Chapter VIII: Communicating Respectfully With or About Clients

In India, in the century B. C, a man named Kautilya (who may have had a disability) wrote one of the earliest laws against discriminatory, disrespectful language.

"Among abusive expressions relating to the body, habits, learning, occupation, or nationalities, that of calling a deformed man by a name such as "the blind", "the lame," etc. shall be punished with a fine. If the blind, the lame, etc. are insulted with such ironical expressions as "a man of beautiful eyes," the fine shall be higher. Likewise when a person is taunted for leprosy, lunacy, impotency and the like."

Introduction

Communication refers to the words we speak, the gestures we make, the tone of voice we use, the significance of our behavior and the way we write about clients, either in their presence or when talking with other staff. As we shall see, even our silence, in certain situations, can communicate powerful messages to clients.

Respectful communication — verbal, non-verbal and written — is a key to building helpful, rather than hurtful, relationships with clients. Respectful communication can help build a sense of worth and self-esteem which ultimately supports clients in their recovery. Disrespectful communication can actually work against the recovery process by instilling fear, humiliation and/or a poor sense of self-worth.

Speaking about clients in disrespectful ways is oppressive because it dehumanizes clients. In an ironic twist, when we dehumanize clients, we also dehumanize ourselves. That is, each time we speak disrespectfully about clients, we become a little less human ourselves. The goal of this performance standard is not to save clients from oppression, but *to save our own humanity*.[1] When we learn to communicate with/about clients with respect, then we renew our own humanity. This in turn helps us build more empowering relationships with clients in which they can experience their own value and worth

[1] See Appendix A for a fuller discussion of this concept

Survey Results

The old saying — "Sticks and stones may break my bones but names will never hurt me" — simply does not hold true in the experience of clients. When surveyed, clients of Advocates Inc. reported 94 situations in which staff communicated disrespect. Even though some of these situations happened years ago in other programs, many clients still felt angered, hurt and even frightened of mental health workers. In addition, when staff were surveyed they reported 85 situations in which they had witnessed clients being treated disrespectfully by staff in mental health programs. Clearly then, "name-calling" and other acts of disrespect do occur in mental health programs and ultimately hurt clients.

The goal of these performance standards is to provide direct service workers with guidelines for communicating respectfully with and about clients. Our vision is that with practice and conscious effort it is possible to stop the cycle of disrespect and dehumanization, and to communicate our respect for clients in ways that build self-esteem and support the recovery process.

A WORD ABOUT WORDS

Words are important. In these standards various words that convey respect and disrespect are discussed. Such discussion must not be dismissed as simply a matter of semantics or "splitting straws". Words convey feelings, attitudes and prejudices that are held by direct service workers and that directly affect the self-esteem of clients. Thus it is of great importance for direct service workers to be sensitive to the power of words to heal or hurt. These standards offer you a guide to becoming more conscious and mindful of how you communicate with/about clients.

Practice Respect

PERFORMANCE STANDARD 1

It is important to consciously practice communicating respect for clients in both word and deed. How do clients feel respected by staff? When surveyed, clients of Advocates offered 123 different examples of times when they felt respected by staff. By far the most frequently mentioned examples of feeling respected by staff involved situations when:

- Staff listened carefully and patiently to a client's point of view or concerns
- Staff had a genuinely kind attitude and made clients feel good about who they are
- Staff simply took time to be with clients
- Staff offered to do kind, considerate and helpful things for or with clients
- Staff treated people as individuals who were intelligent adults

Other ways that clients experienced respect included:

- Being praised by staff
- Having personal space respected (i.e., knocking before entering a room)
- When staff are non-condescending and treat clients as equals
- When staff believe what clients say
- When staff are honest and genuine
- When staff refrain from imposing their ideas on clients
- When staff are able to establish effective professional boundaries and refrain from taking their problems or concerns out on clients

Here are direct quotes from the survey with Advocates clients that illustrate some of the themes given above:

