



Alzheimer's Awareness Family Night

LEADER'S GUIDE

SESSION #6:

Pain and Depression in AD and Caregiver Self-Care

Basic Guidelines for Hosting a Family Night

Educating the loved ones of those with Alzheimer's disease can help improve not only their caregiving experience, but the quality of life of those with the disease. To this end, we have created a series of family night sessions designed to assist you in addressing major topic areas related to Alzheimer's disease.

Family nights have two goals:

1. To provide practical information for families and friends of those living with Alzheimer's disease.
2. To help reduce the stress associated with having a loved one with Alzheimer's disease by offering that information in a friendly and supportive atmosphere.

To facilitate the first goal, this packet contains both information for you as the session leader and ready-made handouts for attendees. The second goal may be achieved in a variety of ways, for example:

- Make **invitations** to the family night warm, enticing, and clear, and provide directions and any important details.
- When a potential attendee **responds** to the invitation, be sure the person who answers the phone has a smile in her voice and is well-informed about the event.
- Provide an **atmosphere** that delights the senses. The setting for your meetings should look and smell pleasant, be an appropriate temperature, and offer comfortable seating. Tasty refreshments should also be available for attendees.
- **Welcome** each attendee as he or she arrives. If you have invited other staff, residents or volunteers to help you, make sure they are trained to do the same. Provide easy-to-read **name tags** for everyone.
- **Learn** as much as you can about each attendee's situation *before* the program begins by chatting with them when they arrive, rather than spending that time making last-minute notes or other preparations.
- **Introduce** attendees to one another so that each person feels a part of the group.
- Do your best to **present information with ease and confidence**. Remember that your audience **WANTS** you to succeed. They want to learn new information and come away with tips for being better caregivers, and they will be grateful that you are genuinely interested in their individual needs and experiences.
- Encourage **participation** from attendees by acknowledging their responses and answering additional questions with a positive demeanor.
- **Follow up** by inviting them back to future sessions. Provide them with handouts even if they miss a session. Get back to them with any questions you could not answer initially.
- **Seek attendees' input** about the session, as well as how to improve future sessions.

Room arrangement

If possible, arrange the room in a circle or semi-circular rows so that people can see each other. This automatically adds an element of friendliness. If there are rows, keep them wide. Because many older adults need to get up and move around regularly to prevent stiffness, make sure they feel free to do so – or build breaks and/or stretches into your session.

Using the materials effectively

- Make sure you have enough pens or pencils and that you have made enough copies of handouts for each attendee before everyone arrives.
- When attendees arrive, we suggest you give them only *Handout #1: Opening Exercise* and a pen or pencil. Each session begins with a puzzle, exercise or conversation starter related to the evening's topic that is intended to arouse their curiosity, along with the questions we expect to answer during the session. These activities will always be labeled as "Handout #1: Opening Exercise."
- Once attendees have completed *Handout #1*, and you have offered a brief explanation of its relevance, give each participant a copy of *Handout #2: No-Pressure Quiz*. Remember to keep the introduction of the opening quiz light and humorous. The quiz is not intended to measure attendees' knowledge as much as it is designed to be a vehicle for a discussion of the evening's important topics.
- Wait until the end of the session to pass out *Handout #3: Important Points and Resources*, but let attendees know at the beginning of the session that you will be providing an additional handout before they leave. We want to promote discussion and draw out the experiences and knowledge of the attendees. If they are given the discussion points at the outset, they are less likely to give original thought to the questions, and it is their comments that are most likely to enliven the session.

Using the leader's guide

- Material intended for the session leader only is provided in Arial type.
- Material to be presented to attendees (such as questions to ask or directions to be given) is provided in Times New Roman type.
- Each leader's guide provides a fair amount of detail about session topics. If your time is limited, you may wish to consider incorporating less of this detail.

