, reliance on others, hope, and having tolerable levels of symptoms, responsibility, support and other domain .

This modified scale by my effort and translation into Arabic language and validates to be suitable the state of client and the Arabic culture, it comprised 44 items . And welling before and after using WRAP, Also I used focusing group after the ending of program to take point of view about the program, and recovery action plane tool program for intervention group to assess and follow up. This programs include strategies and self-guides its contents about 12 section may be longer according patient needs. Otherwise (GAF) international validity scale is. Indicator for level of stability.

Throughout all 12 classes, participants were exposed mental ill experiences, information and activities designed to increase their hopefulness, as well as enhance their skills in taking personal responsibility for their wellness and education Specifically participants discussed how to access credible, personally meaningful and how to advocate for themselves with providers and other supporters.

3.8 Validity and reliability of research tool:

First: Believe scale wellness and recovery for patients with schizophrenia:

To verify the veracity of the scale honesty it was calculated in two ways, namely as follows:

1. Validity arbitrators:

Has been accessed testing in its initial form, the number of specialists in the field of psychological health and in the light of their views have been retained paragraphs that the percentage agreed (85%) and above.

2. Internal consistency:

Correlation coefficients were calculated between the degree of each variables of the scale wellness recovery action plan and the total score of the scale . So to see the relevance of paragraphs college degree of scale, and to verify the authenticity of the target measure, is illustrated by the following table:

Table (7) correlation coefficients between the dimensions of the questionnaire and the total score for the measure wellness and recovery

Dimension	Correlation	P-value
Goal	0.88	0.001**
Self-responsibility	0.91	0.001**
Hope	0.91	0.001**
Support	0.94	0.001**
Knowledge and self-advocacy	0.73	0.001**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ none statistically significant.**

Showing through the previous table that the dimensions of measure wellness recovery action plan has coefficients link strong and statistically significant, ranging correlation coefficients between (0.73 - 0.94), and this shows that the dimensions measure have a high degree of honesty make researcher reassuring the validity of the application of the test on the sample.

Since the measure has five dimensions have been correlation coefficients between the paragraphs of each of the five dimensions and the total score for each dimension alone, and is evidenced by the following tables:

Table (8) correlation coefficients between the items after the goal and the overall degree of dimension

Statement	Correlation	P-value
I have a desire to succeed	.390	0.019*
I am a good person	.820	0.001**
Recovery mean becoming more satisfied with my life	0.82	0.001**
I can participate & communicate with other	0.81	0.001**
I have goals in life that I want to reach	0.67	0.037*
Because mental illness I can't hold a job	0.49	0.003**
I feel depressed ,sadness caused by disease	0.38	0.024*
I go out at least two enjoyable	0.84	0.001**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through the previous table that dimension the goal has coefficients link strong and statistically significant, ranging correlation coefficients between (0.38 - 0.84), and this shows that the dimension goal has a high degree of honesty make researcher reassuring to the validity

of the application of the test on the sample.

Table (9) correlation coefficients between the items dimension of the extent of self-responsibility and the overall degree of dimension

Statement	Correlation	P-value
My symptoms seem to be a problem for shorter periods of time each time they occur	0.80	0.001**
My symptoms interfere less and less with my life.	0.87	0.001**
I feel at peace with my self	0.85	0.001**
I eat balance diet every day	0.84	0.001**
I understand how to control the symptoms of my mental illness	0.89	0.001**
I am the person most responsible for my own improvement	0.84	0.001**
I am still capable of learning about mental illness to be more control	0.80	0.001**
I am often able to over comes barrier	0.75	0.001**
Because the disease I feel disconnected with society	0.80	0.001**
I feel a shame when getting out for any occasion	0.79	0.001**
Even when I don't believe in myself, other people do	0.77	0.001**
Mental health problem are completely out of my control	0.94	0.001**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through the previous table that dimension over the self-responsibility enjoying transactions link is strong and statistically significant, ranging correlation coefficients between (0.75 - 0.94), and this indicates that dimension over the self-responsibility enjoy a high degree of honesty make researcher reassuring the validity of the test application on the study sample.

Table (10) correlation coefficients between the items dimension hope and the overall degree of dimension

Statement	Correlation	P-value
Recovery need to hope and encouragement	0.76	0.023*
There is some source outside myself that give meaning to myself	0.69	0.001**
My religious had made me a strong & resilience	0.65	0.001**
every day is a new opportunity for learning	0.58	0.001**
I am a better person than before my experience is with mental illness	0.71	0.001**
I have a hope about the future	0.78	0.001**
I feel patience with others and myself.	0.67	0.001**
Reading Quran is sources of faith	0.55	0.001**
Spirituality is a part of my recovery	0.70	0.002**
I like to help others	0.57	0.023*
Recovery can occur even if symptom of mental illness present	0.33	0.002**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through the previous table that dimension honesty and hope enjoy transactions link are strong and statistically significant, ranging correlation coefficients between (0.33 - 0.78), and this shows that the dimension honesty and hope enjoys a high degree of honesty make researcher reassure the validity of the application of the test on the sample

Schedule (11) correlation coefficients between the items dimension Support and the overall degree of dimension

Statement	Correlation	P-value
I ask for help, when I need it	0.91	0.001**
I am willing to ask for help	0.76	0.001**
I ask for help when the symptom are getting worse	0.89	0.001**
I have people who are recovering from problem similar to mine	0.89	0.001**
I can help myself become better without professional interact	0.89	0.001**
I have financial support continuously	0.90	0.001**
I have frequent treatment assistant	0.72	0.001**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through the previous table that dimension Support with coefficients link is strong and statistically significant, ranging correlation coefficients between (0.72 - 0.91), and this shows that the dimension Support has a high degree of honesty make researcher reassure the validity of the test application on the study sample.

Table (12) correlation coefficients between the items Knowledge and self-advocacy and the overall degree of dimension

Statement	Correlation	P-value
Symptom is more worsening when out of control & up set	0.39	0.001**
I know when I am getting worse symptom is breaking down	0.87	0.001**
I can identify what triggers the symptoms of my mental illness	0.87	0.001**
Although my symptoms may get worse, I know I can handle it	0.42	0.001**
I know what can I do to be better	0.77	0.001**
I have my own plan for how to stay or become well.	0.39	0.001**

*** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through the previous table that Knowledge and self-advocacy has coefficients link strong and statistically significant, ranging correlation coefficients between (0.39 - 0.87), and this shows that the dimension of Knowledge and self-advocacy has a high degree of honesty make researcher reassure the validity of the application of the test on the sample.

Second: Stability the questionnaire:

After applying the questionnaire stability was calculated to questionnaire by two methods as follows:

1. Alpha persistence - Cronbach Alpha:

After applying the questionnaire alpha coefficient Cronnebah to measure stability, where it was found that the Cronbach alpha value for questionnaire the total equal to 0.94 and this is proof enough that the questionnaire has by a factor of stability is high. It was found that the value of Cronbach's alpha for the dimensions of a scale wellness recovery action plan is greater than (0.65), and this is proof that the dimensions of the questionnaire has high by a factor of stability, and clear results from the following table:

Table (13) shows the Cronbach alpha coefficient a scale wellness and recovery and five dimensions

Dimension	N	Alpha
Goal	8	0.75
Self-responsibility	12	0.93
Hope	11	0.51
Support	7	0.75
Knowledge and self-advocacy	6	0.53
Recovery Assessment Scale	44	0.94

2. Persistence way midterm fragmentation (Split half methods):

After applying the questionnaire stability was calculated in a way that fragmentation midterm, where he was the apportionment of questionnaire items into two halves, as well as all items into two parts, where the correlation coefficient calculated between the total vertebrae the first half and the total vertebrae the second half of the questionnaire, as well as each individual dimension. For the correlation coefficient of the total scale (**wellness s**and recovery) has reached (0.81), and after using the equation Spearman - Brown became modified reliability coefficient (0.90), the results are evident from the following table:

Table (14) Stability transactions in a way fragmentation midterm scale wellness and recovery, dimensions and dimensions

Dimension	Person	Spearman-Brown
Goal	0.34	0.50
Self-responsibility	0.73	0.84
Hope	0.35	0.51
Support	0.39	0.56
Knowledge and self-advocacy	0.63	0.71
Recovery assessment Scale	0.81	0.90

As shown above, the measure of its paragraphs enjoys by a factor of highly constant. Which refers to the validity of the scale to measure the dimensions of the above, and so the researcher adopted safely this measure as a tool to collect data and to answer the hypotheses and questions of the study.

3.9 Intervention and exposure

WRAP groups typically range in size from 10 to 15 participants and are led by two trained facilitators. Information is imparted through seminars, workshops, presentations, support groups and the internet, lectures, discussions, homework, individual ,group exercises, and key WRAP concepts are illustrated through examples from the lives of the facilitators and participants. The intervention is typically delivered each week for three month 2-hour sessions or less of WRAP/week. Participants often choose to continue meeting after the formal 12 cycle of (WRAP) weekly three month period to support each other in using and continually revising their WRAP plans. WRAP is generally offered in mental health clinic center outpatient community programs although the intervention is used primarily by and for people with mental illnesses special schizophrenia.

Also program should include the following session.

- Wellness toolbox
- Daily maintenance plan
- Identification of triggers and associated action plan
- Identification of early warning signs and associated action plan
- Identification of signs that things are breaking down and associated action plan
- Crisis planning
- Post crisis planning see the implementing program in annex one

See the annex four.

3.10 General objective of program.

- promote higher levels of wellness, stability and quality of life.

3.11 Specific objective.

- Decrease the incidence of severe symptoms
- Increase understanding of these illnesses and decrease stigma
- Raise participants' level of hope and encourage their actively working toward wellness,
- Decrease the need for costly, invasive therapies
- Relapsing prevention and decrease uncomfortable distressing feeling.
- Patient can enhance and increase personal empowerment.
- Improve socializing and communicate well with various people and places.
- To maintain daily activity
- Patient can achieve their own life goal and dream
- Hope, Personal Responsibility, Self-Advocacy, Education, Support
- Accessing good health care and managing medications
- Symptom responses: finding and keeping a strong support system, peer counseling, focusing, relaxation exercises, diet, light, exercise, sleep, journaling, music, etc.
- .Ongoing work:
  Changing Negative Thought Patterns To Positive
  Building A Lifestyle That Promotes Wellness
  Expected Long Term Outcomes From a Recovery/Self-Management Focus
- A shift of focus in mental health care from symptom control to prevention and recovery.

3.12 Ethical consideration

A consent form was send to the community mental health director to obtain the requested approval for the study through community mental health administration, and another consent by approval committee from Islamic University. The researcher explain the objective and purpose of the study to all participants and their inclusion of the study . Neither nether name nor personal data will be published, and the photo that is taken should be secret and confidentiality.

3.13 Consent form

Consent form for agreement to participate in the program from patient and his family Agreement to take photo for documental purpose . All information should be secret about the participant.

3.14 Inclusion criteria.

Every schizophrenic female patient age 18-45 years has diagnosed by psychiatrist according DSM-1V, met criteria of schizophrenia, has stability according to GAF criteria 50 % had deterioration in function, has a file in community health center at least five years treatment and continually follow up of antipsychotic medication, attendant to clinic, and cooperate free from any physical disease.

3.15 Exclusion criteria

Any patient not female, or not diagnosed schizophrenia, or under age 25 and over 45 if not compliance with medication if any physical problem should be exclude.

3.16 Statistical tools.

The researcher unloaded and analysis of the test through statistical analysis program (Statistical Package for the Social Sciences (SPSS 17.0) has been used the following statistical methods:

1. **chis square test** "to know the differences between the two samples for demographic variables, to know homogeneity of the samples.
2. **Correlation coefficient Pearson (Person Correlation Coefficient):** to check the sincerity of the internal consistency test between the vertebrae and the overall degree of questionnaire and to measure the degree of correlation. This test is used to study the relationship between the variables.
3. **Alpha persistence - Cronbach Alpha**: To find out test items stability. And the standard deviation is used it mainly to know a repeat variable categories according to the researcher, in the description of the variables of the study.
4. **Persistence coefficient way fragmentation midterm (Split half methods):** and used to ensure that the measure has elevated stability, and Spearman Brown formula to modify the stability test.
5. **Kelmrge off Semenov Kolmogorov- Smirnov-Z test:** to find out if the data follow a normal distribution or not.
6. **Descriptive statistics**: percentage and arithmetic average

7. The arithmetic average of the relative (relative weight): useful to know the amount of the percentage of each of the areas.
8. **Wilcox on Test:** in order to know the statistical significance of the differences between the tribal measurement and dimension measurement of the Intervention group in the scale of recovery
9. **The value of ETA**: to find out magnitude of the impact of home assignments on students in the intervention group.
10. **"Mann-Whitney Test ":** for the difference between the averages of two independent equal groups, because the sample is small, the data is normal and the contrast of the two variables is heterogeneous.

Chapter Four

Results

Result

- **4.1 Questions of the study: First question: Are dimensions degrees for wellness recovery action plan (WRAP) following a normal distribution?**

To identify the extent of normal distribution of data, the researcher use Kolmogorov-Smirnov Z test, to see whether scale and five dimensions follow a normal distribution or not, is illustrated by the following table:

Table (15) shows the test results of Kolmogorov-Smirnov Z to test the normal distribution of scale wellness recovery action plan

Dimension	Kolmogorov-Smirnov Z	P-value
Goal	1.23	0.009**
Self-responsibility	2.48	0.001**
Hope	1.50	0.023*
Support	2.56	0.001**
Knowledge and self-advocacy	2.08	0.001**
Recovery assessment Scale	1.78	0.004**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ non statistically significant**

Showing through results test Kolmogorov-Smirnov Z shown in the previous table that scale wellness recovery action plan and five dimensions, (goal and success, Self-responsibility, honesty and hope, Support, Knowledge and self-advocacy) does not follow the normal distribution because the significance level of less than 0.05. This makes the researcher uses (nonparametric) tests, because the data does not follow a normal distribution and these tests give a high degree of accuracy in the results that can be obtained.

- **The second question: What is the level of the five dimensions of wellness recovery action plan in patients with schizophrenia in the Intervention group before and after the applied of the program?**

To identify the level of five dimensions wellness recovery action plan schizophrenia patients in the Intervention group before and after the applied the program, the researcher calculates the mean, standard deviation and relative weight scale wellness recovery action plan and five dimensions for each group separately, and can be seen in the following table:

Table (16) shows the mean and standard deviation and the relative weight of the dimensions of the scale wellness recovery action plan in the Intervention group

Dimension	kind of test	Pre-test		Post- test		Sequential- test	
	Total degree	Mean	relative weight%	Mean	relative weight%	Mean	relative weight%
Goal	40	13.0	32.5	30.0	75.0	28.6	71.5
Self-responsibility	60	16.3	27.1	43.3	72.1	43.5	72.6
Hope	55	27.5	49.9	40.1	73.0	37.9	68.8
Support	35	8.3	23.8	19.0	54.3	18.3	52.2
Knowledge and self-advocacy	30	11.5	38.4	21.8	72.7	22.7	75.6
Recovery assessment Scale	220	76.6	34.8	154.2	70.1	152.0	69.1

Relative weight is calculated by dividing the mean total score and then multiplied by 100

- For scale wellness and recovery showing through results that schizophrenia patients in the sample have the level of wellness and recovery in the pre-test degree weak where the relative weight was 34.8%, has reached the relative weight of this dimension in the post-test of 70.1%, meaning that schizophrenic patients after receiving the program became in the level of total scale wellness and recovery high. It was found that the relative weight in the sequential test 69.1% meaning that almost schizophrenic patients maintained at the level of total scale wellness and recovery, namely, that the impact of the program on schizophrenia patients in the Intervention sample was not temporary.

As for the five dimensions of the scale they have been shown by the results that:

- Schizophrenic patients in the sample have a weak level of goal degree where the relative weight was 32.5%, while showing that the relative weight of this dimension in the post-test 75.0% meaning that schizophrenic patients after receiving the program became in the level of goal and success high. It was found that the relative weight in the sequential test 71.5% meaning that almost schizophrenic patients maintained at the level of goal and success, namely, that the impact of the program on schizophrenia patients in the intervention sample was not temporary.