- *"Staff show me respect when they call me if they are going to be late."*
- *"Staff show me respect by not acting like they hate the job and don't want to be here."*
- *"Staff show me respect when they listen to my opinion."*
- *"Staff show me respect by giving me attention; by listening to me."*
- *"Staff show me respect when they praise when I'm doing good."*
- *"Staff give me respect by listening to my complaints and problems"*
- *"Staff give me respect when they treat me like a human being."*
- *"Staff show respect when they let you know you are a person first and that you have an illness second."*
- *"Staff show us respect the same way you show other people respect. You treat them courteously, like people first."*
- *"Staff show respect when I get the feeling that they are working for me and I am not working for them."*
- *"Staff show respect by being patient."*
- *"Staff show respect by spending time with me."*
- *"Staff show respect by making me feel important and that I belong here."*
- *"Staff show respect by remembering birthdays and sober anniversaries."*
- *"Staff show respect when they don't impose their own ideas"*
- *"Staff show respect when they listen with full attention; when they really understand what I'm saying."*

The remarkable thing about communicating respect to clients is that it does not cost any money and it is not necessarily correlated with having advanced credentials. Respect is invaluable and being respected can be a healing experience that supports clients in their recovery.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Staff will demonstrate a willingness to consciously practice communicating respect to clients using the examples given above as guidelines.
2. Supervisors will encourage staff to practice communicating respect to clients. A simple exercise can be used such as having staff make a practice of saying five positive things to a client during a one-hour visit, once a week. Discuss the experience during supervision. Ask the staff person if it was difficult to find five positive things to say to a client in an hour. Do we tend to focus on the negatives?

3. At least yearly, arrange for a consultant to your program to conduct a survey of clients. Ask clients, "How do staff show you respect?" Ask them, "Have you ever experienced being treated disrespectfully by a staff person in a mental health program? If so, will you give me an example of that?" Record clients' responses. Review the responses with staff and continue to highlight positive ways that staff can communicate respect to clients.

Staff Will Understand the Reasons that Some Workers Sometimes Disrespect and Devalue Clients

PERFORMANCE STANDARD 2

One would think that mental health services would be distinguished by an increase in sensitivity and kindness to people diagnosed with mental illness. However this is not always the case. As we move through these performance standards you will read many examples of how staff disrespect, hurt and devalue clients. The examples range from unintentional mistakes to overtly abusive ways of communicating with and about clients. Why would direct service workers communicate in ways that devalue and disrespect clients?

Advocates supervisors were able to cite many reasons that staff communicate disrespectfully and devalue clients including:

- Workers devalue clients because of ignorance.
- Workers devalue clients because they lack sensitivity to how the world looks and feels from the client's point of view.
- Workers devalue clients because their efforts to help a client are not resulting in client improvement. It's easier to say the client can't be helped rather than say "I don't know how to effectively help this client."
- Workers devalue clients because they feel devalued in their role as staff. It's a "pecking order" or trickle-down effect.
- Workers devalue clients because they feel powerless in terms of helping a client and/or changing the system.
- Workers devalue clients because it reinforces difference and reinforces the "privilege" of being undiagnosed.
- Workers devalue clients because they are imitating the behaviors and attitudes of their supervisors, teachers and/or other professionals they look up to.
- Workers devalue clients because they need to vent their frustrations and anger on people who have less power and who cannot retaliate easily.
- Workers devalue clients in order to be humorous with co-workers.
- Workers devalue clients in order to feel important and powerful.
- Workers devalue clients because they fear they may be diagnosed with a mental illness someday. In other words, workers distance themselves and create an us/them dichotomy which, in turn, serves to help the worker feel that they will never be diagnosed with a mental illness or will never become "one of them."
- Workers devalue clients because they get confused about the behavior of some clients i.e., is the client "mad" or just "bad"? In such situations staff pass moral judgments on clients and say things like, "He is just taking advantage of the system", "She is manipulating me", and "He's just lazy."

Most direct service workers — if they are honest — would admit that at some point in their career they have communicated disrespectfully to or about clients. None of us are immune to all of the factors listed above. It is expected that we can all improve our skills of communicating respectfully with/about clients

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. During specified staff meetings supervisors will review the list of reasons why staff sometimes devalue and communicate disrespectfully with/about clients. Supervisors will invite discussion of these factors and will role model the skill of openly discussing a situation in which the supervisor communicated disrespectfully or devalued a client.
2. Direct service workers will learn the reasons why staff might devalue or communicate disrespectfully about clients.
3. Staff are strongly urged to reflect on what factors may be at work in instances where they have devalued or communicated disrespectfully with/about clients.