General instructions for each session

- Begin the session by welcoming the group and introducing yourself and any assistants you have asked to help.
- Try to avoid discussing “housekeeping” issues during the session. Instead, provide information, such as the location of restrooms, on a flip chart so that even late-comers will be informed.
- Posting a session agenda is also recommended and should include any planned breaks. If you are not planning a session break, direct attendees’ attention to the restroom flip chart, and encourage them to ‘get up and go’ anytime. Doing so lends a touch of humor while letting attendees know you realize they are adults who can make their own choices about comfort.
- One of the principles on which this material is based is that those in your audience are the best teachers. Throughout each session, we offer questions to ask attendees. Their answers are likely to vastly enrich each session, provide many concrete examples related to various subtopics, and spark interesting and relevant conversations. Offering attendees a chance to respond to questions, and *then* filling in whatever details they don’t mention is an excellent way to keep attendees involved.
- Practice going through the materials before you begin, not only to become familiar with them but to have a sense of how much time each section will take. Assign a time period – depending upon the total amount of time you have – for each section, and be sure to allot enough time for attendee input and questions related to each section. Do your best to adhere to your planned schedule so you don’t feel rushed. You may opt to offer to stay after the session to discuss the experiences of anyone who didn’t have the opportunity to share during the session.
- Make the material your own. Add your own stories, insights, and creativity as time and topics allow.
- Begin and end on time. This is always appreciated – even by late-comers.
- At the end of the session, create a simple parting ritual: Let attendees know when the group will meet again and what topics will be addressed. Invite them to stay for more refreshments and to visit with each other and with you. Thank them sincerely for their shared insights and their devoted efforts as caregivers.

Training techniques to keep in mind

Dealing with the “gotta-have-an-answer” question

As you lead family nights, you are likely to encounter an attendee who has come to your session for the express purpose of finding an answer to a specific question about a particular situation. Once he has asked the question, there are essentially two ways to answer:

- If the question is relevant to the topic being discussed, give a time limit, which you announce (“This is a complex issue, but we can devote the next three minutes to an answer.”). You may wish to ask for more detail about the situation (What interventions has he tried? What were the results?) When you feel you have the needed detail, ask for input from other members of the audience – they may have terrific ideas. If there is still time, provide any answers of your own as well as you are able.
- If the question is *not* relevant, or if your allotted time has run out, write the question on a post-it note and put it in a “parking lot” –a flip chart, white board, or wall that is reserved for unanswered questions. Tell the person you can’t answer his question now, but that you will be happy to address it either at the end of the session if time allows or after the session.

When you don’t know the answer

When you don’t know the answer to an attendee’s question it’s best to say so, but promise you’ll do your best to find out and follow-up. Once you have found an answer, report back to the person who asked by phone, email or in writing. If it’s important to multiple people, provide the answer to the whole group in your next session.

When one person dominates the session

Often, people don’t realize they are monopolizing a group discussion, but as the session leader, you have a responsibility to remedy the situation. Depending on your personal style, you may choose to be straightforward or subtle in your approach. You can say something direct, such as, “I appreciate your input, Mrs. Jones, *and* now I would like to hear from other members of the group.” (Using “and” instead of “but” validates Mrs. Jones’s input while sending the message that others deserve a turn to speak as well.) A more subtle approach might be to toss a Koosh ball, Nerf ball, or beach ball, and establish that only the person holding the ball can speak. That tends to liven up a session with color and motion, and keeps the discussion spread out. Whatever approach you choose, do your best to encourage active participation among all attendees without allowing one person to control the conversation.