- It has been shown by the results that schizophrenia patients in the sample have some degree of Self-responsibility and others in the pretest weak degree where the relative weight was 27.1%, while showing that the relative weight of this dimension in the post-test was 72.0%, meaning that schizophrenia patients after receiving the program became

the degree of Self-responsibility and others was high. It has been shown that the relative weight in the sequential test 72.6% meaning that patients with schizophrenia have maintained a degree of Self-responsibility and others, that the impact of the program on schizophrenia patients in the Intervention sample was not temporary.

- It has been shown by the results that schizophrenia patients in the sample have the degree of honesty and hope weak degree in the pretest where the relative weight was 49.9%, while showing that the relative weight of this dimension in the post-test was 73.0%, which means that patients with schizophrenia after receiving the program became level of honesty and hope they are . It was shown that the relative weight in the sequential test 68.8% meaning that patients with schizophrenia have decreased the degree of honesty and hope.
- Showing through results that schizophrenia patients in the sample have the level of support in pretest degree weak where the relative weight was 23.8%, while showing that the relative weight of this dimension in the post-test was 54.3%, which mean that schizophrenia patients after receiving program became in the level of support have an average, which has been shown that the relative weight in the sequential test was 52.2% to almost schizophrenic patients maintained on the level of readiness in the request for assistance, meaning that the impact of the program on schizophrenia patients in the intervention sample was not temporary.
- It has been shown by the results that schizophrenia patients in the sample have a degree of Knowledge and self-advocacy in the pretest degree weak where the relative weight of 38.4%, while showing that the relative weight of this dimension in the posttest 72.7%, meaning that schizophrenia patients after receiving the program became the degree of Knowledge and self-advocacy they have high which has been shown that the relative weight in the sequential test 75.6% means that patients with schizophrenia have increased the degree of Knowledge and self-advocacy, meaning that the impact of the program on schizophrenia patients in the intervention sample was not temporary.

❖ **The third question: What level of the scale wellness recovery action plan and its five dimensions in patients with schizophrenia in the control group before and after the applied of treatment for them in the normal way?**

To identify the level of five dimensions wellness recovery action plan patients with schizophrenia in the control group before and after the applied the program, the researcher calculates the mean, standard deviation and relative weight scale wellness recovery action plan and five dimensions for each group separately, and can be seen in the following table:

Table (17) shows the mean and standard deviation and the relative weight of the dimensions of the scale wellness recovery action plan in the control group

Dimension	kind of test	Pre-test		Post- test	
	Total degree	Mean	relative weight%	Mean	relative weight%
Goal	40	11.7	29.1	12.0	30.0
Self-responsibility	60	13.5	22.4	17.3	28.8
Hope	55	26.8	48.7	26.2	47.7
Support	35	7.7	21.9	8.0	22.9
Knowledge and self-advocacy	30	11.4	37.8	12.7	42.2
Recovery assessment Scale	220	70.9	32.2	77.1	35.0

Relative weight is calculated by dividing the mean for each dimension on the total score for each dimension and then multiplied by 100

- For scale wellness and recovery showing through results that schizophrenia patients in the sample have the level of wellness and recovery in the pretest degree weak where the relative weight of 32.2%, has reached the relative weight of this dimension in the posttest 35.0%, which means that schizophrenia patients after receiving treatment by the usual way remained at the same level of recovery with a slight increase. Through the results show that.

As for the five dimensions of the scale has been shown by the results that:

- Schizophrenia patients in the sample have the level of the goal in the pretest degree weak where the relative weight of 29.1%, has reached the relative weight of this dimension in the posttest 30.0%, which mean that schizophrenic patients after receiving treatment by the usual way stayed at the same level of goal .
- It has been shown by the results that schizophrenia patients in the sample have degree of Self-responsibility in the pretest degree weak where the relative weight of

22.4%, has reached the relative weight of this dimension in the posttest 28.8%, which mean that schizophrenia patients after receiving treatment by the usual way have increased the degree of Self-responsibility and others.

- It has been shown by the results that schizophrenia patients in the sample have degree honesty and hope pretest moderately reaching the relative weight of 48.7%, has reached

  the relative weight of this dimension in the posttest 47.7%, meaning that schizophrenia patients after receiving treatment by the usual way stayed on the same degree of honesty and hope.
- It has been shown by the results that schizophrenia patients in the sample have the level of the Support in pretest degree weak where the relative weight of 21.9%, has reached the relative weight of this dimension in the posttest 22.9%, which mean that schizophrenia patients after receiving treatment by the usual way remained at the same level of the readiness to ask for help.
- It has been shown by the results that schizophrenia patients in the sample have a degree of Knowledge and self-advocacy in the pretest moderately reaching the relative weight of 37.8%, has reached the relative weight of this dimension in the posttest 42.2%, which mean that schizophrenia patients after receiving treatment by the usual way stayed on the same level of Knowledge and self-advocacy.

4.1 Question of the studies

- **First questions : states that "is there a significant difference in the degree of the wellness recovery action plan dimensions in the Intervention group and the control group before implementing the program ?**

The researcher compared between the average grade level for grades intervention group and the average grade level for grades control group in the dimensions of the wellness recovery action plan before implementing the program, using the test "Mann-Whitney" for the difference between means in independent group because the sample is small, the data is not normal and the variance between two variables is non-assumed, illustrated through the following table:

Table (18) shows Mann-Whitney test to study the differences between the average of the control group and the Intervention group in the dimensions of wellness recovery action plan (n = 35)

Dimension	Intervention(15)		Control(20)		Z – value	P-value
	Mean Rank	Sum of Ranks	Mean Rank	Sum of Ranks		
Goal	19.57	293.50	16.83	336.50	-0.800	0.424//
Self-responsibility	18.90	283.50	17.33	346.50	-0.612	0.540//
Hope	17.67	265.00	18.25	365.00	-0.171	0.864//
Support	18.97	284.50	17.27	345.50	-0.692	0.489//
Knowledge and self-advocacy	17.27	259.00	18.55	371.00	-0.409	0.683//
Recovery assessment Scale	18.17	272.5	17.88	357.5	-.084	0.933//

*** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is statistically significant**

Evidenced by the results that there are no statistically significant differences at the level (0.05) between the mean scores schizophrenic patients in the intervention group and degrees of schizophrenic patients in the control group in the dimensions of scale wellness recovery action plan, that schizophrenic patients in the two groups (Intervention and control) have the same level in the dimensions of scale wellness recovery action plan (goal and success, Self-responsibility and others, honesty and hope, Support, Knowledge and self-advocacy).

- **The second question: states that " are there significant differences in the degree of wellness recovery action plan dimensions in the Intervention group and the control group after the implementation the program ?**

-The researcher compared between the average grade level for grades Intervention group and the average grade level for grades control group in the dimensions of the wellness recovery action plan after implementing the program, using the test "Mann-Whitney" for the difference between means in independent group, because the sample is small, the data is not normal and the variance between two variables is non-assumed, illustrated through the following table:

Table (19) shows Mann-Whitney test to study the differences between the average of the control group and the Intervention group in the dimensions of wellness recovery action plan (n = 35)

Dimension	Intervention(15)		Control(20)		Z – value	P-value
	Mean Rank	Sum of Ranks	Mean Rank	Sum of Ranks		
Goal	27.93	419.00	10.55	211.00	-5.07	0.001**
Self-responsibility	27.50	412.50	10.88	217.50	-4.78	0.001**
Hope	26.67	400.00	10.26	195.00	-4.82	0.001**
Support	27.17	407.50	11.13	222.50	-4.75	0.001**
Knowledge and self-advocacy	26.23	393.50	11.83	236.50	-4.19	0.001**
Recovery assessment Scale	26.60	399.0	10.32	196.0	-4.73	0.001**

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is statistically significant**

For scale overall (wellness and recovery) shows that there are significant differences in patients with schizophrenia in the Intervention and control groups (Z =-4.73.p-value = 0.001), and the differences were in favor of the Intervention group, with an average grade of the Intervention group 26.6 degrees, while the average level of the control group 10.32 degrees, which means that patients with schizophrenia in the Intervention group had the degree of wellness recovery action plan more than schizophrenia patients in the control group. As for the five dimensions of the scale has been shown by the results that:

-The presence of statistically significant differences in the scores after the goal in patients with schizophrenia in the intervention and control groups (Z =-5.07.p-value = 0.001), and the differences were in favor of the Intervention group, with an average grade of the Intervention group 27.9 degrees, while the average ranks of the control group 10.6 degrees, meaning that patients with schizophrenia in the Intervention group had a goal degree more than schizophrenia patients in the control group.

-The presence of statistically significant differences in the scores after Self-responsibility patients with schizophrenia in the Intervention and control groups (Z =-4.78.p-value = 0.001), and the differences were in favor of the intervention group, with an average grade of the Intervention group 27.5 degrees, while the average level of the control group 10.9

degrees, which mean that patients with schizophrenia in the Intervention group to have some degree of Self-responsibility more than schizophrenia patients in the control group.

-The presence of statistically significant differences in the scores after hope in patients with schizophrenia in the Intervention and control groups (Z =-4.82.p-value = 0.001), and the differences were in favor of the Intervention group, with an average grade of the Intervention group 26.7 degrees, while the average ranks of the control group, 10.2, which mean that patients with schizophrenia in the Intervention group to have some degree of hope more of schizophrenia patients in the control group.

-The presence of statistically significant differences in the scores dimension of the Support in patients with schizophrenia in the intervention and control groups (Z =-4.8.p-value = 0.001), and the differences were in favor of the intervention group, with an average grade of the Intervention group 27.1 degrees, while the average level of the control group 11.1 degrees, meaning that patients with schizophrenia in the Intervention group have a degree of the Support more than schizophrenia patients in the control group.

-The presence of statistically significant differences in the scores dimension Knowledge and self-advocacy in patients with schizophrenia in the Intervention and control groups (Z =-4.19.p-value = 0.001), and the differences were in favor of the Intervention group, with an average grade of the Intervention group 26.2 degrees, while the average ranks of the control group 11.8 degrees, which mean that patients with schizophrenia in the intervention group have a degree of Knowledge and self-advocacy more than of schizophrenia patients in the control group.

- **Third question : Are There a significant differences between the degrees of pre-test and post-test in degrees dimensions scale of wellness recovery action plan in the Intervention group ?**

The researcher compared the average grade level for grades of the Intervention group in the measurement of tribal average grade level for grades of the intervention group in measurement dimensional regarding the five dimensions of scale wellness recovery action plan, using the test (Wilcox on T-statistic) and because the sample size is small and the data is not normal . To study the two medial together in the case of samples associated with, and has been found box ETA (ή2) and by ή2 possible calculate the value of d that reflects the size of the impact of the program (WRAP) on the dimensions of scale wellness

recovery action plan in patients with schizophrenia in the Intervention sample between tests pre and post, the results illustrated by the following table:

Table (20) test of Wilcox on T-statistic to detect differences between pre and post measurement in the Intervention group in the dimensions of scale wellness recovery action plan (n = 15)

Dimension Pre- post		Rank	Mean Rank	Sum of Ranks	Z – value	P-value	Eta	D	Effectiveness
Goal	**N.R**	0	0.0	0.0	3.41-	0.001**	0.5	1.82	Big
	P.R	15	8.0	120.0					
Self-responsibility	**N.R**	1	1.0	1.0	-3.35	0.001**	0.4	1.79	Big
	P.R	14	8.50	119.0					
Hope	**N.R**	1	1.50	1.50	-3.32	0.001**	0.4	1.77	Big
	P.R	14	8.46	118.50					
Support	**N.R**	2	1.50	3.00	-3.25	0.001**	0.4	1.74	Big
	P.R	13	9.00	117.00					
Knowledge and self-advocacy	**N.R**	3	2.00	6.00	-3.12	0.002**	0.4	1.67	Big
	P.R	12	9.50	114.00					
Recovery assessment Scale	**N.R**	1	1.00	1.00	-3.35	0.001**	0.4	1.79	Big
	P.R	14	8.50	119.00					

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is statistically significant**

Since scale wellness and recovery have been shown and there were statistically significant differences in patients with schizophrenia in scores of pre and posttests in the intervention group (Z =-3.35.p-value = 0.001), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP in increasing degrees of recovering patients with schizophrenia in the intervention group significantly, and this indicates that the degree of recovery have risen when members of the intervention group implemented the program for them.

As for the five dimensions of the scale has been shown by the results that:

-The presence of statistically significant differences in the degrees the dimension of goal and success in patients with schizophrenia in scores the test pre and post in the Intervention group (Z =-3.41.p-value = 0.001), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP increasing degrees goal and success in patients with schizophrenia in the intervention group significantly, and this

indicates that scores of the goal and success have increased the Intervention group after implemented the program for them.

-The presence of statistically significant differences in the degrees of the dimension of Self-responsibility in patients with schizophrenia in scores the test pre and post in the Intervention group (Z=-3.35,p-value=0.001), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP increasing degrees Self-responsibility in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Self-responsibility have increased the Intervention group after implemented the program for them.

-The presence of statistically significant differences in the degrees of the dimension of Hope in patients with schizophrenia in scores the test pre and post in the Intervention group (Z=-3.32,p-value=0.001), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP increasing degrees Hope in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Hope have increased the Intervention group after implemented the program for them.

-The presence of statistically significant differences in the degrees the dimension of Support in patients with schizophrenia in scores the test pre and post in the intervention group (Z=-3.25,p-value=0.001), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP increasing degrees Support in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Support have increased the Intervention group after the implemented program for them.

-The presence of statistically significant differences in the degrees of the dimension of Knowledge and self-advocacy in patients with schizophrenia in scores the test pre and post in the Intervention group (Z=-3.12,p-value=0.002), and the differences were in favor of the post test, which indicates the effectiveness of the program WRAP increasing degrees Knowledge and self-advocacy in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Knowledge and self-advocacy have increased the Intervention group after implemented the program for them.

❖ **Forth question : are There significant differences between the degrees of pre-test and post- test in degrees dimensions scale of wellness recovery action plan in the Control group ?**

The researcher compared the average grade level for grades of the control group in the measurement of tribal average grade level for grades of the Control group in measurement dimensional regarding the five dimensions of scale wellness recovery action plan, using the test (Wilcox on T-statistic) and because the sample size is small and the data is not normal , to study the two medial together in the case of samples associated with, and has been found box ETA (ή2) and by ή2 possible calculate of the value of d that reflect the size of the impact of the program (WRAP) on the dimensions of scale wellness recovery action plan in patients with schizophrenia in the Control group sample between tests pre and post, the results illustrated by the following table:

Table (21) test of Wilcox on T-statistic to detect differences between pre and post measurement in the Control group in the dimensions of scale wellness recovery action plan (n = 15)

Dimension Pre- post		Rank	Mean Rank	Sum of Ranks	Z – value	P-value	Eta	D	Effectiveness
Goal	N.R	11	9.41	103.50	-0.06	0.955//	0.0	0.03	-
	P.R	9	11.83	106.50					
Self-responsibility	N.R	2	16.00	32.00	-2.35	0.019*	0.3	1.26	Big
	P.R	16	8.69	139.00					
Hope	N.R	12	9.83	118.00	-0.93	0.353//	0.1	0.50	Median
	P.R	7	10.29	72.00					
Support	N.R	5	4.70	23.50	-0.41	0.683//	0.0	0.22	Weak
	P.R	5	6.30	31.50					
Knowledge and self-advocacy	N.R	9	7.50	67.50	-1.11	0.267//	0.1	0.59	Median
	P.R	10	12.25	122.50					
Recovery assessment Scale	N.R	6	8.50	51.00	-1.50	0.132	0.1	0.80	Big
	P.R	12	10.00	120.00					

**** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is no statistically significant**

The evidenced of the previous table is as follow.

- The presence of statistically significant differences in the degrees of dimension of Self-responsibility patients with schizophrenia in test scores pre and post in the control group (Z = -2.35, p-value = 0.019), and the differences were in favor of the post test, which indicates

the effectiveness of traditional method increase degrees Self-responsibility in patients with schizophrenia in the control group significantly, and this indicates that degrees of Self-responsibility have risen when members of the control group received treatment by the traditional way.