4. When a supervisor learns that a direct service worker has devalued or communicated disrespectfully with/about a client, the supervisor will address this in supervision and seek to help the worker identify the factors listed above that may have contributed to the offense.

Derogatory Slurs and Stereotypes Have No Place in Mental Health Work Settings

PERFORMANCE STANDARD 3

A slur is a slang word or phrase that is derogatory and disparaging. Stereotypes are commonly held misperceptions attributed to members of a socially devalued group. The intent of slurs is to devalue, shame and/or belittle another person or group of persons. Stereotypes tend to blur the unique humanity of members of a group. Our culture has many slurs and stereotypes that are used to devalue, shame and/or belittle people diagnosed with mental illness. Slurs such as "crazy", "schizo", and "psycho", and stereotypes such as "the harmless, old, burnt-out schizophrenic" usually go unchallenged in our general culture. However in the mental health setting such slurs and stereotypes are unacceptable. Slurs and stereotypes are unacceptable because they dehumanize and devalue clients and ultimately dehumanize staff. With time, increased awareness and increased sensitivity, slurs and stereotypes that devalue clients should become as unacceptable in our workplace as are racist, homophobic and sexist slurs.

In the surveys that we conducted, Advocates staff and clients reported many examples of slurs that were used in mental health programs including the following:

- Crazy
- Nuts
- Schizo
- Retarded
- Wacko
- Loonier than a…
- Dummy
- Stupid
- Sick
- Crazy as a bed bug
- Screwy
- Back to the nuthouse
- Wacko wards
- Hospital ward referred to as Nutcracker Suite
- Nut-job
- Faggot

The goal of these performance standards is to save our own humanity by learning to avoid dehumanizing slurs and stereotypes. The goal is to build a culture within Advocates where clients are valued and where derogatory slurs and stereotypes are unacceptable. Staff will become sensitized to the harmful and dehumanizing effect of derogatory slurs and stereotypes, and will refrain from using them.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Supervisors will raise the issue of derogatory slurs and stereotypes on a monthly basis in staff meetings. Routinely reviewing the above listed slurs and stereotypes, and asking staff to identify others they have encountered, will help to raise consciousness about how unacceptable these words are in mental health settings.

2. It is expected that staff will feel free to correct each other when they "slip" and use a common slur such as "crazy". Supervisors will role-model a willingness to be corrected and openly invite staff to offer correctives.

3. Supervisors are encouraged to be creative in their approach to helping staff learn to avoid the use of derogatory slurs and stereotypes when talking about clients. One creative approach might be to see if staff are willing to put a nickel in a jar each time they "slip" and use a slur or stereotype. At the end of the year the funds could go toward a special client outing or meal. Another approach might be to have a designated listener at each staff meeting. The designated listener would agree to ring a bell each time a colleague "slipped" and made a slur. Those who made the offense might then be asked to make amends to the group by bringing the refreshments for the next meeting.

4. The use of derogatory slurs can, in certain situations, constitute verbal abuse and therefore would be an ethical violation calling for disciplinary action by the supervisor. An example would be a situation in which a staff person directly addressed a client with a slur, i.e., "Come over here you faggot" or "You're totally schizo today". In such

situations the supervisor will take disciplinary action.

5. If a supervisor hears a staff person use a slur or stereotype, and if it goes uncorrected by colleagues, then the supervisor will role model correcting the staff person in a respectful way. The supervisor will then address the issue in individual supervision with that staff person.