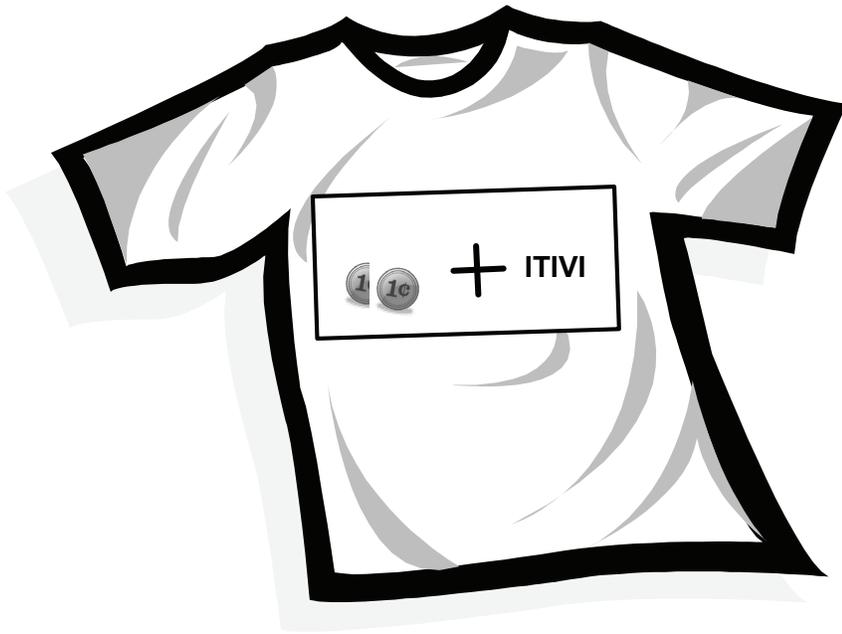
When someone doesn’t participate at all

In any group there is likely to be someone who chooses to simply listen. Respect that choice. If a ball is tossed to him (such as in the approach above), make sure he understands he can pass it to someone else without commenting. At the same time, after the session or during a break, make a point of talking with him to find out if he is finding the session useful or if he has any specific questions. He will appreciate not being put on the spot in front of everyone and will probably give you honest feedback. Often, those who choose to listen are perfectly content, but just don’t wish to speak in front of a group.

Opening Exercise and No-Pressure Quiz

As attendees arrive, give each person a copy of Handout #1, and ask them to figure out what word the drawing represents. When everyone has arrived, and after welcoming them all, ask them for their answers.

The answer is “Insensitivity.” (“Cents” + ITIVI in a box on a Tee)



You may get some groans. Then tell participants this story:

One day a little boy came to his father who was sitting in a chair reading the newspaper. He said, “Daddy, daddy! Look at my knee. I fell on the playground at school.” His father was pre-occupied with the sports page, glanced at the knee long enough to see a colorful band-aid, and before returning to reading, said, “Well, what can I do about it?” The little boy looked at his dad, and as he walked away, he said, “You could say ‘Ouch’.”

Tonight we’re going to talk about the importance of sensitivity related to recognizing and dealing with the “ouches” of the person we are caring for, as well as in our own lives.

In the first part of the class, we’re going to talk about pain and depression in Alzheimer’s disease and how we can become more sensitive and responsive to signs of discomfort. In the second half, we’re going to be talking about how to cope with our *own* sorrows, and how to be sensitive to our *own* needs.

Because tonight's focus is a little different from our previous Family Nights, tonight's short quiz is only half as long as the previous ones have been – just 5 questions. Still, it's called a "no-pressure quiz" because it's just that. It won't be graded, and no one will see your answers but you. And those of you with real test anxiety can choose to leave your quiz paper blank for now, and just fill in the correct answers as we go!

While tonight's course is intended to provide information on pain and depression in Alzheimer's disease, pain and depression are often challenges that caregivers face themselves, so it's important to help them gain awareness and insight into their own feelings and emotions as well.

Once attendees have finished completing their no-pressure quizzes, use the quiz questions to facilitate discussion. The answers to each question are highlighted. (You will notice that each question is followed by related discussion topics in this leader's guide.)

Dementia, Depression and Pain Are Intertwined

Dementia, depression, and pain are like three strands of a braided rope. When they are woven together, it's hard to distinguish one from another.

Ask participants for their answer to the first question.

Question #1

One premise of this session is that pain, depression, and dementia are intertwined, meaning that their symptoms overlap. Which of the following are possible symptoms of all three conditions?

- a. An inability to concentrate
- b. Change in appetite and sleep patterns, restlessness
- c. Withdrawal from activities and lack of energy
- d. All of the above**
- e. B and C only

For now, let's leave dementia out of this mix and just talk about how physical pain and emotional pain are intertwined. Older adults frequently experience both, and they may be related or unrelated to each other. Their physical pains may be arthritis, a bad back, or bruises from a fall. Their emotional pain may be related to the death of a spouse, a beloved sibling, or a close friend.