-There is no statistically significant differences in the degrees of dimensions scale wellness recovery action plan following (goal, hope, , Knowledge and self-advocacy) in patients with schizophrenia in test scores pre and post in the control group (p-value> 0.05), and this shows that dimensions degrees scale wellness recovery action plan following (goal, hope, Knowledge and self-advocacy) made no difference There is no statistically significant differences in the degrees dimensions scale wellness recovery action plan following (goal, hope, , Knowledge and self-advocacy) in patients with schizophrenia in test scores pre and post in the control group (p-value> 0.05), and this shows that dimensions degrees scale wellness recovery action plan following (goal, hope, Knowledge and self-advocacy) made no difference.

- **Fifth question : Are there a significant differences between the degrees of tribal measurement and degrees of sequential measurement dimensions scale wellness recovery action plan in the Intervention group ?**

The researcher compared the average grade level for grades of the intervention group in the measurement of tribal average grade level for grades of the Intervention group in measurement sequential regarding the five dimensions of scale wellness recovery action plan, using the test (Wilcox on T-statistic) because the sample size small and the data is not normal , to study the two medial together in the case of samples associated with, and has been found box ETA (ή2) and by ή2 possible calculate the value of d that reflect the size of the impact of the program (WRAP) on the dimensions of scale wellness recovery action plan in patients with schizophrenia in the Intervention group sample between tests pre and post, the results illustrated by the following table:

Table (22) test of Wilcox on T-statistic to detect differences between pre and sequential measurement in the Intervention group in the dimensions of scale wellness recovery action plan (n = 15)

Dimension pre- Sequential		Rank	Mean Rank	Sum of Ranks	Z – value	P-value	Eta	D	Effectiveness
Goal	**N.R**	0	0.0	0.0	-3.41	0.001**	0.5	1.82	Big
	P.R	15	8.0	120.0					
Self-responsibility	**N.R**	0	0.0	0.0	-3.43	0.001**	0.4	1.83	Big
	P.R	15	8.0	120.0					
Hope	**N.R**	1	1.0	1.0	-3.24	0.001**	0.4	1.73	Big
	P.R	13	8.0	104.0					
Support	**N.R**	1	1.0	1.0	-3.36	0.001**	0.4	1.80	Big
	P.R	14	8.5	119.0					
Knowledge and self-advocacy	**N.R**	0	0.0	0.0	-3.33	0.001**	0.4	1.78	Big
	P.R	14	7.5	105.0					
Recovery assessment Scale	**N.R**	8	9.00	72.00	-3.29	0.001**	0.4	1.76	Big
	P.R	7	6.86	48.00					

** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is statistically significant

As for the five dimensions of the scale that haves been shown by the results they are:

-The presence of statistically significant differences in the dimension scores of the goal and success in patients with schizophrenia in the test scores of tribal and sequential in the Intervention group (Z =-3.41.p-value = 0.001), and the differences were in favor of sequential test, which refers to the effectiveness of the program WRAP in increasing degrees of goal and success in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the goal and success have increased for the Intervention group after implemented of the program for them and the passage of time that the improvement they have is not temporary.

-The presence of statistically significant differences in the dimension scores of the Self-responsibility in patients with schizophrenia in the test scores of tribal and sequential in the Intervention group (Z=-3.43,p-value=0.001), and the differences were in favor of testing sequential, which refers to the effectiveness of the program WRAP in increasing degrees of Self-responsibility in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Self-responsibility have increased for the Intervention group after implemented of the program for them and the passage of time that the improvement they have is not temporary.

-The presence of statistically significant differences in the dimension scores of the Hope in patients with schizophrenia in the test scores of tribal and sequential in the intervention group (Z=-3.24,p-value=0.001), and the differences were in favor of testing sequential, which refers to the effectiveness of the program WRAP in increasing degrees of Hope in patients with schizophrenia in the intervention group significantly, and this indicates that scores of the Hope have increased the Intervention group after implemented of program for them and the passage of time that the improvement they have is not temporary.

-The presence of statistically significant differences in the dimension scores of the Support in patients with schizophrenia in the test scores of tribal and sequential in the Intervention group (Z=-3.36,p-value=0.001), and the differences were in favor of testing sequential, which refers to the effectiveness of the program WRAP in increasing degrees of Support in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Support have increased the Intervention group after implemented the program for them and the passage of time that the improvement they have is not temporary.

-The presence of statistically significant differences in the dimension scores of the Knowledge and self-advocacy in patients with schizophrenia in the test scores of tribal and sequential in the Intervention group (Z=-3.33,p-value=0.001), and the differences were in favor of testing sequential, which refers to the effectiveness of the program WRAP in increasing degrees of Knowledge and self-advocacy in patients with schizophrenia in the Intervention group significantly, and this indicates that scores of the Knowledge and self-advocacy have increased for the Intervention group after the implemented of the program for them and the passage of time that the improvement they have is not temporary.

- **six question : Are there differences between the degree of post- test and sequential test in degrees dimensions scale wellness recovery action plan in the Intervention group...**

The researcher compared the average grade level for grades of the intervention group in the measurement of dimensional average grade level for grades of the Intervention group in measurement sequential regarding the five dimensions of scale wellness recovery action plan, using the test (Wilcox on T-statistic) and because the sample size small and the data is not normal , To study the tow medial together in the case of samples associated with, and has been found box ETA (ή2) and by ή2 possible calculate the value of d that reflect

the size of the impact of the program (WRAP) on the dimensions of scale wellness recovery action plan in patients with schizophrenia in the Intervention group sample between post- test and sequential test , the results illustrated by the following table:

Table (23) test of Wilcox on T-statistic to detect differences between post and sequential measurement in the Intervention group in the dimensions of scale wellness recovery action plan (n = 15)

Dimension Post- Sequential		Rank	Mean Rank	Sum of Ranks	Z – value	P-value	Eta	D	Effectiveness
Goal	**N.R**	10	6.95	69.50	-1.68	0.092//	0.2	0.90	Big
	P.R	3	7.17	21.50					
Self-responsibility	**N.R**	5	7.70	38.50	-0.49	0.623//	0.0	0.26	Weak
	P.R	8	6.56	52.50					
Hope	**N.R**	8	6.00	48.00	-2.09	0.036*	0.2	1.12	Big
	P.R	2	3.50	7.00					
Support	**N.R**	8	6.75	54.00	-0.60	0.550//	0.0	0.32	Weak
	P.R	5	7.40	37.00					
Knowledge and self-advocacy	**N.R**	4	3.25	13.00	-0.72	0.473//	0.0	0.38	Weak
	P.R	4	5.75	23.00					
Recovery assessment Scale	**N.R**	8	9.00	72.00	-.68	0.495//	0.0	0.36	Weak
	P.R	7	6.86	48.00					

*** Statistically significant at 0.01 * statistically significant at 0.05 \ \ is statistically significant**

The evidenced of the previous is as follows :

-The presence of statistically significant differences in the dimension scores of hope in patients with schizophrenia in degrees post- test and sequential in the Intervention group = -2.09, p-value = 0.036), and the differences were for the benefit of post-test, and this indicates that for degree of hope may dropped when members of the Intervention group after the passage of time.

-There is no statistically significant differences in the degrees of dimensions scale wellness recovery action plan following (goal, Self-responsibility, Support, Knowledge and self-advocacy) in patients with schizophrenia in degrees posttest and sequential in the Intervention group (p-value> 0.05), and this shows that dimensions degrees of scale wellness recovery action plan (goal, Self-responsibility, Support, Knowledge and self-advocacy) made no difference or a significant increase when members of the Intervention group after implemented the program for them and the passage of time that the improvement they had was not connected with time that mean not temporary.

4.2 Focusing group

What level of satisfaction of the intervention group for the program (WRAP)?

To get to know the level of beneficiary satisfaction with the program (WRAP), the researcher showed the opinion of over viewed of the total review of the program some question about how to take advantage from the program, and is evidenced by the following point:

What helps people in the process of recovery?

How useful did you find the session?

How useful were the topics covered relevant to your managing your symptom ?

How did you believe that spirituality affect positively for increase your own feelings towards recovery

Have you feeling any relapse in recent months

- The most of beneficiary satisfaction with the program (WRAP) reached degrees, of satisfaction and this shows that members of the intervention group were satisfied with the guidance sessions and perpetrator introducer .
- That the most of them believed beneficiary of the program that recovery plan has benefited managing some of the symptoms and this shows that the intervention group have benefited from recovery plan in the program to manage some of the symptoms significantly and by while the degree of belief beneficiary believe that spirituality affect positively for increase their own n feelings towards recovery of the program that religious morals contributed to the recovery process in a positive way ,and this shows that the intervention group of religious morals have contributed to the recovery process positively. The most average of not feeling relapse in the last months of the beneficiary in the program reached , and this shows that the intervention group did not feel relapse in recent months after receiving treatment . Recovery for me is a series of steps. Sometimes the steps are small, like fixing lunch, taking a walk and following my daily routine. Small steps add up "find that the more I do to stay active during the day, the better things go. I make a list each day of what I want to do. I try to list fun things as well as work things. Just being active makes me feel more confident."

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taking a walk and following my daily routine. Small steps add up." find that the more I do to stay active during the day, the better things go. I make a list each day of what I want to do. I try to list fun things as well as work things. Just being active makes me feel more confident."

It helps me to have friends and family I can do things with and talk things over with. Sometimes I have to work on these relationships and make sure I stay in touch. It's better for me not to rely on just one person." Developing a support system"

Chapter Five

Discussions, Conclusion and Recommendations

5.1 Discussion:

- Demographic characteristic:

For patients with schizophrenia for the type of group (Intervention , control):

Shows through the results that there are no statistically significant differences between schizophrenic patients in the control group and the schizophrenia patients in the intervention group for all the demographic variables , and this indicates that there is homogeneity in the two groups for all variables , and can be seen from the previous tables .

This is the first randomized trial of WRAP and results show that it is an effective treatment when compared with usual community care. Psychiatric symptom severity scores are significantly reduced among WRAP participants compared with those receiving services as usual, while hopefulness and QOL are significantly increased among WRAP vs. Usual care recipients. Thus, a major finding of this study was that, compared to services as usual, intervention participants reported significantly greater improvement in 3 outcome areas that are widely acknowledged to be indicators of recovery. This was the case controlling for the effects of time, showing that positive changes persisted for at least four months after the intervention .

Study results point to somewhat divergent effects of WRAP on the different recovery outcomes studied. On psychosocial measures of hopefulness and QOL, WRAP recipients reported not only significantly greater improvement relative to controls, but this advantage appeared to grow over time. On the other hand, the experimental vs. control differences in symptom severity were larger between T1 and T2 and seemed to attenuate over the long term, even though WRAP participants were still doing better at T3 in the multivariate analysis. Future research is needed to understand the differences between these outcomes and their relationship to other personal changes in areas such as functioning, empowerment, self-advocacy and self-esteem. Data from the present study will be used in subsequent analyses to explore these questions and thus illuminate the subjective components of recovery.

Also noted in these results was mild improvement among control-condition subjects on all 3 outcomes especially in self-responsibility. This may have been due to the high number of clinical services they were receiving in this period and/or may have been due to an "anticipation effect" because controls were promised an opportunity to receive WRAP at the end of the study. The fact that noteworthy proportions of subjects in both conditions

were receiving peer support at both follow-up time points may also account for both improvement among the control subjects and convergence of the symptom outcome between the 2 study conditions at T3. WRAP participants reported greater feelings of hope related to "agency" or their views of their own ability to influence their lives and make sustained changes. However, there were no differences by study condition in subjects' self-perceived ability to construct successful plans of action, as measured by the "pathways" subscale. This suggests that while WRAP improves confidence in one's ability to take action, additional supports may be needed to help people make plans for rebuilding their lives in the community. These might include, e.g. access to financial resources, social support, employment services, peer supports, and health care as well as traditional clinical psychiatric services.

- **First question : states that "are there significant difference in the degree of the wellness recovery action plan dimensions in the Intervention group and the control group before implementing the program?**

The researcher shown that there are no statistically significant differences at the level between the mean scores schizophrenic patients in the .Intervention group and degrees of schizophrenic patients in the control group in the dimensions of scale wellness recovery action plan. That schizophrenic patients in the two groups (Intervention and control) have the same level in the dimensions of scale wellness recovery action plan (goal and success, Self-responsibility and others, honesty and hope, Support, Knowledge and self-advocacy).see table(18).

- **The second question : states that " are there significant differences in the degree of wellness recovery action plan dimensions in the Intervention group and the control group after the implementation the program?**

For scale overall (wellness and recovery) shows that there are significant differences in patients with schizophrenia in the intervention and control groups the differences were in favor of the Intervention group, that patients with schizophrenia in the Intervention group had the degree of wellness recovery action plan more than schizophrenia patients in the control group. And the improvement was in all aspect of the five dimensions of the scale that meaning the effectiveness of the WRAP program significantly greater improvement over time in hopefulness score and subscale for goal directed hopefulness, and, enhanced improvement over time in as assessed by. These results indicate that peer-delivered mental

illness self-management training reduces psychiatric symptoms, enhances participants' hopefulness, and improves their self-responsibility over time. Awareness of their own early warning signs of decompensating use of wellness tools in their daily routine; awareness of their own symptom triggers having a crisis plan in place; having a plan for dealing with symptoms; having a social support system; and ability to take responsibility for their own This confirms the importance of peer-led wellness management interventions, such as WRAP, as part of a group of evidence-based recovery-oriented services this result agree with study of Copeland.,(2005),

Bullock & colleagues.,(2000). (cooketal.,2011). And Jessicaetal.,(2011). Wellness Psychiatric Rehabilitation Journal, Vole 34(2), 2010, 113-120, Coleman, (1999). And agree with others previous studies as Recent research indicates that WRAP has a positive impact on key recovery outcomes including helps participants to identify and access personal resources and natural supports to facilitate recovery from mental illness (Copeland., 2001). WRAP participants develop an individualized plan for managing mental health difficulties and creating a meaningful life, while acquiring skills to become self-advocates by increasing their knowledge, making choices, and expressing personal preferences (Copeland., 2002). But disagree with one dimension (Starnino et al., 2010). A significant positive time effect was found for hope and recovery orientation but according symptom Participants showed improvement in symptoms, the change was slightly below statistical significance. This is differ caused by good management with medication that was temporary available in this time and for continuously follow up during this period for program otherwise researcher shown this study disagree with study of Cook et al., 2009). Group. PSYCHIATRIC SERVICES volume: 58 ,2007(significant and no change in social support was found for either group.

The researcher showed this variation rational that the increasing in significant degree related to social support because our community strong in many sides and culture prosperities such as (social ,religion ,closed relation ,extended family). So these aspect and good moral were the most effectiveness reason for improvement of social support level in our study by contrast the western cultural that characteristic is differ community , and living with nuclear family and weak relation.

- **Third question : are there significant differences between the degrees of pre-test and post-test in degrees dimensions scale of wellness recovery action plan in the Intervention group?**

For scale wellness and recovery has been shown and there were statistically significant differences in patients with schizophrenia in scores of pre and posttests in the intervention group and the differences were in favor of the posttest which indicates the effectiveness of the program WRAP in increasing degrees of experimental group participants increased from pre- to post-intervention by almost 5 points on average, and then rose another point by the end of the 6-month follow-up. Control group RAS with minimal variation recovering patients with schizophrenia in the intervention group favor post-test significantly, and this indicates that the degree of recovery have risen when members of the intervention group after implemented the program for them. Result found significant increases in consumers' self-reported knowledge of early warning signs of psychosis, tools and skills for coping with prodromal symptoms, preference for using natural supports, support groups, and other people with mental illness for support, use of wellness tools in their daily routines, and hope for recovery. The degree level of hope is greater significant increase researcher rational that because our culture had strong believed in Islamic religion and strong faith with Allah and in our spiritual believe because that we used to be more patient. Also found were significant increases in consumers' self-rated ability to create crisis plans, and to create plans that: expressed their needs and wishes, listed their supporters and people to contact in an emergency, and explained their early warning signs. Mental illness. This result agree with study of Coleman,(1999)., (Bullock &colleagues.,(2000) ,(Buffington, 2003). Jessica et al.,(2011) . Cooke et al., (2011),

(Starnino et al., 2010). But disagree with (Cook et al., 2009). That empowerments decreased significantly and no significant changes were observed in social support.