Insulting Clients is Disrespectful

PERFORMANCE STANDARD 4

Insults refer to both verbal and non-verbal forms of communication that devalue, belittle, dehumanize and shame clients as individuals or as a group. Examples of insults experienced by Advocates clients in mental health programs, or witnessed by Advocates staff in mental health programs, included the following:

- You're acting like a child
- You are just a crazy person, what do you know!
- Is she always a drama queen?
- Pain in the ass
- She weighs a thousand pounds
- This room has a schizophrenic smell to it
- You need a rubber room
- That person belongs in the state hospital
- How can you work with that person?
- Get a life
- She was stuffing her face
- Never mind - you just don't understand
- It's just Joe playing games again
- You are just using the system (said directly to a client)
- Are you out of your mind?
- I'm sick of your shit
- You're acting like a fifteen year old
- My taxes pay for your SSI
- You're just lazy

These examples range from overt insults to more subtle insults. For example, "I'm sick of your shit" or "Is she always a drama queen?" are overtly disrespectful and it is not possible to imagine a situation in which such communication would ever be respectful. In contrast, the question "How can you work with that person" is ambiguous and is not necessarily an insult. It could be a question asked in great earnestness by a new worker who wants to learn from a more experienced staff person. In this case the question is not an insult. On the other hand the same words, said in a tone of disgust and disbelief, would be an insulting statement about a client. These examples help us understand that in some situations bodily gestures and/or tone of voice - as opposed to specific words - convey the insult.

The goal of these performance standards is to save our own humanity by learning to avoid insulting clients. The goal is to build a culture within Advocates where clients are valued and where insults are unacceptable. Staff will become sensitized to the harmful and dehumanizing effect of insults and will refrain from using them - whether directly or when talking about clients to other staff.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Staff will hold each other accountable for communicating respectfully about clients and avoiding insulting remarks that devalue or belittle clients. It is a job expectation that staff will confront each other if a remark or bodily gesture conveys an insult to or about a client. Examples of how to confront a co-worker include saying:
    - I am uncomfortable with what you are saying about the client. Can you find another way to phrase that?
    - What you just said sounds disrespectful to me. Please rephrase what you are saying.
    - That sounds disrespectful to me. Did you intend that?
    - When you rolled your eyes as that client was talking with you, it seemed disrespectful. Why did you roll your eyes?
    - You kept typing your email while that client was talking to you. To me, that seemed disrespectful. What's up?
2. Insults can, in certain situations, constitute verbal abuse and therefore would be an ethical violation calling for disciplinary action by the supervisor. An example would be a situation in which a staff person directly insulted a client i.e., "My taxes pay

for your SSI" or "I'm sick of your shit." In such situations the supervisor will take disciplinary action.

3. In Supported Housing Programs clients will do quarterly surveys and will be asked to report on any situations in which they felt insulted, disrespected and/or devalued. They will also be asked to report on any situations in which they felt particularly well respected. The results of these quarterly surveys will be reviewed by staff and supervisors during staff meetings.

4. In Group Homes, supervisors will meet quarterly with clients to hear their experience of situations in which they felt insulted, disrespected and/or devalued in the program. Clients will also be asked to report on any situations in which they felt particularly well respected. The results of these meetings will be discussed with staff.

5. Supervisors are encouraged to be creative in their approach to helping staff learn to avoid insults when talking about clients. One approach might be to have a designated listener at each staff meeting. The designated listener would agree to ring a bell each time a colleague spoke in a way that was particularly *respectful* of clients. On the other hand, the designated listener could ring a bell each time a colleague made an insulting remark about an individual client or clients as a group.

6. If a supervisor hears/sees a staff person make an insult, and if it goes uncorrected by colleagues, then the supervisor will role-model correcting the staff person in a respectful way. The supervisor will then address the issue in individual supervision with that staff person.

7. Supervisors will be careful to remind staff of the importance of tone of voice, body language and words when communicating with/about clients. Supervisors will help staff increase their sensitivity by inviting staff to share their own experiences of being insulted and how that affected them.

Don't Use Pet Names or Other Terms of Endearment When Referring to Clients

PERFORMANCE STANDARD 5

When we surveyed Advocates clients and staff, some reported that pet names and certain terms of endearment conveyed disrespect. Examples included:

- Adorable
- Cute
- Tiny (a nickname for a very large elderly man)
- Campers
- Sweetie
- Honey
- Chum-pal
- Kiddo

It is best to refer to people by their proper names and to avoid nicknames. Under no circumstances should *staff* give a pet name or nickname to any client.