On the other hand, people who have experienced some physical disability, such as vision loss or mobility challenges that keep them from doing work or activities they once loved, will often feel emotional pain – meaning sadness – because of those losses. Similarly, people who are mourning a loss frequently have physical symptoms, such as sleeplessness, diarrhea, and headaches. People who are stressed by an emotional loss are more accident prone, which can lead to physical injury.

Prolonged pain, either physical or emotional, can cause a person to feel hopeless, as if life no longer has meaning and value. This is known as *depression*.

Many people use the term “depression” flippantly, exaggerating normal feelings: “We lost the football game. I’m so depressed!” Others make light of dire signs: “Well, of course, she’s depressed! Her husband of 50 years just died three months ago!” Clinical depression is a serious mental illness that requires active treatment. Professional help is probably needed if you or someone you love has several of the following symptoms that are pervasive throughout each day and last longer than two weeks:

- Change in appetite and accompanying weight loss or gain
- Change in sleeping patterns (sleeping either too much or too little; having fitful, restless sleep; feeling constantly tired)
- Loss of interest in previously enjoyed activities
- Loss of energy
- Feelings of hopelessness, worthlessness, and/or guilt
- Inability to concentrate accompanied by indecisiveness
- Physical symptoms, such as stomach aches or headaches, without obvious causes

Of course, the most serious sign of depression is thoughts of suicide. A person who expresses suicidal thoughts, should *a/ways* be taken seriously and given immediate professional attention.

We will be talking a little later about caregiver sadness, but if you recognize yourself rather than the person for whom you are caring in the above list, be sure to talk to your physician or a counselor.

Give attendees an opportunity to respond to this information with questions or comments.

All of us have days when we feel “blue” or “down,” but most of us recover fairly quickly. People who are clinically depressed can’t just “snap out of it,” but they may be jump-started on the road back to good mental health with the aid of anti-depressants and talking to a psychiatrist, psychologist, or counselor.

Now let’s look at you answer to question #2.

Question #2

The cause of depression can be a sad event, such as the loss of a spouse, but it might also be a side effect of certain medications.

- a. True
- b. False

The answer is “true.” Sometimes a persistent low mood is a side effect of a medication being taken for another condition, such as high blood pressure or heart disease. Medication-related depression can be easy to identify if the onset follows quickly after a new medication is introduced, but sometimes the low mood builds up over time with prolonged use of a medication. In such cases, changing the medication can have a dramatic effect.

What is perhaps equally important to recognize is that great benefit can often come from simple lifestyle changes such as improved eating habits, regular exercise, exposure to the outdoors, pleasant social contact with others, or a project that helps a person feel valued.

The challenge for caregivers of people with Alzheimer’s disease is that many symptoms of depression, such as:

- apathy and disinterest in what were formerly enjoyable activities
- poor sleep patterns
- lack of energy and initiative
- difficulty concentrating
- indecisiveness and
- lowered self-esteem

are also signs of *dementia*. For instance, is the fact that Mother is losing weight due to depression now that Father has died, or had he been cooking for both of them to help her cover her dementia?

Furthermore, people who become inactive lose stamina and flexibility. If a woman who had played tennis regularly gives up the game because her dementia has affected her ability to keep score, she may soon find her lack of activity brings her more aches and pains, and the lack of interaction with friends could lead to depression.

Depression can also result from the awareness of a person with AD about his loss of abilities and powerlessness to stop the progression of future losses. When a person is given a diagnosis that he has an incurable disease, shock and sadness are natural reactions. Depression is a more serious manifestation of that sadness.

While it may be difficult to untangle the tightly woven strands of pain, depression, and dementia, the lesson is that each can and should be treated. When people have dementia, they eventually lose their “self-reporting” abilities. As the brain damage caused by AD takes its toll, those affected can no longer tell you they have a headache or a sore thumb, or that they feel hopeless and useless. Nevertheless, you can do them a great service by recognizing their symptoms and treating them accordingly.