- **Forth question : are there significant differences between the degrees of pre-test and post-test in degrees dimensions scale of wellness recovery action plan in the Control group?**

There is no statistically significant differences in the degrees dimensions scale wellness recovery action plan following (goal, hope, , Knowledge and self-advocacy) in patients with schizophrenia in test scores pre and post in the control group. This result for this hypothesis agree with all previous study

and this shows that dimensions degrees scale wellness recovery action plan following (goal, hope, Knowledge and self-advocacy) did not make difference. There is no statistically significant differences in the degrees dimensions scale wellness recovery action plan following (goal, hope, Knowledge and self-advocacy) in patients with schizophrenia in test scores pre and post in the control group (p-value> 0.05), and this shows that dimensions degrees scale wellness recovery action plan following (goal, hope, Knowledge and self-advocacy) did not happen difference. except in on dimension (self-responsibility) the presence of statistically significant differences in the degrees dimension of Self-responsibility patients with schizophrenia in test scores pre and post, in the control group and the differences were in favor of the post test, which indicates the effectiveness of traditional method increase degrees Self-responsibility in patients with schizophrenia in the control group significantly, and this indicates that degrees of Self-responsibility have risen when members of the control group after receiving treatment by the traditional way.

Researcher rational this result because the researcher give promise to control group for applied like this program for them after it is success it, the researcher consider that is as study limitation because it was a motivation for them .

- **Fifth question : are there significant differences between the degrees of tribal measurement and degrees of sequential measurement dimensions scale wellness recovery action plan in the Intervention group** ?

The presence of statistically significant differences in the dimension scores of the recovery program and success in patients with schizophrenia in the test scores of tribal and sequential in the Intervention group and the differences were in favor of sequential test, which refers to the effectiveness of the program WRAP in increasing degrees of key recovery outcomes and success in patients with schizophrenia in the intervention group

significantly, and this indicates that scores of the Outcomes were self-reported engagement in self-advocacy with service providers, and the relationship between patient self-advocacy and other key recovery outcomes. In a multivariable analysis, at 6-month follow-up, WRAP participants were significantly more likely than pretest to report engaging in self-advocacy with their service providers. Higher self-advocacy also was associated with greater hopefulness, better environmental quality of life, and fewer psychiatric symptoms among the intervention group.

Goal and success have increased for the intervention group after implemented the program for them and the passage of time that the improvement have is not temporary.

- **Sixth question : are there significant differences between the degree of posttest and sequential test in degrees dimensions scale wellness recovery action plan in the Intervention group. ?**

Even though WRAP participants were still doing better at T3 in the multivariate analysis there is no statistically significant differences in the degrees of dimensions scale wellness recovery action plan following (goal, Self-responsibility, Support, Knowledge and self-advocacy) in patients with schizophrenia in degrees posttest and sequential in the Intervention group and this shows that dimensions degrees of scale wellness recovery action plan (goal, Self-responsibility, Support, Know ledge and self-advocacy) did not show difference or a significant increase for Intervention group after implemented the program and the passage of time the improvement was not temporary.

But only one domain the presence of statistically significant differences in the dimension scores of hope in patients with schizophrenia in degrees posttest and sequential in the Intervention group and the differences were favor for post-test, and this indicates that for degree of hope may dropped when members of the Intervention group after the passage of time. The researcher rational this differences caused by (Gaza ware, siege of Gaza strip, Israeli occupation, bad economic statues, unstable political condition, and moreover decrease in Medicaid and social affair .

Focusing group immediate post-intervention: From responses in focus groups

What helps people in the process of recovery?

How useful did you find the session?

How useful were the topics covered relevant to you managing your symptom ?

How did you believe that spirituality affect positively for increase your own feelings towards recovery?

Have you feeling any relapse in recent months ?

Recovery for me is a series of steps. Sometimes the steps are small, like fixing lunch, taking a walk, following my daily routine. Small steps add up." find that the more I do to stay active during the day the better things go. I make a list each day of what I want to do. I try to list fun things as well as work things. Just being active makes me feel more confident.

It helps me to have friends and family I can do things with and talk things over with. Sometimes I have to work on these relationships and make sure I stay in touch. It's better for me not to rely on just one person." Developing a support system, having a mental illness is part of my life, but not the center of my life, Making time for leisure and recreation, intervention participants reported significantly greater improvement than controls in QOL regarding opportunities for acquiring new skills and information, enhanced leisure and recreation, and feelings of security and freedom, being in touch with my spirituality is essential to me. I belong to mosque ,managing our symptom, workshop has the substantial benefit of increasing participants' sense of belonging and hope and gives them the support they need to work on their own recovery and/or assist others as they move through the recovery process.

Conclusion

Wellness recovery action plan improves participants' self-perceived recovery and hopefulness over time, even controlling for severity of symptoms and because it may take a long time before we realize the results of our use of the discouraging nature of these illness effort a recovery. Learning and sharing information it many of us find it very

difficult to motivate ourselves to work on our workshop have the substantial benefit of increasing participants' sense of belonging hope and gives them the support they need to work on their own recovery and/or assist others as they move through the recovery process.

All this means some radical changes to traditional power relationships and, possibly, to traditional recruitment practices. This is for the future. in the meantime, we hope that this literature will help to galvanize a national commitment to making recovery-oriented practice the norm in Palestinian mental health services. This paper marks the beginning of work at the psychiatric center to refine this vision and define the steps that need to follow. We look forward to working with others to support the changes that will make recovery a reality for all.

5.2 Study limitation:

Overall the results are very positive, although they need to be interpreted in light of the following issues:

- The first major caveat to our findings is that the study's subjects were not drawn from a national probability sample of individuals with severe and persistent mental illness, which limits the generalizability of our results.
- Only a small number of participants who completed the three month program participated in the focus groups, therefore it cannot be assumed that their views are representative of the group as a whole.
- Also noted in these results was improvement among control-condition subjects on all 2 outcomes. This may have been due to the high number of clinical services they were receiving during this period and/or may have been due to an "anticipation effect" because controls were promised an opportunity to receive WRAP at the end of the study.

Recommendations

In light of the findings of this study, the researchers make 7 recommendations:

1. A national strategy for mental health recovery education be developed, with due consideration of the need to have a wider public focus and expand recovery education outside traditional mental health care environments into general health settings and the wider community, including schools and community networks.
2. Funding is made available to implement a mental health Recovery education program for all mental health practitioners in GAZA city that is inclusive of family members/careers and people with self-experience.
3. Educational accrediting bodies ensure the inclusion of recovery principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Palestine.
4. Funding is made available for evaluating initiatives developed to promote recovery in people living with mental health problems. .
5. Future programs need to address the concerns expressed by participants regarding content, facilitation and issues such as duration and room layout and recruitment of family members/careers and medical practitioners.
6. A follow-up study of participants be undertaken to examine whether the changes reported in this study were maintained over time, and examine how participants who completed the program used their knowledge and skills to support their own or others' mental health.
7. Further evaluation studies are conducted using experimental approaches. In addition, international researchers with an interest in Recovery and WRAP education agree on core outcome measurement tools so that direct comparisons between future Recovery and WRAP education evaluations can be made.

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Appendixes

annexes One

قائمة بأسماء السادة المحكمين لأدوات الدراسة

اسم المحكم	مكان العمل
د/عايش سمور	مدير عام الإدارة العامة للصحة النفسية
د/عاطف الاغا	استاذ مشارك في الجامعة الاسلامية
د/اشرف الجدى.	استاذ مشارك في الجامعة الاسلامية
د/ضياء صايمة	منسق في منظمة الصحة العالمية
د/حبيب الحواجري .	اخصائي نفسي
ا /خليل مقداد .	مدير الدراسات الاحصائية
د/نبيل دخان.	استاذ مشارك في الجامعة الاسلامية

Annex Two

WRAP

WELLNESS

RECOVERY

ACTION

PLAN

WRAP

The Wellness Recovery Action Plan or WRAP, is an evidence-based system effective approach to overcoming distressing symptoms, and unhelpful behavior patterns that is used world-wide in USA,UK and other region.WRAP was originally developed by Mary Ellen Copeland is an author, educator and mental health recovery advocate. She specializes in the successful self-management of psychiatric symptoms,and people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience of mental health difficulties; people who were searching for ways to resolve issues that had been troubling them for a long time. WRAP® involves listing your personal resources, your Wellness Tools, and then using those resources to develop Action Plans to use in specific situations which are determined by you. WRAP® is adaptable to any situation. WRAP®

also includes a Crisis Plan or Advance Directive

خطة للعمل في استعادة العافية ,هو نهج نظام قائم على الأدلة الفعالة للتغلب على الأعراض المؤلمة، وأنماط السلوك غير المفيد هذا البرنامج يتم استخدامه في جميع أنحاء العالم في الولايات المتحدة الأمريكية والمملكة المتحدة ومناطق أخرى. وضعت أصلا من قبل د كتورة ماري ايلين كوب لاند وهى مؤلفة، ومربية ومناصرة استرداد الصحة العقلية. وهي متخصصة في الإدارة الذاتية الناجحة من الأعراض النفسية وناس اخرون يتعاملون مع الصحة العقلية وغيرها من التحديات الصحية، والناس الذين يرغبون في تحقيق أعلى مستوى ممكن من الصحة والعافية. تم تطويره من قبل مجموعة من الناس الذين لديهم تجربة معايشة مشاكل تتعلق بالصحة العقلية، والناس الذين كانوا يبحثون عن سبل لحل القضايا التي سببت لهم قلق لفترة طويلة .هذه الخطة تنطوي على سرد الموارد الشخصية، والأدوات الصحية الخاصة بك ، ومن ثم استخدام هذه الموارد لتطوير خطط معينة والتي تحددها أنت في العمل، لاستخدامه في حالات معينة وهذا النظام قابل للتكيف مع أي وضع كما انها تضمن خطة الازمة أو تعليمات مسبقة.

Personal Workbook **كتيب العمل الشخصي**

Wellness Toolbox **أدوات العافية**

Some words that other have used

قائمة كلمات يستخدمها الآخرين مثل

bright ,happy ,competent , humorous , ,optimistic, industries, content ,responsible

مشرق، وسعيد، المختصة ،وروح الدعابة ،متفائل، الإنتاجية ،والمحتوى ،مسؤولية

❖ **Daily Maintenance Plan** **الخطة اليومية**

List OF things you do to keep yourself well and the things you do to help feel better when you don't feel well. List any tools that you currently use or would like to try. You can keep adding new ones or cross off ones that aren't right for you.

قائمة الأشياء التي تقوم بها للحفاظ على نفسك جيدا، والأشياء التي تشعرك على نحو أفضل ان كنت لا تشعر جيدا.

إدراج الأدوات التي تمكنك بالاحتفاظ بإضافة جديدة أو شطب الاشياء المزعجة مثل

, planning the day, stress reduction and relaxation techniques, focusing exercises, diversionary activities & fun, journaling, exercise, sleep, being outside, increasing or decreasing stimulation, light exposure peer counsel .talk to a supportive person

قراءة مجلة خطط يومية, ممارسة التمارين الرياضية ,التعرض للضوء, الضحك ,الاسترخاء ,نشاطات ترفيهية, مشاركة في الحديث ,الانضمام للأصدقاء ,استشارة الأصدقاء الداعمين

Triggers . العوامل المثيرة

external events or circumstances that could trigger symptoms, that make you feel like you are getting ill. Make a list of events and/or circumstance that, if they happened, might increase your symptoms or cause you to have unpleasant or distressing feeling

تقديم قائمة بالأحداث /أو الظروف التي، إذا ما حدثت، قد تزيد الأعراض الخاصة بك أو تسبب لك مشاعر مزعجة ومحزنه

such as an argument with a friend or getting a big bill, and responses that might keep this event from causing or worsening symptoms

❖ **Early Warning Signs.** **العلامات المنذرة بالأزمة**

Early warning signs are internal and may be unrelated to reactions to stressful situations. In spite of our best efforts at reducing symptoms, we may begin to experience early warning signs, subtle signs of change that indicate we may need to take some further action.as

هي عبارة عن علامات داخلية وليس بالضرورة ان يكون لها علاقة بردة الفعل لأي ضغوطاتولكن يشعر الشخص بانه مقبل علي انتكاسة وهذا يتطلب مزيد من التدخل والخطط للتعامل مع أي تغيير

Make a list of your early warning signs (feelings, thoughts, behaviors, etc. Irritability or anxiety that indicate you need to take further action. Make a list of what you need to do such as - about your early warning signs in order to keep your symptoms from getting worse:

جعل قائمة خاص بك تحذر بوادر (المشاعر، والأفكار والسلوكيات، إلخ) التي تشير إلى انك تحتاج إلى اتخاذ المزيد من الإجراءات الخاصة بعلامات الإنذار المبكر بغية الحفاظ على الأعراض الخاصة بك من التفاقم

❖ **When Things Are Breaking Down** **عند الوقوع في الأزمة**

symptoms that indicate the situation is getting much worse, such as reckless behavior or isolation, and an action plan to stabilize the situation

اعراض تنذر بالانتكاسة و بان الوضع قد ازداد سوءا ويجب وضع خطة للتدخل لبقاء الحال اكثر استقرار

This is how I think and feel, and how I behave when the situation has become uncomfortable, serious or even dangerous: Make a list of the symptoms which, for you, mean that things have worsened and are close to the crisis stage Make a list of things you can do that you think will help reduce your symptoms.

كيف تفكرين ، وتشعرين، وكيفية التصرف عندما يصبح الوضع غير مريح أو خطير . جعل قائمة الأعراض التي تعني أن الأمور قد ازدادت سوءا، بالنسبة لك، وتكون قريبة من مرحلة الأزمة جعل قائمة بالأشياء التي يمكن القيام بها تظن انها ستساعدك في تخفيض الأعراض الخاصة بك

❖ **Crisis Planning.** **خطة الأزمة**

Write a personal crisis plan to be used when your symptoms have become so severe and/or dangerous that you need others to take over responsibility for your care. Your crisis plan includes

هي عباره عن خطة يرسمها الشخص لنفسه قبل الازمة يستخدمها الشخص عندما تزداد الامور سوء وخطورة وتمكن الاخرين من مساعدته وتحمل المسئولية

This many point plan can be just for your own use and reference or can be shared with others involved in the plan. It will take time to set up, and can be changed whenever you have new ideas or information. When you change it, consider sending updated versions to those it involves

هذه الخطة عدة نقاط يمكن أن تكون فقط للاستخدام والمرجعية الخاصة بك أو يمكن تقاسمها مع الآخرين المشاركين في الخطة. سوف تستغرق وقتاً للإعداد، ويمكن أن تتغير كلما كان لديك معلومات أو أفكار جديدة. عندما تقوم بتغييره، النظر في إمكانية إرسال الإصدارات المحدثة إلى تلك التي تنطوي على.

Part 1. Remembering What I am like when I'm feeling well

When I am well I am……..

❖ **Post Crisis Planning.** **الازمة** **خطة ما بعد**

If despite your best efforts at caring for yourself and working with others, you still go through a crisis – this is not the end of the world, nor does it mean you cannot recover. Recovery is a process that you can get back to at any time and after any experience, no matter how bad. But in order to do so it will be very helpful to reflect on what has happened to you and learn from it. Some can do this alone, most of us are greatly helped by having someone we trust to turn to, and talk it over to get.

❖ **_WRAP)Action plan** **الية عمل الخطة**

1) DAILY MAINTENANCE LIST: **قائمة الاعمال اليومية**

you can use these term for help.