When surveyed, the majority of Advocates clients said they preferred the term "client" to other terms such as "consumer", "mental patient", "psychiatric survivor" or "ex-patient". Thus when referring to the people we work with as a group, call them clients.

In addition, although nicknames and terms of endearment may be intended to convey warm affection, the result can be quite the opposite. For instance, a young staff person working with an elderly client may enter the client's apartment and warmly greet her by saying, "Hey, how are you doing today honey!" In this situation the staff person does not intend to insult the client. However, in our culture it is customary for younger people to show respect for elders and the word "honey" breaks from this social tradition and could be received as disrespectful.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Direct service workers will call clients by their proper names.

2. Staff will work to sensitize themselves to the harmful effects of nicknames by recalling unwanted nicknames that they or loved ones were called when growing up.

3. If clients use a common nickname i.e., Margaret calls herself Maggie or William calls himself Bill, then it is best to ask how they would prefer you address them. Caution should be exercised here. Be careful never to add your own "version" to a preferred nickname: i.e., if William tells you that he prefers to be called Bill, workers must not get in a habit of calling this client "Billy". The addition of the "y" makes it more of a child's name and may be disrespectful.

4. If a client has a nickname other than a common variation of a proper name, the general rule is not to use that nickname. Simply explain that within your role as a direct service worker it is expected that you will call clients by their proper name as a sign of respect. Sometimes this may mean refusing to call a client what they say they want to be called. Here are some examples:

    - A long-term client of a mental health system had been given the nickname Tiny" by staff in the state hospital. His proper name was Robert. This 60 year old man towered well over 6 feet tall and routinely demanded that community based staff call him Tiny. Staff consulted with their supervisor because they were uncomfortable calling the client Tiny. They felt the nickname was disrespectful and they preferred to call him by his proper name. The supervisor agreed, the decision of staff was carefully explained to the client and eventually the client proudly reclaimed his proper name. Staff should never use a nickname that has been given to a client by other staff in other programs/institutions.

    - A client likes to be called by his chosen nickname "Baby." It is fine for the client to invite friends, lovers and family to use that nickname. However staff must respectfully decline to use such a nickname. The name "Baby" assumes an ease of familiarity that is not consistent with the role of the direct service worker. In such a situation the worker should respectfully explain that they prefer to call the client by his proper name because it is a sign of respect and it reinforces the professional nature of the relationship.

    - If a client, in treatment for dual diagnosis, has chosen the nickname "China" because on the streets she had a reputation for selling "china rocks" (an illegal drug), then it would not be appropriate to call the client by this preferred nickname. Respectfully tell the client that you will call them by their proper name because of the professional nature of your relationship.

5. It is conceivable that situations may arise in which it is more respectful to use an "adopted name" or nickname that the client has chosen, rather than a client's legal name. In such situations discuss the situation with your supervisor. Care should be taken to balance the significance of a nickname to a client, with expectations that the direct service worker must be a respectful professional. Here are some examples:

    - If a client is transgendered and refers to "himself' as Mary, then it would be respectful to call "him" Mary.

    - If a client has a history of childhood abuse and has claimed a new name as a sign of personal power and/or independence from the abusive birth family, then it may be respectful to call the client by the new name.

    - A client has decided that she wants to be called "Bond." The preferred nickname is very empowering for the client. The name seems to remind her of her personal power and her ability to take charge of her life. This is a difficult situation that must be reviewed carefully. In rare instances it is conceivable that staff might use the empowering nickname chosen by the client. Things to consider would include:

    a. Are there clinical implications that might prohibit staff from calling the client by the empowering nickname?

    b. How long has the client been using it and is it likely to change in the future?

    c. Should new staff also call the client by the nickname or is the nickname reserved for staff who have an established relationship with the client? What are the implications if some staff call the client by the empowering nickname and others do not?

    d. Does the familiarity implied in the use of a nickname blur the professional role?

6. Sometimes clients may assign a nickname to a staff person. Under no circumstances should staff accept being called nicknames that convey disrespect or adulation. If a more neutral name is given, then the staff person should explore their personal limits with their supervisor. For instance clients in a group home began calling a staff person named Veronica — "V". In such a situation, staff should reflect with their supervisor on their personal limits with regard to the nickname that has been given. Refer to guidelines for establishing your personal limits in the Professional Boundaries performance standards for further details on how to handle such situations.