We're going to talk about pain next, but before we do, does anyone have questions or comments?

Assessing Pain and Discomfort

Both doctors and patients often see pain as a natural side effect of aging. In fact, reports of pain from older adults are so pervasive, they are the most common complaint made to primary care physicians. The view that pain is a normal part of the aging process leads many physicians to ignore complaints of pain among older adults. It's also why many patients themselves expect they'll have to endure a certain amount of pain as they age (although they tend to prefer words like soreness, discomfort, or ache). Baby Boomers, of course, prefer to think they are immune.

Some older adults intentionally minimize or make light of their discomfort, perhaps hoping to postpone its consequences. For example, Mrs. Jones chooses not to reveal her knee pain because she fears that her doctor will press her to have the surgery she has delayed or encourage her to use a cane that she believes will make her look “old and decrepit.”

People with dementia present an additional challenge. As their condition progresses, they have a particularly difficult time expressing their discomfort or its cause. For instance, they cannot communicate that they have not had a bowel movement for a week, or that they feel a burning sensation when they urinate. Even something as simple as, “My shoulder hurts,” or “I have a headache,” may be beyond their verbal abilities.

Mary Lucero, a respected consultant in the field of Alzheimer's care, noted that one man in a nursing home accosted his family when they arrived for a visit, insisting he had been “attacked by wild Indians with bows and arrows.” His family, well aware that this couldn't possibly be true, tried to tell him so. The commotion brought a nurse who listened for the real message behind the man's claim about being attacked with bows and arrows and asked, “Where does it hurt?” The man pointed to his shoulder, and indeed, when the nurse examined it, his bursitis was badly inflamed. Mrs. Lucero is one of many consultants who warn that when a person with AD expresses his discomfort in terms of frightening hallucinations or delusions, caregivers should always look for a possible source of pain.

It's much more common, however, for people with AD, who cannot express their discomfort with words, to exhibit that discomfort through anxious or restless behavior. This behavior is often misinterpreted and treated with anti-anxiety drugs when what the person actually needed was a pain-reliever. Studies have shown that people with AD are severely under-

treated for pain, probably in part because caregivers don't link behaviors like restlessness to physical discomfort.

Give attendees an opportunity to respond to this information with questions or comments.
Ask participants for their answer to question #3.

Question #3

People with Alzheimer's disease who cannot express their pain in words usually give us many non-verbal clues that they are uncomfortable, such as:

- a. Labored breathing, groaning, distressed facial expressions
- b. Wringing hands, irritability, fidgeting, pacing
- c. A fake smile or a calm, blank expression
- d. All of the above**
- e. A and B only

Encourage people to realize there are many signs of discomfort we will notice if we simply look for them.

You can begin to reverse the under-treatment of pain trend by recognizing the classic non-verbal signs of discomfort:

- Noisy breathing – labored, loud, gasping, or rapid, for example
- Distressed vocalizations – moaning, groaning, muttering, repeating words in a mournful tone; the commonly uttered “help me” is often an expression of physical pain, emotional pain, or both
- Facial expressions – clenched jaws, distorted and distressed expressions, tightly closed eyes or dilated, glazed eyes, frowning, pleading looks
- Body position/language – clenched fists, wringing hands, rocking, fetal position, hunched shoulders, self-protective gestures such as an arm in front of one's stomach
- Fidgeting – restlessness, impatience, altered gait or posture, forceful rubbing of a body part such as a sore arm
- Pacing – this is sometimes an effort to escape the pain – to literally walk away from it
- Uncharacteristic anxiety, irritability, or aggression – crabbiness, hostility, striking out
- Change in daily activities, habits – difficulty sleeping, loss of appetite, decreased ability to concentrate, withdrawal from activities; many of these are also signs of depression.

A person with dementia who has a pre-existing condition such as arthritis or osteoporosis does not suddenly stop feeling discomfort from the condition when she is unable to express that discomfort. Moreover, as people age, joint stiffness and other forms of physical deterioration are likely to increase. Some studies have shown that people with AD who are

given a daily analgesic (aspirin or ibuprofen) under a physician's supervision, exhibit fewer signs of discomfort through their behavior. More study is needed, but it seems to be an avenue worth pursuing further.