يمكنك الاستعانة ببعض المصطلحات او البدائل مثل

quiet, active, happy , love responsible, religiously believed ,empathic calm,cooperation, friends ,optimistic,pray. god.poetry, poems, satisfying. video,time for pleasure ,balance,

نشيط, السعادة , الحب ,المسؤولية,. معتقدات دينية ,هادئ,. متعاون ,.صداقة.,. التفاؤل, الهدوء, الله , الصلاة, النجاح ,, وقت السعادة ,الشعر , القصائد

What I'm like when I am feeling all right

كيف أبدو عندما اشعر أنني بخير

_____

_____

DAILY MAINTENANCE LIST

Things I need to do for myself every day to keep myself

feeling all right: اشياء يومية امارسها لتمكنني من الشعور بخير

_____

_____

TRIGGERS: **عوامل الاثارة**

Things that, if they happen, might cause an increase in my symptoms:

أشياء ، في حال حدوثها، قد تؤدي إلى زيادة في الأعراض

_____

TRIGGER RESPONSE

TRIGGERS

Action Plan -- Things that I can do if my triggers come up to keep them from becoming more serious symptoms:

الاشياء التي يمكنني القام بها اذا ظهرت المثيرات للتغلب عليها.

_____

_____

EARLY WARNING SIGNS **علامات الانذار المبكر**

Some early warning signs that others have reported

and/or I have observed: بعض الاشارات كإنذار مبكر يلاحظها الاخرين او يشعر بها المريض

_____

_____

EARLY WARNING SIGNS

Action Plan -- Things I must do if I experience early warning signs:

بعض الاشياء او الارشادات التي يمكن ان افعلها عند ظهور علامات الانذار

_____

_____

EARLY WARNING SIGNS

Things I can do if they feel right to me:

اشياء استطيع القيام بها عندما أشعراني بخير

_____

_____

WHEN THINGS ARE BREAKING DOWN **علامات دخول الازمة .**

Signs/symptoms that indicate that things are getting worse: اعراض وعلامات تنذر بحدوث الازمة

_____

_____

WHEN THINGS ARE BREAKING DOWN

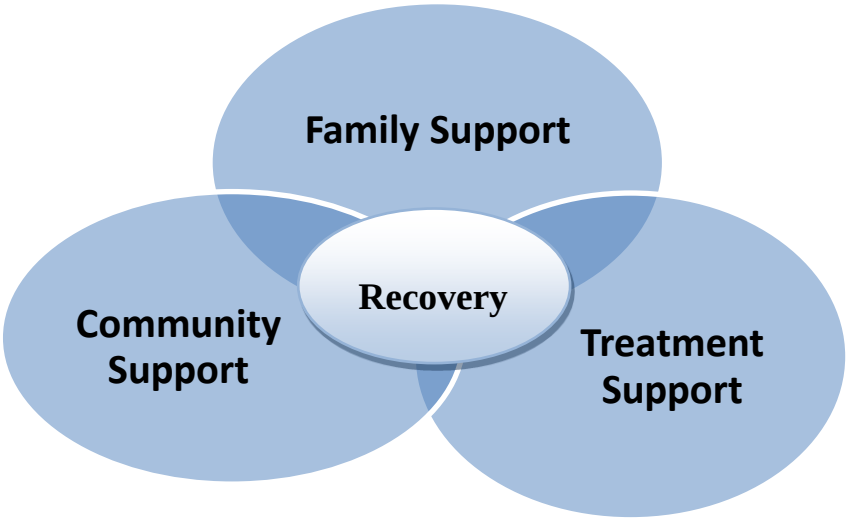
Action Plan – Things that can help reduce my symptoms when they have progressed to this point.

خطة تشمل بعض التصرفات التي بإمكانها التقليل من تطور الاعراض

_____

_____

CRISIS PLAN **التخطيط للازمة**



This crisis plan is written when I am well. The purpose is to instruct others about how to care for me when I am not well. This keeps main control even when it seems like things are out of control.

هذه الخطة اكتبها عندما اكون بخير لكي ترشد الاخرين بمساعدتي في حال الانتكاسة وعدم السيطرة على الاعراض

Part 1 – What I'm like when I'm feeling well? كيف اشعر وانا بخير؟

(reference Daily Maintenance List)

بإمكانك الاستعانة بالجزئية الاولى من الخطة

_____

_____

CRISIS PLAN

Part 2 – SYMPTOMS that indicate that others need to takeover full responsibility for my care and make decisions on my behalf:

الاعراض التي تشير الى التدخل وتحمل المسؤولية واتخاذ القرارات للتعديل

_____

_____

CRISIS PLAN

These are my SUPPORTERS, the people who I want to take over for me when the symptoms I listed in

الأشخاص الداعمين الذي اريد منهم ان يساعدونني عند الدخول في الازمة.

I would like the following people to support me if possible during this

Name _____

Relation to me _____

Phone number _____

Role I want this person to play and/or task(s) I need him/her to do

_____

_____

Name _____

Relation to me _____

Phone number _____

Role I want this person to play and/or task(s) I need him/her to do

_____

What Spirituality is. **الروحانيات**

Spirituality includes feeling more connected to our God, to one's self, to other people, community, and to Nature, or Life in general.

القيم الروحية ويشمل الشعور أكثر بالله والذات ، و إلى أشخاص آخرين، لمجتمعنا، أو الطبيعة أو الحياة بشكل عام

Spirituality is encouraged and increased by an attitude of gratitude.

Two or more things I am grateful for today.

الروحانية تشجع وتزيد من مواقف الاطمئنان : خمسة أو أكثر افعلها من الأمور وأكون ممتن لهذا اليوم

1_____

2._____

Specific people I know who can help me on my spiritual journey:

اعرف بعض الاشخاص اللذين يساعدوني في الجانب الروحاني

_____

_____

Things I do to increase my own feelings of spirituality .

اشياء تقربني من الله وتزيد من الوازع الديني

Read inspirational books

I belong to a mosque

Spend more time in nature, the great outdoors

Establish a schedule for daily prayer/meditation/inspirational reading Quran in Quiet Time ,Volunteer to help other people

Keep daily contact with likeminded positive people

Forgive someone who has hurt me

Medications/Supplements العلاج

Medications/supplements I am currently taking and why I am taking them:

ملحق العلاجات التي اخذها حاليا ولماذا تناولها ؟

_____

_____

Medications/supplements that must be avoided and reasons why:

ملحق الادوية التي يجب ان اتجنبها ولماذا

CRISIS PLAN

Treatments

Treatments that help reduce my symptoms and when they should be used:

العلاجات التي تساعد في التقليل من الاعراض ومتى ينبغي ان تستخدم

Community Plan **المصادر المجتمعية**

What can be put into place in order for me to including Public assistance social welfare school , housing ,mind, body, spirit, employment, education, stay at home or mental health and healthcare treatment and services in my community and still get the care I need .these needs to meet my daily effort.

.ما يمكن ان يوضع من خطة لتلقي الخدمة التي احتاجها من المنزل او من الرعاية المجتمعيةومراكز الرفاهية

من المراكز التأهيلية , العمل, المجتمع ,الرعاية الصحية, التعليم والمساعدات المجتمعية والانسانية , المدارس

_____

Part – Help From Others المساعدة من الاخرين

Things that others can do for me that would help reduce my symptoms or make me more comfortable:

اشياء بإمكان الاخرين ان يفعلها لي وهى تساعد في التقليل من الاعراض وتجعلني اكثر راحة.

_____

_____

List those things you need others to do for you and who you want to do what.

قائمة الأشياء التي احتاج من الآخرين القيام بها ومن تريد ان يفعلها لك

What I need done ,Who I'd like to do it

If I am in danger

If my behavior endangers me or others I want my supporters to:

اذا كان سلوكي يشكل خطر على نفسي وعلى الاخرين فانا بحاجة الى دعم ل

Inactivating the plan

How will your supporters know when it is safe to stop this Crisis Plan?

Describe what positive changes indicate to your supporters that you are in control of things again, and they no longer need to use this plan.

You will know it is safe to cease using this plan when:

Post Crisis Planning خطة ما بعد الازمة

If despite your best efforts at caring for yourself and working with others, you still go through a crisis – this is not the end of the world, nor does it mean you cannot recover. Recovery is a process that you can get back to at any time and after any experience, order to do so it will be very helpful to reflect on what has happened to you and learn from it. Some can do this alone, most of us are greatly helped by having someone we trust to turn to, and talk it over together.

What have you learned about yourself and others through this crisis?

ماذا تعلمت والاخرين من هذه الازمة

What changes can you make now to your WRAP to make a further crisis less likely?

ما هي التغيرات في خطة الدمج والاستشفاء التي تجعل الازمة اقل ما يمكن

How would you like to feel when you have recovered from this crisis

ما هو شعورك بعد شفاءك من الازمة

يمكنك الرجوع الى الجزئية الاولى في الخطة ولكن مع وجود اختلاف في نظرتك بعد الازمة

(refer to the section where you described what you are like when you are having a good day)? This list may be different from the one written before post crisis time:

_____

_____

Name Phone # Relationship What I need them to do

List things and people you need to avoid while you are recovering from this crisis:

قائمة الاشخاص الذين اريد ان اتجنبهم عند التعافي من هذه الازمة

_____

_____

I will know that I am "out of the crisis" and ready to use this post crisis plan when I am able to:

انا اعرف انني قد تعافيت وسيطرت علي الامور وعلي جاهزية لاستخدام خطة ما بعد الازمة عندما اكون قادر علي

_____

_____

repercussions from this crisis:

Signs That This Post Crisis Phase Is Over: العلامات التي تدل على انني قد استعدت عافيتي

List things to do for yourself every day قائمة اشياء تريدي ان تفعليها كل يوم

_____

List any changes to your crisis plan that might ease your recovery:

قائمة التغيرات التي من الممكن ان تسهل في عملية التعافي

_____

List any changes you want to make to your lifestyle or life goals

قائمة التغيرات التي اثرت في نمط حياتي او هدف حياتي

_____

What did you learn from this crisis? ماذا تعلمت من هذه الازمة

List any changes you want to make in your life as a result of what you have learned قائمة التغيرات التي تجعل حياتك ثمرة لما تعلمت

If you do want to make some changes, when and how will you make them?

اذا اردت ان تغير بعض الاشياء في ضل ما تعلمت من هذه الازمة فكيف ومتي

Annex Three Bold point for program

General objectives	■To teach participants recovery and self-management skills and strategies for dealing with psychiatric symptoms so as to promote higher levels of wellness, stability and quality of life ■decrease the need for costly, invasive therapies ■decrease the incidence of severe symptoms ■decrease traumatic life events caused by severe symptoms increase understanding of these illnesses and decrease stigma ■ arise participants' level of hope and encourage their actively working toward wellness. ■ tailoring helps people take medication as prescribed ■relapse prevention programs reduce symptom relapses and hospitalizations ■ .reduces the severity and distress of persistent symptoms
Specific objective	■Hope, Personal Responsibility, Self-Advocacy, Education, Support ■Build individual and community resilience • ■Accessing good health care and managing medications ■Changing Negative Thought Patterns To Positive ■Self-monitoring using WRAP: A Wellness Recovery Action Plan (an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness(■Building A Lifestyle That Promotes Wellness
Program sample	female Schizophrenic patient
Implemented by	Researcher by her self
Place	West GAZA clinic
Session number	Twelve session
Period of session	From 60- 180 minutes
Period of program	twelve weeks
Program techniques	Lectures ,presentation ,discussion ,active dialog ,self Talking ,relaxation ,imagination ,playing ,arts ,homework ,roleplaying the key concepts of WRAP and recovery.
evaluation	Focusing group ,pre –posttest ,.post posttest

Recovery Program.

First week session one	Objective	Material	Time
Part one Introduction: Help participant to get to know each other part two Identifying and understanding the general concept of the program &how should apply it.	• trusting relation ship • increase skill communication substantial benefit of increasing participants' sense of belonging • to achieve the highest possible levels of wellness	Direct interviewing and meeting group ball activity discussion on flipchart and pens for each pair group	One hour
Second week session two: *Discussion on idea of recovery Break time Complete the session recreational activity	• Allowing participant to contemplate debate Develop a personal WRAP to maximize wellness and minimize symptoms. *to reflect on their knowledge and understanding of recovery and mental illness • refreshment to keep yourself well make them to express their feeling	Group discussion One copy of what do we think about recovery and mental illness and writing on A4 paper and colored pens to record any discussion	30 minutes 20 minutes
Third week Daily Maintenance Plan- identify a regular those things you need to do every day. Relaxation techniques	• those things you need to do every day to keep yourself well, such as eating three healthy meals and getting a half-hour of exercise. • to keep yourself well manage one's disability	demonstration of paper and masking tape to display the finished poster apply the relaxation technique during ---the relaxation session.	One hour

fourth week *Discussion on five key concept of WRAP(hope, self-responsibility ,education information, self-advocacy, goal In between session its break time	• to promote higher levels of wellness, stability and quality of life. • or assist others as they move through the recovery process. Sense of belonging and hope	Lecture Poster for another experience Collection of articles, Homework assignment A card-sort exercise	one hour Half hour
Fifth week Journey to Gaza sea for recreation time for pleasure& leisure Lunch time	• Creation and pleasure session • Basic needs	Playing skipping Other activities One meal for every person	Three hours
Sixth week **Identify trigger& its action planes**	• To identify negative impact of trigger on self and environment and device a plan to limit impact. • To develop Decide what you want to happen during difficult times	Lecture Group therapy homework assignments. Some activities deep breathing, progressive relaxation	One hour

seventh week ***Identify early warning sign &its action planes** that impending episode and symptom. Relaxation technique	• To identify character that things are unmanageable and device plan to limit impact. • decrease the incidence of severe symptoms. • to identifying the negative impact for triggers and try to change to positive aspect. • to oriented for their problem and select appropriate solution. • to learn how to distract idea of hallucination and delusion	Group discussion home work sort cards Applying laxation technique	one hour
week eight Picnic to alba sheer playing Lunch meal	• Recreational needs • Basic needs	Play some activities and practice their happiest	Three hours
ninth week ***Things are breaking down** Action Plan and showed video for patient had schizophrenic and recovered	• To maintain control even when the situation is out of control. • To be oriented of recovery service and essential component. • to protect the person or others. If severe episodes	Group discussion and lecture expressed by demonstrating on paper Home work group therapy relaxation techniques was applied	One and half hour

Tenth week **Part one** ***Crisis plan** These are **my supporters** Get good medical care treatments, supporters, facilities.	• To reflection crisis and implement change to try to avoid another crisis. • to maintain control even when the situation is out of control. • to take over some of my responsibilities. • Recognize everyday well-being activities. • Increase support mechanisms available. • To prevent relapse	group discussion discussion on a model home work	One & half hour
Part two **Spirituality session**	• To be more feeling more connected to our God, to one's self, to other people, community, and to Nature, or Life in general more honest. • Build individual and community resilience. • To planning for extra services/supports when this occurs	Presentation	Half hour
eleventh week *Post crisis plan	• to revise one's WRAP plan after a crisis. • advance and even write some things to do in that time. • To Review your plans every day, noting how you feel and doing what you need to do to help yourself get better or to keep yourself well. • Dealing With Trauma. • Monitor impact of use of WRAP	Family intervention Group discussion	**two hours**

Twelfth week Evaluation session **Activity session journey to the sea** Break time(Dinner meal	• to determine any additional change and how they feels and evaluate any impression or expression and evaluate any negative point. • and reflect their knowledge. • creative feeling, pleasure. • feeling refreshing and expressing feeling. • basic needs and motivation	Writing Activity as swimming tourney , gift for winners playing football, singing skipping Produce one meal for every Person	Four hours

Annex Four

General over view about running program.

Wellness Recovery Action Plan (WRAP) is a tool that can be used to manage and maintain good mental wellbeing. It is a self-help plan designed by the individual, which allows them to identify resources and strategies that keep them well, recognize what makes them unwell and develop systems to limit the impact of this. The approach gives control to the individual, who is at the center of the structured and personalized plan, provides hope, opportunity and builds on strength and resilience.