Staff Will Refrain from Conveying Ideas and Messages that Serve to Demoralize Clients

PERFORMANCE STANDARD 6

Hope is central to the recovery process. Words and phrases that communicate hopelessness and chronicity can be truly hurtful to clients as conveyed in this story told by a former client in the mental health system:

> *"Sheila had been in (the hospital) for a long time in real bad shape. But one day I noticed something changing in her. She seemed hopeful or something. She seemed happy. And it lasted awhile and finally I asked her and she said she had talked to her social worker and there were a bunch of government jobs available. She had some shorthand and typing skills. Her plan was to get one of those government jobs. And she was really starting to get better cause she had a reason to hope.. .But one day she was talking to two attendants and telling them about her big idea (of getting a government typing job). And one of the attendants says, 'You've got to be kidding. Do you really think you're gonna get that job? You'll never get that government job because you've been in here. This is a state hospital!' After that it was like she just slid down a razor blade they had set her on. It was a shot right to her heart. It took a couple of months but soon she no longer wore shoes, she no longer took a bath, she no longer washed her hair or brushed her teeth. She barely spoke to people. She was still like that, even after I left."*

Although we would hope that such demoralizing and hurtful statements would not occur in this agency, our survey results indicate otherwise. Examples of the types of demoralizing words and statements witnessed by staff and clients include:

- She is never going to change
- He/she is chronic
- You're a substance abuser and that's all you'll ever be
- Loser
- You'll never get better
- You're doing well for a schizophrenic
- You can forget about getting a job

Sometimes staff feel they are being kind when, in fact, they are giving a demoralizing message to a client. Examples include:

- Telling a client they are doing well for someone with a particular diagnosis i.e., "For a schizophrenic, you are doing very well."
- Telling a client to lower his/her expectations i.e., "You are not that high functioning. You should try a volunteer job."
- Presenting a client with a double standard i.e., "The medications help you be less psychotic so you'll just have to learn to live with the medication side-effect of sexual dysfunction (even though I would never expect myself to live with that impairment)."
- Pretending to be able to predict a client's future i.e., "You should make things easier on yourself and just accept that you can never get your kids back"; "Why put yourself through the stress! People with your illness can never get a driver's license and it's best for you to learn to use public transportation"; "It's important for you to remember that you'll have to stay on medications for the rest of your life."

Demoralizing messages are never kind. In truth such messages say more about a staff person's crisis of hope, than about clients' capacity to progress and recover. Staff crises of hopelessness should not be projected onto clients.

In order to build a more hopeful culture in Advocates programs, staff will become more sensitive to messages and ideas that serve to demoralize clients, will attend trainings that engender hope, and will refrain from making demoralizing statements to clients.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Staff will learn to distinguish between their own crises of hope, and the potential of clients to progress and recover. If noticed, supervisors will address staff hopelessness during supervision.

2. Supervisors will encourage staff to attend conferences and read materials about recovery. Information about recovery and other hope engendering information will be presented during staff trainings and orientation. Materials such as videotapes, audiotapes and papers about recovery will also be available through the program.

3. Supervisors will encourage staff to become sensitized to messages and ideas that convey hopelessness. One possible way to do this is to assign, on a rotating basis, one staff person to be a designated listener during clinical meetings, intake meetings and/or staff meetings. When a demoralizing idea that reflects a staff person's crisis of hope has been communicated, the designated listener should ring a bell and bring the group's attention to the situation.

4. Working in mental health programs can be extremely challenging and at some point, every staff person will encounter a client that impresses them as 'chronic", "hopeless", "low functioning", 'unable to recover", "will never get well", etc. There is nothing wrong with having such feelings and supervisors should encourage staff to share such experiences during supervision. Supervisors are encouraged to role-model a willingness to talk about their own experiences with feeling hopeless about a client and how they worked through the situation. The goal is to help staff recognize their *own* crisis of hope rather than projecting that crisis onto the client.