Give attendees an opportunity to respond to this information with questions or comments. Then ask them for their response to question #4.

More reasons to provide relief

Question #4

Treating pain is important, not only because it's the compassionate thing to do, but because it can prevent other physiological symptoms including all of the following EXCEPT:

- a. Delayed healing
- b. Hyperactive immune system**
- c. Increased heart rate
- d. Lowered appetite that can lead to nutritional deficiencies
- e. Sleep deprivation

Whenever it is in our power to do so, most of us would choose to relieve the physical or emotional pain of others out of simple human kindness. However, there are also a number of other legitimate reasons for helping people with AD live as pain-free as possible.

Untreated pain:

- Increases stress
- Inhibits the immune system and delays healing
- Interferes with sleep
- Tends to reduce appetites and lower chances for adequate nutritional intake
- Compromises mobility and puts people at increased risk for falls
- Can raise heart rates and blood pressure and exacerbate other medical conditions
- Is a primary contributor to depression

Relieving pain or discomfort automatically improves a person's quality of life, and that is something that health care professionals and caregivers alike are beginning to take into greater consideration as care for older adults improves.

Give attendees an opportunity to respond to this information with questions or comments. Then ask them for their response to question #5.

Caregiver tips for relieving your own pain and others'

Question #5

Medications for treating pain, depression, and dementia are available, but people with these conditions can also be eased by kindness and distraction. Which of the following is NOT an example of these methods?

- a. Providing a quiet, calm environment, such as rocking on an outdoor porch
- b. Giving the person a hug or a gentle hand massage with scented lotion
- c. Singing old, familiar songs together
- d. Putting the person in the middle of a class of a dozen running, bouncing, vocal pre-schoolers**
- e. Laughing together at a humorous video, such as an old "I Love Lucy" show

We hope this is obvious, but it may be good to remind participants that even though a person with AD often enjoys playing with a grandchild or observing youngsters from a distance, he is likely to be easily overwhelmed and upset by excessive noise, movement and general chaos.

With new and more effective drugs constantly being tested, we are fortunate to live in a time when there are medicines to treat pain, depression, and the symptoms of Alzheimer's disease. We are also fortunate to have many non-medicinal means of providing comfort. For example:

- Changing the environment – Leaving noise and the confusion of crowds behind
- Changing a person's body position – Stretching; fluffing pillows, elevating feet
- Changing the temperature – Adding a sweater or a fan
- Providing tasty food, a relaxing atmosphere, and pleasant company at mealtime
- Providing distraction – Including soft music, colorful kites, singing birds, an affectionate cat or dog to pet, or an engaging game
- Providing purpose – People always appreciate opportunities to help others
- Increasing a person's sense of being valued – Offering a hug, the loving touch of a hand or foot massage, or kind words
- Helping a person to relax – Deep breathing, singing, laughter, and a walk outdoors are among the best means.

Give attendees an opportunity to respond to this information with questions or comments.

Caring for yourself

Now let's talk about you. If you are caregiver, chances are that you are frequently torn between opposites. You want to be an unfailingly loving caregiver, yet you want your life to be the way it used to be. You want to be in control, and you want to go with the flow. Some days you feel like laughing; other days you feel like crying. *I'd Rather Laugh, How to Be Happy Even When Life Has Other Plans for You*, by Linda Richman (New York: Warner

Books, 2001) nurtures readers through the particular brand of schizophrenia that is so common to dutiful caregivers.

Richman's cathartic book aims to validate your sadness, while also giving you permission to feel joy. Linda Richman is the former mother-in-law of Mike Myers (of *Austin Powers* fame) and the real-life inspiration for his Saturday Night Live "Coffee Talk" comedy sketches.