❖ Introduction

researcher opinion. That. Many people feel that medications can be helpful in slowing down the most difficult symptoms. , medications are one of many options and choices for reducing symptoms. I believe that medication compliance as the primary goal is not appropriate. People who experience psychiatric symptoms have a hard time dealing with the side effects of medication designed to reduce these symptoms side effects like obesity, lack of sexual function, dry mouth, constipation, extreme lethargy and fatigue. In addition, they fear the long-term side effects of the medic ions As Tar dive's Dyskinesia was not recognized as a side effect of neuroleptic medication for many years. irreversible and destructive side effects. We want to be respected by health care professionals for having these fears and for choosing not to use medications that are compromising the quality of our lives.so there is another alternatives. method a recovery based environment, more effort needs to be spent focusing on choice, and self-responsibility around behavior. there is a need to develop a way we talk about symptoms so that each of us has many choices and options for dealing with them. For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. Professionals in the mental health sector often refer to the 'recovery model' to describe this way of thinking. Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms. There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle. and Relapse prevention that is defined as a return to a pattern of living that leads

to an inability to sustain recovery/ remission. This workbook is designed to encourage you to take an active role in your wellness. The workbook is designed to assist you to recognize early signs of relapse and to independently develop and apply behavioral skills to reduce the risk of relapse. This through this book, it can empower you to begin to build a MAP for your emotional, mental and spiritual well-being

❖ Goals.

To teach participants recovery and self-management skills and strategies for dealing with psychiatric symptoms so as to:

- ❖ promote higher levels of wellness, stability and quality of life
- ❖ decrease the need for costly, invasive therapies
- ❖ decrease the incidence of severe symptoms
- ❖ decrease traumatic life events caused by severe symptoms
- ❖ increase understanding of these illnesses and decrease stigma
- ❖ raise participants' level of hope and encourage their actively working toward wellness, as outlined in the model developed by Mary Ellen Copeland in coordination with other
- ❖ tailoring helps people take medication as prescribed;
- ❖ relapse prevention programs reduce symptom relapses and hospitalizations;
- ❖ reduces the severity and distress of persistent symptoms.
- ❖ increase participants' sense of personal responsibility and empowerment
- ❖ Expected Long Term Outcomes From a Recovery/Self-Management Focus
- ❖ Raise greater awareness of Mental Health• A shift of focus in mental health care from symptom control to prevention and recovery.

❖ Objectives

- Hope, Personal Responsibility, Self-Advocacy, Education, Support
- Symptom responses: finding and keeping a strong support system, peer counseling, focusing, relaxation exercises, diet, light, exercise, sleep, journaling, music, etc.
- Accessing good health care and managing medications
- Self-monitoring using WRAP: A Wellness Recovery Action Plan (an individualized system for monitoring and responding to symptoms to achieve the highest possible levels of wellness)
- Ongoing work:

Changing Negative Thought Patterns To Positive

- Building A Lifestyle That Promotes Wellness
- Engage as many people as possible around Mental Health
- Reach people and communities not readily accessing and/or accessible to Mental Health services
- Normalize discussion on Mental Health so as to reduce stigma and stereotypes
- Early intervention
- Build individual and community resilience
- Increase support mechanisms available
- Provide more community based and localized support
- WRAP to act as a catalyst for positive implications of family, social, work life that the individual operates in
- Providing a positive and constructive environment around the subject of mental health
- Increase uptake of use of WRAP in various mental health provisions
- Monitor impact of use of WRAP
- Collate evidence relating to the impact of WRAP

- **What supports recovery ?**

Researcher has found that important factors on the road to recovery include• :

- good relationships
- satisfying work
- financial security
- personal growth
- the right living environment•
- developing one's own cultural or spiritual perspectives•
- developing resilience to possible adversity or stress in the future

In alignment with the above mentioned aims, it should be noted that this programed was designed and individual in getting well, staying well.

- being in a supportive environment surrounded by people who are positive and affirming, but at the same time are direct and challenging--avoiding people who are critical, judgmental or abusive.
- peer counseling--sharing with another person who has experienced similar symptoms.
- stress reduction and relaxation techniques--deep breathing, progressive relaxation and visualization exercises.
- exercise--anything from walking and climbing stairs to running, biking, swimming.
- creative and fun activities--doing things that are personally enjoyable like reading, creative arts, crafts, listening to or making music, gardening, and woodworking.
- journaling--writing in a journal anything you want, for as long as you want

A plan can help you realize you are a whole person with talents and strengths in addition to your mental health issue. The plan helps you to :

- Learn how best to take care of yourself
- Recognize everyday well-being activities
- Decide what you want to happen during difficult times
- Track trigger events and early warning signs
- Define what you will do if feeling badly
- Say what kind of help you want, who you want to help and when you want it
- Create a crisis plan if things are breaking down

.

❖ Theoretical frame work of program

Intervention

This is consistency over time WRAP groups typically range in size from 10 to 15 participants and are led by two trained facilitators. Information is imparted through seminars, workshops, presentations, support groups and the internet. lectures, discussions, home work, and individual and group exercises, and key WRAP concepts are illustrated through examples from the lives of the facilitators and participants. The intervention is typically delivered each week for three month 2-hour sessions or less of WRAP/week. Some session take more than 2 hours this is because recreational activity and journey. Participants often choose to continue meeting after the formal 12-week period to support each other in using and continually revising their WRAP plans. WRAP is generally offered

in mental health clinic center programs, residential facilities, and peer-run programs.. Although the intervention is used primarily by and for people with mental illnesses special schizophrenia.

❖ **Key elements of WRAP:**

- Wellness Toolbox
- Daily Maintenance Plan
- Identifying Triggers and an Action Plan
- Identifying Early Warning Signs and an Action Plan
- Identifying When Things Are Breaking Down and an Action Plan
- Crisis Planning
- Post Crisis Planning. (http://www.mentalhealthrecovery.com/e-learning/)

❖ Definition of trigger.

Triggers can be internal (self-thoughts or emotions) or external (situations, events or what people do or say). In order to cope with triggers I, have rages, withdraw from others, feel nervous or anxious, feel suspicious, or hear voices. It is important to be able to identify my specific triggers in order to develop coping strategies to avoid relapsing. Some groups of triggers may be:

- Physical Triggers - things that affect my body.
- Life Stressors - personal or world events that affect me.
- Social Triggers – situations that evoke negative thoughts/feelings.
- Emotional Triggers – situations or feelings that negatively affect my sense of self.

❖ Discussion on wellness.

The following topics will be covered using a workshop style, including presentations, demonstrations, interactive discussion and related activities as individual and group exercises, and voluntary homework assignments. An introductory session conveyed the key concepts of WRAP and recovery.

• Generate discussion on idea of **wellness** allowing participants to contemplate, debate and formulate their own ideas on wellness. Small group collage on wellness

❖ Discussion on recovery

- Generate discussion on WRAP **idea of recovery**, other ideas and views on topic and encourage sharing examples of recovery. Discussion on the Five **Key Concepts of (WRAP)** Hope, Self-Responsibility, Education/Information, Self-Advocacy, and Support.
- Group encouraged to debate concepts and offer examples of each to aid understanding
- Evaluation should be form completed at the end of the session gathering the information

❖ Key Recovery Concepts

Five key recovery concepts provide the foundation of effective recovery work.

- **Hope** - People who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
- **Personal Responsibility** - It's up to you, with the assistance of others, to take action and do what needs to be done to keep yourself well.
- **Education**- Learning all you can about what you are experiencing so you can make good decisions about all aspects of your life.

- **Self-Advocacy** - Effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery.

- **Support**- While working toward your wellness is up to you, receiving support from others, and giving support to others will help you feel better and enhance the quality of your life.

- to develop a Wellness Recovery Action Plan that will help you feel well more often and move forward with your recovery. This will include listings of Wellness Tools that might keep this event from making you feel worse

❖ **Daily maintenance.**

those things you need to do every day to keep yourself well, such as eating three healthy meals and getting a half-hour of exercise

(triggers), external events that could make you feel worse such as an argument with a friend or getting a big bill

Early Warning Signs - such as irritability or anxiety that indicate you might be starting to feel badly, and a response plan

Breaking down signs that indicate the situation is getting much worse, such as reckless behavior or isolation, and an action plan to stabilize the situation.

crisis plan You can also develop a personal crisis plan to be used when you need others to take over responsibility for your care. Your crisis plan includes list of your supporters, their roles in your life, and their phone numbers

signs that let your supporters know they need to make decisions for you and take over responsibility for your care

instructions that tell your supporters what you want them to do.

❖ Post crisis

What we learn after this crisis

During the last class, instructors discussed the value of **post-crisis planning**, strategies to revise one's WRAP plan after a crisis

❖ Discussion on wellness

Throughout all 12 classes, participants were exposed to information and activities designed to increase their hopefulness, as well as enhance their skills in taking personal responsibility for their wellness and education. Specifically, participants discussed to manage their mental illness. WRAP has the following goals.

- Teach participants how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives
- Help participants organize a list of their wellness tools--activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising..
- Assist each participant in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf
- Help each participant develop an individualized post crisis plan for use as the mental health difficulty subsides, to promote a return to wellness Strategies to implement and operationalize recovery in the mental health system in those states that have moved beyond the service name changing stage, include education for consumer and family involvement, support for consumer operated.

❖ **Beginning the Journey.**

Through careful observation you will learn.

- those things you need to do every day to keep yourself well, such as eating three healthy meals and getting a half-hour of exercise.
- external events that could trigger symptoms, such as an argument with a friend or getting a big bill, and responses that might keep this event from causing or worsening symptoms
- early warning signs - such as irritability or anxiety - that indicate your symptoms may be worsening, and a response plan
- symptoms that indicate the situation is getting much worse, such as reckless behavior or isolation, and an action plan to stabilize the situation.

❖ .**Session of program**

The first week session one

getting to know you.

Introduction Meeting.

The researcher introduced herself , the aim of this program , her scientific & work life, then after getting to know You: instructions for an exercise to help participants to know each other. by ball exercise. Every one defines her name, job, live, social life & educational level.

- **Basic foundation of program.**

The researcher notifies that every session should run out by systematically each other and notifies to keep attendance , avoid absence , so the basic foundation has applied for program as respect each other also any opinion , fairness ,quite, good listening ,and participant activation . So this session supported trusting relationship between participant , honest and woke attendance.

.After that I thank all for well co-operation and reminded them for next meeting .

- **Notes.**

Before starting the program I have demonstrated pretest individually through follow up medical management. Pretest was demonstrated for each other to reflect their knowledge , attitudes and opinion.

Second week session one

Understanding of idea of recovery.

The researcher welcomes participants and thank them for good attendance and remind them of previous session. Then she discusses with participants what is program and.

What do we think about recovery and mental illness?

- **aim**
- Is to change negative thought to positive aspect, decrease stigma.
- reflect on their knowledge and understanding of recovery and mental illness.
- **Material:**
- digital camera to photograph the session.
- flip chart ,paper and cultured pens to record any discussion
- **instructions .**
- Defining Recovery: A power-point presentation to accompany the exercise What does recovery mean to me personally?
- An exercise in which participants write and draw a personal definition of recovery which they then share with others to produce a poster use follow master pen and paper.
- Generate discussion on idea of mental health and recovery**.** allowing participants to contemplate, debate and formulate their own ideas on recovery.
- organize the groups into pairs small group to work with pairs

session two

- **Wellness &wellness tool**
- What does wellness mean to you?

the researcher ask question about what is wellness? in small group discussion, Group encouraged to debate concepts and offer examples of each to aid understanding by using of .

Material

poster, lecture, power point.

poster discussion with group to had a chance for everybody to achieved preparation of poster

answer any question and clarified any misunderstand finally concluded this session by reminded people to keep copies on their complete work sheet in their folder.

Used activity by writing on A4 paper. what the meaning of wellness everyone has differ explanation and differ way to express.

Aim to help them feel better when they are experiencing mental health difficulties and prevent these difficulties from arising. Creative and fun activities--doing things that are personally enjoyable like reading, creative.

Help participants organize a list of their wellness tools--activities they can use . Researcher used relaxation technique & deep breathing exercise this lecture affect their feeling and make them express their feeling and what they feel internally

Third week: Session three.

Daily maintenance plan

The researcher welcomes of participants and thank them for good attendance , remind them of previous session**,** and discussion on home work**.**

After that instructor helped participants to developed their own daily maintenance plans, strategies to facilitate mental and physical wellness .Each day recognize and proactively respond to their self-defined symptom ,trigger . She reviewed personal strategies .

Aim

To help participant explore the used of wellness tool and their daily maintenance.

To facilitate mental and physical wellness each day recognize and proactively respond to their self-defined symptom triggers. she reviewed personal strategies to maintain wellness and self-manage one's disability.

material

poster, flip chart colored pens .

Through careful observation you will learn: the things you need to do every day to keep yourself well, activities, routines, thoughts & behaviors that maximize wellness and minimize symptoms include: prayer Quran reading spirituality , reaching out for support, peer counseling, maintaining an ongoing dialogue with health and social care professionals, planning the day, stress reduction and relaxation techniques, focusing exercises, fun, affirming creative activities, journaling, daily planning, exercise, light exposure peer counsel - share talking diversionary activities & fun ,proceed, so there are good sharing and open discussion.

Every one expresses feeling by differ way .Daily Maintenance Plan- identify a regular those things you need to do every day to keep yourself well,

circle any of these that you would be suit you

such as eating three healthy meals, and getting a half-hour of exercise, pay attention to nature, practice centering prayer, talk to a friend, laugh, avoid negative people, journal, get enough sleep, read a fun book, play the piano and sing, get in touch with my spiritual side, avoid caffeine, sugar, junk foods, alcohol, nicotine, get outside in the sunlight, We should apply the relaxation technique during the relaxation session, talk about problems with close friends, don't go to bed angry – deal with any negativity, be reasonable in scheduling time, remember someone's birthday or anniversary, go for a long walk or do some other extended outdoor activity (gardening, fishing, play softball)

make a note of any key point.

Be creative: there may be a small prize for most creative poster.

The next meeting should be writing how everyone spend daily maintenance.

Evaluation should be form completed at the end of the session and gathering the information. The researcher ended the session by thank them and remind them of the next session & the important of attendance.

Fourth week session four

- **Idea of Five Key Concepts recovery**

Generate discussion on WRAP idea of recovery, other ideas and views on topic and encourage sharing examples of recovery. Discussion on the Five Key Concepts of WRAP.

- Teach participants how to implement the key concepts of recovery
- **Aim**
- To help the participants identify some of the characteristics and features of lifestyles that promote recovery.
- Explain and generate discussion on the five 'Key Concepts' underpinning WRAP. Hope, Self-Responsibility, Education/Information, Self-Advocacy, and Support•

- Group encouraged to debate concepts and offer examples of each to aid understanding

materials

- lecture ,power point,. Homework assignment

Promoting Recovery: A card-sort exercise designed to help the participants identify some of the characteristics and features of lifestyles that promote recovery .

Promoting Recovery: A power-point presentation to introduce the exercise

Titles: Three title statements to copy on to card for the card sort exercise peer counseling--sharing with another person who has experienced similar symptoms.

Let them express their feeling e.g. hope by writing on A4 Paper This activity make participant feel pleasure and recreation, deprivation feeling. The researcher welcomes participants and say good bye thank them for attendance. Evaluation should be form completed at the end of the session and gathering the information. The researcher ended the session by thank them and remind them of the next session &the important of attendance. Give home work for them.

- **Fifth week**

Recreational session to the sea

Including recreational activities and one meal for everyone to meet their basic needs.

Transportation after the day end .

Sixth week

Trigger

The researcher welcomes of participants and thank them for good attendance and remind them of previous session**.** Discussion on homework all client try to do best work and creative thing.

The researcher discussion with participants about what is trigger. and ask each one to write about their special expertise & feeling what it means .And then demonstrate sore cards about many things that could be upset feeling and put assign in front of each one

Aim:

To protect the person from others crisis. And learn the action plane.

Material

poster, flip chart colored pens . presentation

Action Plan: Things that I can do if my triggers come up to keep them from impairing my ability to function:

- Deep breathing, progressive relaxation and visualization exercises.

- Trigger can create Some relapses can be managed at home, but other relapses may require hospitalization to protect the person or others. If severe episodes.

use diversionary activities, attend more support group meetings, reach out to support people, talk to someone else ,paint walls , exercise , do a hobby , garden ,sit quietly with loved one , take a walk , pray ,Group encouraged to debate concepts and offer examples of each to aid understanding express by this lecture research make sense of deprivation and good sharing give homework in the end she thanks for all about activity and sharing and attendance

Seventh week:

Early warning signs

The researcher welcomes participant and thank them for good attendance and remind them of previous session and discussion on home work**.** For the six class*During class seven, instructors introduced the concept of early warning signs that a crisis might be impending and advance planning for extra services/supports when this occurs.