In the book, she is outrageously candid and personally revealing. She describes how grief overtook her after the death of her son, Jordan, in an automobile accident when he was 29. As a result, she did some loony things. She got into the habit of telling total strangers all about his death. She said she was not satisfied with startling people in grocery store check-out lines where they could slink away fairly quickly, and began taking the bus from Queens to Manhattan just so she could have 45 minutes to sit next to a passenger and spell out all the details. "Imagine the absurdity of it," she writes. "This nice little depressed lady from Queens would get on a bus every day and shock people out of their shoes. You go out in the morning with a plan to destroy someone's day, and it makes you feel good! It's crazy. But it's funny, too. You can't imagine the faces on these people as they looked around for the emergency exit. I think people actually moved out of Queens because of me."

As a lecturer at the Canyon Ranch spa in Tucson, Richman shared this story with another woman who had lost a child, and the woman laughed hysterically – not at the loss of Richman's child and not at her sadness, neither of which is funny, but "at how we human beings react to horror. Sometimes that can be very funny. And finding something funny – anything – under those painful circumstances is good. If you can laugh even while you feel pain, there's hope." Richman insists you can't actually stop feeling pain, but you can integrate it into your life as part of what makes you a whole human being.

As caregivers, taking care of yourself means finding laughter in the tough times – finding those hopeful moments when you recognize that Alzheimer's disease may be a part of your life, but that it doesn't have to define you or your loved one.

On the other hand, according to Linda Richman, taking care of yourself can also mean giving in to your grief – letting it all out. She writes that when people ask her how she fights pain that seems too hard to bear, she answers, "I don't . . . I give in." Her particular brand of "Pity Party" consists of lying in bed all day with two bags of potato chips and the covers over her head. She cries, she curses, she feels sorry for herself, and she watches movies that make her weep. One of her favorites is *An Affair to Remember*. She cries until she cannot cry another tear. Then she looks around at the soggy mess of tissues and starts to laugh at how ridiculous she must look. Some people laugh 'til they cry, she notes, but she cries 'til she laughs. The bottom line, she writes, is each of us has to accept our own pain. We can't spare ourselves and we can't spare others.

She notes, however, that her pity parties are rare. Being attuned to yourself, she says, can head off a bad day. To do so, she watches out for red flags, like snapping at friends who are trying to help or being rude to strangers – usually signs that she needs to slow down and nurture herself. That means, as much as possible, avoiding anything that brings her down. “People have to learn to treat their minds at least as well as they treat their stomachs.” She controls how much media news enters her life, because “98% is bad news.” Instead, she uses her VCR to replay programs or scenes that lift her spirits. She explains that she watches the Oscar acceptance speech of Roberto Benigni the year he won for directing *Life Is Beautiful*, “until she finds herself “catching some of his joy.” She plays the music of her favorite singers and sings loud, off-key duets with them. She fills her living room with smiling pictures of family and friends, and she shuts negative people out of her life, choosing to spend time only with those who are positive.

As Richman points out in her book, as a society, we have become increasingly aware of how we destroy our physical health with pollutants like junk food, smoking, drugs, and unclean air. Yet many of us fail to reject the emotional pollutants of despair, pettiness, hate, fear, guilt, and hopelessness that invade our lives from various sources. Richman relates many truly awful personal experiences, but her book is, nonetheless, funny and uplifting. “I program the soundtrack of my life,” she writes.

How can you find ways to do the same?

Lead a discussion on this topic using the following questions.

- What brings you joy?
- What unfailingly makes you smile or laugh?
- What makes time fly for you?
- How can you incorporate those moments of joy into your daily life – even five minutes at a time?

This is a simple way to end the session on a thoughtful, upbeat self-care note that also begins to give them some concrete ideas for bringing joyful moments into their lives. Following this discussion, give them the last handout summarizing the session, and consider reading the closing story offered in the final paragraph.

Since we always like to close with an upbeat story, let me remind you that there is always a more cheerful way of describing any situation. A woman preparing a hamburger for her 4-year old daughter was trying hard to get the ketchup out of the jar. During her struggle, the phone rang, so she asked her daughter to answer it. When her daughter did so, she said to the person on the other end, "Mommy can't come to the phone right now. She's hitting the bottle."