Aim:

To limit impact feel worse.

Material

poster, flip chart , colored pens and presentation .

Early Warning Signs/ Early Warning Signs Action Plan- identifies negative impact of triggers on self and environment and devise a plan to limit impact feel worse, I used poster, presentation group discussion

Participant feeling sadness and deprivation and someone began to crying .

Some early warning signs that others have reported and/or I have observed which indicate that I am experiencing stress and may be having difficulty functioning:

- increased anxiety
- can't concentrate or function
- experiencing frustration – "Here we go again…"
- decreased sleep or increased sleep, increased crying, can't leave loved one alone
- sadness, over-reacting• irritability, anger nervousness, headaches, resentment, desire to escape, get away, use a "magnifier" when looking at loved one, isolating, fear of increased financial pressure, fear of police and judicial system – their actions and attitudes, forgetfulness, inability to experience pleasure , feeling discouraged, hopeless ,over-eating, feeling overwhelmed , watching a lot of TV ,knots in my stomach

Action Plan:

Applying relaxation technique.

Things I should:

- temper tantrum then again, using your Wellness Toolbox, developing an action plan for responding to these signs you feel better quickly and prevent a possible difficult times.
- do the things on my daily maintenance list whether or not I feel like it.
- attend support group meetings • spend time with grandchildren
- take my loved one to a movie
- do at least one activity I enjoy each day give myself permission not to be perfect
- do at least one activity I enjoy each day

The researcher asked the participants to fill homework of what they feel emotionally physically, behaviorally - identify negative impact of triggers on self and environment

❖ **Eighth week:**

Recreational session at the Al basher play guard

for recreation , refreshments , changing daily routine, enjoyment**.**

❖ **Ninth week:**

Signs of Breaking down.

The researcher welcomes of participants and thank them for good attendance and remind them of previous session**.** And discussion of homework.

Aim:

limit impact .When Things are Breaking Down.

Material

poster, flip chart , colored pens and presentation.

Signs of Breakdown/ Signs of Breakdown Action Plan- identifiable characteristics that things are unmanageable and breaking down and devise a plan to limit impact . When things are Breaking Down. In this section, you list those signs that let you know you are feeling much worse, like you are feeling very sad all the time or you are hearing voices. And again, using your Wellness Toolbox, aim to develop a powerful action plan that you will help feel better as quickly as possible and prevent an even more difficult time.

In the end of this session video was showed about other experiences of mentally ill and how those people recovered and adapting well,. As (names) of key persons

Signs that indicate that things are getting worse:

- don't want to get out of bed
- forgetting → blocking things out → "being unconscious"
- increasing arguments• on edge• can't concentrate or focus
- thinking the worst and anticipating what I will do
- calling the therapist and/or psychiatrist
- go to the Internet and search for the answer(s)

- denial • unable to sleep
- unable to eat • obsessed with negative thoughts
- feeling over whelmed In this session the researcher used other technique of drawing ,arts and craft deprivation.

Action Plan: Things that I can do to help relieve my distress at this time: by relaxation technique.

The researcher recommended and validate this discussion by prophet Muhammad(peace upon him). how to manage anger , nervousness and stress feeling., during relaxation and, other activity prayers .

- exercise
- call the professionals – to listen to me – and ask for and follow their advice if it makes sense
- reduce stress for family member by taking on more responsibilities
- call and talk, as long as I need, to my supporters
- take actions so my loved one cannot hurt me or other family members.
- check in with my relatives at least 2 times daily.

❖ **Tenth week**

crisis planning.

- The researcher welcomes of participants and thank them for good attendance and remind them of previous session**.** this session is very important for the participants.
- The researcher try to reflect their knowledge ,what they understand ,change, modify discover skills and improve according the strategies.

Aim :

to maintain control even when the situation is out of control.

Material

poster, flip chart , colored pens and presentation

In self-help recovery groups, people who experience symptoms are working together to

redefine the meaning of these symptoms, and to discover skills, strategies and techniques that have worked for them in the past and that could be helpful in the future.

who you want to take over for you and support you through this time, health care information, a plan for staying at home through this time,

the researcher demonstrate group and then make all group discuss whom their supportive to help them manage crisis. list schedules by list of some relatives and services.

Others things can do that would help and things they might choose to do that would not be helpful. This kind of proactive Part– Signs that indicate that others need to take:

- when I can't keep up with "general maintenance" –cooking, housework, etc.
- when I can't keep up with work responsibilities
- when I can't give other siblings (children) attention
- when I need someone to talk to regarding "Is this a
- crisis?" "Am I thinking clearly?"
- when I'm not taking good care of myself
- when others are not acknowledging I am in the middle
- of a crisis
- when I need someone to listen
- when I'm not sleeping at all
- when I'm neglecting personal hygiene
- when I'm not eating

These are my SUPPORTERS, the people who I want to take over some of my responsibilities when I need it:

Name:

_____

Relationship:

Phone_____

number: _____

Role(s) I want this person to play / Task(s) I would like this person to do / Skill(s) I would like them to use:

- be educated about mental illness
- listen to me vs. problem solve
- let me call them at any time when things are out of control
- get me out of the house

The people I don't want them to be involved in any way and why:

- family members/friends who tell me what I should do without asking me.
- family members/friends who blame me for the crisis

As you begin your recovery journey, there are two important things you need to do for yourself:

- **Get good medical care**. At least once a year, and whenever your symptoms change or worsen, has a complete physical examination to determine if there is a medical problem which is causing or increasing your symptoms. When you go to see your doctor take a complete listing of treatments, supporters, facilities and helpful strategies others can employ when participants experience crisis and are unable to advocate for Themselves.

A. all medications and health care preparations you are using

B. any new, unusual, uncomfortable or painful symptoms.

Manage your medications carefully. Learn about your medications, how they work, what to expect, possible side effects, and dietary/lifestyle restrictions.

- Take them only as prescribed.
- Use a daily reminder/pill saver system to insure regular use.

- **Spirituality side**

The researcher welcomes participants and thank them for good attendance and remind them previous session.

What spirituality means to us.

Spirituality includes feeling more connected to our God, to one's self, to other people, community, and to Nature, or Life in general. There are many examples in the Qur'an and Hadith of the virtues of a positive mental attitude, perseverance and optimism

in the face of adversity. However, did you know that patience and positive outlook on life are two of the greatest healing tools that you can use ?.and. A number of researchers have now reported lower rates of suicide (the direct consequence of depression) among those who are more religiously involved.

Well-designed studies have examined the relationship between mental health and religious belief, commitment or practice. Between 85 to 90 percent of persons responded that religion is a source of comfort.

The blessings and mercy of their Lord, and such are the guided ones." According to the findings of modern science, it appears that this mercy may often come in the form of improved health. Islamic teachings encourage patience, prayer and turning to Allah (SWT) in times of need and for guidance.

For a Muslim his/her faith provides hope and a sense of control over his/her destiny. The Noble Qur'an emphasizes that something good can result from every situation if the believer puts his/her complete trust in Allah (SWT). Allah (SWT) can be reached and influenced by prayer and Du'a. Guilt is erased by the simple act of asking for forgiveness. Complete trust in Allah (SWT) may have powerful psychological consequences, and may indeed bring comfort to those who are lonely, anxious, discouraged, or feeling out of control.

Prayers in a mosque brings people into contact with others of similar age who have common interests and with whom social relationships may form. Religious doctrines promote social interaction by encouraging positive social attitudes and self-sacrifice.

There is much wisdom in the Prophet's (SAW) statement (narrated by Abu Hurayrah), "The strong [person] is not the one who overcomes the people by his strength, but the strong [person] is the one who controls himself while in anger." In fact, staying patient and calm is key to physical strength.

It produces calm and health to practice saying, "thanks to God " for what we have and for what we are faced with. We should try to keep our home and work environments peaceful and free from stress possible. One way we can counteract the effects of stress are to simply be aware of the stress we are encountering, and to consume sufficient nutrients and supplements such as herbs.

The best manner to avoid having negative attitudes and emotions control our bodies is simply to practice the wisdoms that we have been given throughout the Qur'an and Hadith. We should say, "Alhamdulillah" for what we have; "Insha'Allah" for what we intend; and, "Subhana' Allah" when we see something exciting or amazing. We should remember to say, Astaghfir 'Allah" when we lose our tempers or become weak, and most importantly, "Allah Akbar" when we are faced with the challenges of life. These five phrases are said regularly, are like taking a multi-vitamin for holistic health.2.Ibrahim B. Syed.: **Medical Benefits of Tarweeds Prayers. WWW.IRFI.ORG**

Things I do to increase my own feelings of spirituality .as…I belong to a mosque.,…Volunteer to help other people, Read inspirational books,……..Join a group of spiritually minded positive people…… Establish a schedule for daily prayer/ meditation / inspiration reading Quran in Quiet Time.

True spirituality in action helps us lead better, more fruitful and happier lives.

Spirituality is encouraged and increased by an attitude of gratitude.

five or more things omens I am grateful for today.

1. _____
2. _____.
3. _____

❖ eleventh week

post crisis plane

The researcher welcomes of participant and thank them for good attendance and remind them of previous session**.** And discussion on home work **.**

During the last class, instructors discussed the value of post-crisis planning, strategies to revise one's WRAP plan after a crisis.

The next two classes focused on advance crisis planning, including identification of preferred medications.

Throughout all 12 classes, participants were exposed to information and activities designed to increase their hopefulness, as well as enhance their skills in taking personal responsibility for their wellness and education. Specifically, participants discussed:

1) how to access credible, personally meaningful treatment information
2) how to advocate for themselves with providers and other supporters. They also practiced making choices and expressing preferences, based on their personal knowledge of successful illness self-management strategies .

❖ **Twelfth session**

Evaluation session.

The researcher welcomes of participant and thank them for good attendance and remind them of previous session**.** The researcher thank participants for good sharing &attendance .

Evaluation form for day one an evaluation form for participants to give feedback on the entire learning experience.

1-Focusing group.

About three patient from intervention group, I let them to answer some open question about the opinion and any comment of program post intervention immediately.

and I liked to take feedback and reflected their knowledge & what they understand ,changes, additions, negative & positive point and modifying this is was by Journey to the GAZA sea, the activity by group discussion sharing view all to gather.

Let's everyone to expressed feeling alone what advantages and disadvantages this help group to belonging, sense of hope ,empower have goal pleasure and meaningful life and reflect their feeling.

How well was the session presented?

-**2**.A WRAP evaluation form 12 completed three, once before the WRAP session and one approximately after the session that would map changes in attitudes and the third one after, four month by the ending of post one.

1. .Discussion that was loosely based on the following questions

- How did you believe that spirituality affect positively for increase your own feelings towards recovery?
- Have you feeling any relapse in recent months?
- Have you been using WRAP ?
- Can you give examples of how you been using WRAP?
- How is your medication situation?

Annexes five

Questioner in English

First	Goal	Strongly Not agree	Not agree	agree	Not sure	Strongly agree
1	I have a desire to succeed					
2	I am a good person					
3	Recovery mean becoming more satisfied with my life					
4	I can participating & communicate with other					
5	I have goals in life that I want to reach					
6	Because mental illness I can't hold a job					
7	I feel depressed ,sadness caused by disease					
8	I go out at least two enjoyable					
Second	**Self-responsibility**	**Strongly Not agree**	**Not agree**	**agree**	**Not sure**	**Strongly agree**
1	My symptoms seem to be a problem for shorter periods of time					
2	My symptoms interfere less and less with my life.					
3	I am feel at peace with my self					
4	I eat balance diet every day					
5	I understand how to control the symptoms of my mental illness					
6	I am the person most responsible for my own improvement					
7	I am still capable of learning about mental illness to be more control					
8	I am often able to over comes barrier					
9	Because the disease I feel disconnected with society					
10	Because the disease I feel disconnected with society					
11	I feel as a shame when getting out for any occasion					
12	Even when I don't believe in myself, other people do					

Third	**Hope& honest**	**Strongly Not agree**	**Not agree**	**Agree**	**Not sure**	**Strongly agree**
1	Recovery need to hope and encouragement					
2	There is some source outside of myself that give my lf meaning					
3	My religious had made me a strong & resilience					
4	every day is a new opportunity for learning					
5	I am a better person than before my experience with mental illness					
6	I have a hope about the future					
7	I feel patience with other and me					
8	Reading Quran is sources of faith					
9	Spirituality is a part of my recovery					
10	I like to help others					
11	Recovery can occur even if symptom of mental illness present					
Fourth	**Support**	Strongly Not agree	Not agree	Agree	sure Not	Strongly agree
1	I ask for help, when I need it					
2	I am willing to ask for help					
3	I asking for help when the symptom are getting worse					
4	I have people who are recovering from problem similar to mine					
5	I can help myself become better without professional interact					
6	I have financial as continues					
7	I has frequently treatment assistants					
Fifth	**self-advocacy**	**Strongly Not agree**	**Not agree**	**Agree**	**sure Not**	**Strongly agree**
1	Symptom more worsening when out of control &up set					
2	I know when I , m getting worse symptom is breaking down					
3	I can identify what triggers the symptoms of my mental illness					
4	Although my symptoms may get worse, I know I can handle it					
5	I know what can I do to be better					
6	I have my own plan for how to stay or become well.					

focusing group

What helps people in the process of recovery?

How useful did you find the session?

How useful were the topics covered relevant to you managing your symptom?

How did you believe that spirituality affect positively for increase your own feelings towards recovery?

Have you feeling any relapse in recent months?

بسم الله الرحمن الرحيم

السيد الدكتور: ..... المحترم تحية طيبة وبعد .

الموضوع :تحكيم استبانة:

انا الباحثة حنان الشيخ علي: ملحق ببرنامج الماجستير للصحة النفسية المجتمعية علوم التمريض بالجامعة الاسلامية رهن القيام برسالة الماجستير كمتطلب تكميلي لنيل درجة الماجستير بعنوان.

مدى نجاح برنامج الدمج والاستشفاء على مرضى الفصام في مدينة غزة:

Effectiveness of Wellness Recovery Action Plan (WRAP) on Schizophrenic patients in Gaza city.

ارجو منكم الاطلاع على المقياس المرفق وافادتنا ونصحنا برايكم وابداء الملاحظات ان وجدت للتعديل.

الباحثة : حنان الشيخ علي

جوال / 9655803

pros.7000@ hotmail.com

بسم الله الرحمن الرحيم

الجامعة الاسلامية

عمادة الدراسات العليا

قسم التمريض

البيانات الأولية:

اختبار مقياس الدمج و الاستشفاء لدى مرضى الفصام

الفئة العمرية	أقل من 20		أقل من 30		30 فأكثر

الحالة الاجتماعية	متزوجة	عزباء	مطلقة	ارملة

الوظيفة	عاملة		غير عاملة

الدخل الشهري	500 شيكل	1000 شيكل	2000 شيكل

المستوى التعليمي	امية	ابتدائي	إعدادي	ثانوي	دبلوم	جامعي

منطقة السكن	مدينة		مخيم

الباحثة :حنان الشيخ علي

Effectiveness of Wellness Recovery Action Plan (WRAP) on Schizophrenic patients in Gaza city.

Goal

To understand the effectiveness of WRAP among schizophrenic patients in Gaza city.

Objectives of the study

* To identify the effectiveness of WRAP on schizophrenic patients in intervention group

*To identify the effectiveness of traditional method on schizophrenic patients in control group

*To compare between intervention and control group in regarding hope, skills, self-management and relapse symptoms.

*To provide recommendations and suggestions for the decision makers about

implementation of WRAP in governmental sectors.

key concept of wrap.

number of core principles.

■hope, Personal Responsibility, Self-Advocacy, Education, Support, goal

اختي الفاضلة بين يديك مجموعة من العبارات والمطلوب منك الاستجابة للعبارة التي تصف حالتك او وضعك وذلك بالتأشير على واحدة فقط من هذه الكلمات

(لا اوافق بشدة ، لا اوافق ، غير متأكدة ، اوافق ، اوافق بشدة) :

علما بانه لا توجد اجابة صحيحة او خاطئة ، وما النتائج سوى للبحث العلمي.

اولا	الهدف والنجاح	لا اوافق بشدة	لا اوافق	اوافق	غير متأكد	اوافق بشدة
1	لدي الرغبة بالنجاح.					
2	اشعر انني انسان جيد.					
3	عملية الشفاء تعني لي اكثر مرحلة نجاح في حياتي.					
4	يمكنني المشاركة والحديث مع الاخرين.					
5	انا قادر على تحقيق هدفي الذي اسعى اليه.					
6	اخرج على الاقل مرتين للتنزه كل اسبوع.					
ثانيا	مدى الاعتماد على الذات والاخرين	لا اوافق بشدة	لا اوافق	اوافق	غير متأكد	اوافق بشدة
1	اصبحت الاعراض لا تشكل حيز كبير من تفكير.					
2	اصبحت الاعراض تؤثر بشكل اقل على حياتي.					
3	اشعر بأمان مع نفسي.					
4	اتناول وجبات غذائية متوازنة كل يوم .					
5	بإمكاني السيطرة على الاعراض ان شعرت بها .					
6	اشعر بالمسئولية عن مدى تحسني.					
7	لدي المقدرة باكتساب كل ما تعلمته للسيطرة على الاعراض المرضية .					
8	باستطاعتي التحكم بالتوتر والضغوطات.					
9	هناك اشخاص داعمين لي يساندونني عندما اكون غير قادر على العناية بنفسي.					
10	اشعر ان مسار حياتي خارج عن السيطرة					

ثالثا	الصدق والامل	لا أوافق بشدة	لا أوافق	اوافق	غير متأكد	اوافق بشدة
1	عملية التعافي تحتاج الى امل و شجاعة.					
2	هناك بعض المصادر الخارجية تعطيني معنى لحياتي .					
3	التمسك بالدين يكسبني صلادة وقوة.					
4	كل يوم لدي فرصة افضل للتعلم.					
5	انا اصبحت افضل من الاول.					
6	اتحلى بالصبر مع نفسي والاخرين.					
7	ا صبح لدي امل في المستقبل.					
8	الصلاة وقراءة القران مصدر الهامي.					
9	تديني جزء مهم في حياتي.					
10	احب مساعدة الناس الاخرين.					
11	يمكن التعافي ان يحدث حتى لو بقيت الاعراض.					
رابعا	الجاهزية في طلب المساعدة	لا اوافق بشدة	لا اوافق	اوافق	غير متأكد	اوافق بشدة
1	اطلب المساعدة متى احتاج اليها					
2	انا مرتاح وسعيد بطلبي للمساعدة					
3	اسعى لطلب المساعدة عند ظهور علامات تنذر بالانتكاس.					
4	اعرف اشخاص قد تعافوا من المرض النفسي.					
5	يمكنني التعافي من المرض النفسي بدون مساعدة مهنية					
6	اتلقى مساعدات مالية بشكل مستمر					
7	يمكنني الحصول على العلاج بصورة مستمرة					

خامسا	الحماية والمعرفة	لا اوافق بشدة	اوافق	لا اوافق	غير متأكد	اوافق بشدة
1	عندما اتعرض لأمور مزعجة في الحياة تتفاقم الاعراض لدي					
2	اعرف متى اكون مقبل على انتكاسة عند بدء ظهور بعض الاعراض.					
3	عندي المقدرة على معرفة العوامل التي تثيرني او تظهر لدي المشكلة					
4	ما زالت لدي بعض الاعراض استطيع التعامل معها.					
5	اعرف ما الذي يمكنني ان اقوم به لأكون بأحسن حال					
6	انا قادر على مساعدة نفسي للبقاء بأفضل حال					

Focusing group

مقابلة تقييمية لبعض المشاركين في البرنامج.

- ما هو مفهومك لعملية التعافي او الاستشفاء.
  - *هل تشعرين بالرضا بعد نهاية البرنامج؟*
  - *هل تعتقدين ان خطة التعافي قد افادتك في ادارة بعض الاعراض؟*
- *هل باعتقادك ان الوازع الديني قد ساهم بشكل ايجابي في عملية التعافي*
  - *هل شعرت بانتكاسة في الاشهر الاخيرة ؟ وان حدث كم عدد المرات*

☺ **شكرا على حسن تعاونكم ...**

Annexes Six

كتيب العافية

الشعور بحياة افضل

اعداد : اخصائية الصحة النفسية المجتمعية

حنان محمد الشيخ علي

ماجستير: الصحة النفسية المجتمعية

إشراف الدكتور: يوسف الجيش

استاذ : الصحة العامة المشارك

بسم الله الرحمن الرحيم

دليلك لدعم العافية والانتعاش الخاصة بك

هذا الكتيب المتواضع إهداء من الباحثة إلى كل انسانة تعاني من عدم التكيف مع ضغوطات الحياة و لإدارة الأعراض السلبية للازمة .

الانتعاش أو العافية : بمثابة تذكير ودليل، . تم تصميمه كأداة مساعدة لتوجيه نفسك، بالشيء الذي يساعدك ، وكيفية الحصول على المزيد من المعلومات للسيطرة على حياتك وتجربتك. فإنه يشمل أيضا على إرشادات حول وضع خطة التعامل مع الأزمة النفسية، كوسيلة لتوجيه الآخرين حول أفضل السبل لتحمل المسؤولية من خلال استغلال المصادر الداخلية للإنسان مثل الإيمان ,القوة , الانتماء, التمسك بالدين, والدعم العائلي.... وتتضمن خطة استراتيجية تعليمية ذاتية يستخدمها أي إنسان معني بإدارة الأعراض المرضية علي المدى البعيد و لتحقيق هدفه. (الشعور بالأمل بالتعافي ,الاعتماد علي النفس , الثقة بالنفس, التواصل مع الناس ,ومنع الانتكاسة, الحماية والمعرفة) ,والخلو من الأعراض. إليك الخطة.

أدوات العافية

السعادة ,الأمل ,التفاؤل, الإنتاجية ,الحب, النشاط , الهدوء ,المرح, الإبداع, التميز, الاطمئنان ,الايجابية, تناول وجبات صحية ,الأمان , القناعة , الإيمان , الوضوح , الحياة الثقة بالنفس القوة , الاتزان , المرونة , المسؤولية, التكيف .الصلاة , قراءة القران , الدعاء , التأمل.

الخطة اليومية

أشياء تفعليها لتبقي سعيدة وهي عبارة عن ممارسات يومية بسيطة يقوم بها الإنسان كل يوم لتشعره بالراحة النفسية والعافية

- تناول علاجي بانتظام
- ممارسة التمارين الرياضة

* الصلاة

- قراءة القرآن ,أتأمل في ملكوت الله
- التصحف في مجلة أو قصة مسلية .,أتذكر حفلة عيد ميلاد لأحد المقربين.
- الاعتناء بالحديقة ,اخرج للتنزه.
- تناول وجبة متكاملة, قسط وافر من النوم.
- التأمل في الطبيعة, أتنفس الهواء الطلق.
- ممارسة هوايتي المفضلة.
- الحرص على اخذ حمام دافئ.
- مناقشة مشاكلي مع شخص مقرب.
- مشاهدة التلفاز.
- الاستماع إلى الموسيقي الهادئة واخذ قسط من الراحة.
- تجنب الأشخاص المزعجين.
- تجديل ضفائري ،المشاركة في فيس بوك.

العوامل المثيرة

وهي عن عوامل القدح بمثابة الشرارة الأولي لإثارة الأعراض وتتمثل بالعوامل الداخلية أو الخارجة

- الشعور بالعجز و الخوف من المجهول
- مشاحنات مع احد أفراد الأسرة
- تغيير في روتين الحياة
- مرض احد أفراد العائلة
- ضغوطات حياتية
- عدم توفر العلاج

•المعاناة المادية

•فقدان الأشياء

•عدم التقبل, فكرة الموت

•الانتقادات من الآخرين ,قلة النوم

أشياء افعلها لتفادي العوامل المثيرة.

وهي عبارة عن روتين أو مهارة بسيطة يمكن لأي شخص أن يستخدمها في حياته اليومية مثل

•التحدث إلى شخص ما

•الالتزام بالعلاج

•الابتعاد عن المثير, الانضمام إلى الشخص المقرب

•ممارسة التمارين الرياضية و الاعتناء بالحديقة , ممارسة العبادات

•ممارسة أي هواية ,الخروج للتنزه, اسرح شعري

•الخروج للتنزه., الاتصال بالأخصائي النفسي.

الأعراض المبكرة

وهي علامات تشعر الإنسان بأنه ليس بوضع نفسي مريح.

وهذه العلامات أو الإعراض تتمثل كالتالي:

• الشعور بالغضب لأتفه الأسباب.

• الإهمال في النظافة الشخصية.

• الم في الرأس.

• النسيان و التشاؤم.

• الشراهة.

• الم في المعدة.

- الشعور بالبعد عن الأهل والأصدقاء, زيادة الحركة.
- اضطراب في النوم , الشعور بالعجز .
- خلل في الدور الوظيفي.
- الإحباط , الشعور بالحزن.
- البكاء, اضطراب المزاج.
- الرغبة في الهروب
- الخوف من تفاقم المشكلة

كيف تتخلصين من ظهور الأعراض المبكرة

وهى عبارة عن وسائل بسيطة وسهلة تمكنك من ادارة هذه الاعراض والتخلص منها مثل اللجوء الى.

العائلة, الأصدقاء, الأخصائيين النفسيين وداعمين اخرين سوف يساعدوك في استدراك الإعراض المبكرة

ارجعي لخطة العمل اليومية في صفحة (1)

1..تنظيم الوقت

2.تفريغ للمشاعر مع شخص تثقين به

3.ممارسة نشاط واحد تحبينه

4. تمرين الاسترخاء ا والتنفس العميق.

5. الانضمام إلى فريق داعم تحبينه

6. قضاء وقت ممتع مع الأطفال

7. .تأدية العبادات

8 ..تناول العلاج حسب وصف الطبيب والأخصائي

9 ..سماع القران الكريم عن طريق وضع سماعة الجوال في الاذن لتجاهل الأفكار وسماع الأصوات.

10 . عدم الإكثار من شرب القهوة بعد السادسة مساءا .

11. النوم والاستيقاظ في نفس الموعد كل يوم.

12.عدم مشاهدة أفلام العنف.

13.تناول كاس من الحليب الدافئ

14.تجنب القيلولة أثناء النهار

تفاقم الأزمة

العلامات التي تدل على تفاقم الحالة, وان الأعراض تزداد سوءا.

* الشعور بالإرهاق.

* فقدان الشهية .

* البكاء طوال اليوم.

* القلق في النوم.

* العدوانية. الثرثرة* كثرة الحركة

* تكسير أثاث المنزل

* عدم المقدرة على التركيز.

* الإنكار.

* هاجس الأفكار السلبية.

*سماع أصوات و تهيؤات لم يسمعها احد.

* الشعور بأنني على شفا حفرة.

* استدعاء المعالج أو الطبيب النفسي

خطة عمل

أشياء بإمكاني أن افعلها للتخفيف من حدة الأعراض

وهي بمثابة وسائل دفاعية تحميك من هذه الاعراض

** تناول العلاج المناسب.

**اللجوء إلى المقربين الداعمين.

** اتخاذ الإجراءات التي تمنعني من إيذاء من أحب.

** قسط من الراحة.

* * الاستمتاع بالمواقف المرحة .

** التحدث إلى من نحب.

** تذكير نفسي بالمواقف الناجحة في الحياة

** استدعاء المهنيين لأخذ نصائحهم.

خطة إدارة الأزمة

خطة يحضرها المريض وهو بنفسية جيدة للاستعانة بها إثناء حدوث الأزمة (الانتكاسة).

وهذه الخطة تساعدك في تجنب انتكاسة أخرى.

يجب أن تعلميها لأشخاص مقربين تثقين بهم حتى يكونوا على استعداد لتقديم المساعدة .

ارجعي إلى البند الأول في الصفحة الأولى من الخطة اليومية.*

الجزئية الأولى

الإعراض المؤشرة التي تتطلب من الآخرين تحمل المسؤولية والتدخل مثل.

• عدم المقدرة على القيام بالشؤون المنزلية.

• إ همال أطفالي.

•عدم تحمل المسؤولية.

•عندما أهمل نفسي.

•عدم انتباه الآخرين بأنني أمر بالأعراض المبكرة.

•عدم مفارقة السرير.

•عندما اشعر بالعزلة.

•إهمال النظافة الشخصية.

•فقدان الشهية.

الجزئية الثانية

قائمة بأسماء الأشخاص المقربين الذي بإمكانهم تحمل المسؤولية ومساعدتي عند الضرورة.

الاسم.....

القرابة:.....

رقم الهاتف أو الموبايل.....

الاسم.....

القرابة:.....

رقم الهاتف او الموبايل.....

الدور او المهارة الذي أريد منه القيام بيه.

** مثل تجهيز الطعام

** العناية بأطفالي الصغار

** العناية بأطفالي في المدرسة

** توفير المواصلات.

** إعطاء نوع من الأمل

** تشجيعي على القيام بالعبادات

** الاستماع لي وحل المشكلة

** السماح لي باللجوء إليهم في أي وقت في حال عدم السيطرة

** الخروج بصحبتي للتنزه

** وضع خطة لمناقشة وحل المجريات ودعمي نفسيا

أناس لا أريد منهم أي مساعدة ولا بأي طريقة . ولماذا

** مثل احد أفراد العائلة أو صديق.

** لأنهم يلومونني على هذا الوضع ويتذمرون من وضعي.

** يجبرونني على فعل أشياء دون الاستماع إلى رأي.

الجزئية الثالثة.

توفير العلاج

العلاج المناسب والضروري لحالتي.

.....

العلاج الغير مناسب ويجب أن أتجنبه

.....

تزويدي بالمعلومات المهمة بالنسبة للدواء من الأخصائيين أو الطبيب

معرفة سبب تغيير العلاج.

استماع الأخصائي لي.

أهم شخص يجب الاتصال به وقت الأزمة.

تعليم العائلة ومتابعتهم بخطة التعافي والعلاجات الممنوعة.

الجزئية الرابعة

الدعم المجتمعي

هي عبارة عن المؤسسات الداعمة في المجتمع وتساهم في حل المشكلة .

الخدمات الصحة النفسية التي تقدمها وتتمثل في الاتي•

العلاج بالأدوية, الجلسات العلاجية الجلسات الفردية أنشطة ترفيهية.

مراكز التأهيلية المجتمعية لتعليم بعض المهارات .

المؤسسات التعليمية وخاصة مدارس الأطفال.

المراكز التي تقدم المساعدات الإنسانية.

وزارة الشؤون الاجتماعية.

خطة ما بعد الأزمة

المؤشرات الدالة على إنني ليس بحاجة أكثر الى متابعة خطة التعافي من قبل الناس الداعمين.

1- اجتياز الأزمة في وقت اقل

القيام بمهامي المنزلية

العودة لممارسة مهامي بنفسي

عدم الشعور بالخوف

أصبح نومي طبيعي على الأقل ليلتين متتاليتين

القدرة والرغبة في الرجوع إلى العمل.

2- ماذا تعلمت والآخرين من هذه الأزمة؟

ما هي التغيرات في خطة الدمج والاستشفاء التي تجعل الأزمة اقل ما يمكن؟

ما هو شعورك بعد شفاءك من الأزمة؟

يمكنك الرجوع إلى الجزئية الأولى في الخطة ولكن مع وجود اختلاف في نظرتك بعد الأزمة

قائمة الأشخاص الذين أريد أن أتجنبهم عند التعافي من هذه الأزمة

العلامات التي تدل على إنني قد استعدت عافيتي

قائمة التغيرات التي من الممكن أن تسهل في عملية التعافي

قائمة التغيرات التي أثرت في نمط حياتي أو هدف حياتي

إذا أردت أن تغير بعض الأشياء في ضل ما تعلمت من هذه الأزمة فكيف ومتى

(((وفي الختام أتمنى للجميع صحة نفسية سليمة وحياة ملؤها الهناء والسعادة)))

للاستفسار .

عيادة غرب غزة للصحة النفسية المجتمعية .

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Annex Seven

Program Photo's