Clinical Language Can Communicate Disrespect

PERFORMANCE STANDARD 7

Clinical language can be used to communicate disrespect either verbally or in writing progress notes, clinical notes, psycho-social histories, intakes, discharge summaries, etc. When Advocates staff and clients were asked to give examples of situations in which clinical language was used to convey disrespect, they reported the following:

- She is just seeking attention; she is attention seeking
- She's so borderliney
- Very borderline
- Referring to clients as a diagnosis i.e., she's a schizophrenic; he's a multiple
- He is manipulative
- She has a low IQ
- He is low functioning
- She is high functioning
- He is so dependent
- She is so needy
- He is so demanding

These examples range from the overt use of clinical language to convey disrespect to more subtle uses of clinical language to convey disrespect. For example, it is difficult to imagine a situation in which the phrase, "She's so borderliney" would be acceptable. The following phrases should never be used in Advocates programs or meetings:

- She's so borderliney — **NEVER**
- Very Borderline — **NEVER**
- Referring to a client as a diagnosis — **NEVER** say "John is a schizophrenic". Do say "John is diagnosed with schizophrenia" or "Mary is diagnosed with bi-polar disorder."

In contrast the statements "He is dependent" or "She is needy" are ambiguous and are not necessarily disrespectful. The situation, tone of voice and bodily gestures would all contribute to whether such phrases are clinically useful or if they are being used as judgmental insults serving to vent staff frustration.

As a rule staff should strive to be descriptive. This means that staff should refrain from making judgmental statements and instead describe what they are observing. For example:

- Instead of saying/writing "John is so demanding" (judgment) the worker should be descriptive and say/write "John has been calling every fifteen minutes during this shift. He hangs up on me if I tell him that I cannot have long phone conversations with him every time he calls."
- Instead of saying/writing "John is decompensating" (judgment) the worker should be descriptive and say/write "John is pacing back and forth, talking to

voices that others cannot hear. He has been wringing his hands and picking at his skin. When I ask him what's wrong, he doesn't respond and is refusing all activities, even van rides."

If staff feel it is important to draw conclusions or to make inferences about a client's behavior, then the worker should "own" their remarks. For instance:

- Instead of saying/writing, "Joe is getting paranoid again" the worker will say/write "Joe continues to report that someone is stealing his belongings even though we have checked and rechecked his room and found that nothing is missing. *I think* he may be getting more paranoid since beginning the new medicine."

- Instead of saying/writing, "Janet is manipulating staff and playing us against each other" the worker will say/write "*It is my conclusion* that Janet is telling each of us different information and we are not working and communicating well as a team about her."

- Instead of saying/writing, "Jack is a scary client" the worker will say/write "*I* am frightened by Jack".

Clinical language is often used out of habit or as a type of shorthand. Although this may be a quick way to communicate, it is not necessarily a respectful way to communicate about clients. Words like low functioning, high functioning, decompensating, etc. are so widely used that they have lost any specific meaning and communicate very little information. It is best to avoid these words and to be descriptive.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Supervisors will role-model self-correction when they "slip" and use clinical phrases to pass judgment on a client or to vent frustration or exasperation, or when they use non-descriptive clinical phrases out of habit i.e., high/low functioning or decompensating.

2. Supervisors will encourage staff to self-correct in these ways and to correct each other in a similar fashion.

3. Supervisors are encouraged to approach this issue in creative ways. Staff can be asked to put a nickel in a jar each time they "slip" or catch a colleague "slipping". The funds can be used for a client outing. Supervisors might appoint a designated listener at each clinical meeting, intake meeting or staff meeting. The designated listener has the job of listening for non-descriptive clinical terms and bringing the situation to the attention of the group.

4. Supervisors will review the quality of staff progress notes and clinical notes and work with staff to improve their non-judgmental skills.

Verbal Abuse is Unethical and Is Grounds for Being Fired

PERFORMANCE STANDARD 8

Verbal abuse is an ethics violation (see the code of ethics in the performance standards on the role of the direct service worker). Here are examples of verbal abuse experienced by Advocates clients or witnessed by staff in mental health programs:

- Our taxes are supporting you and I am not going to pay for your horseshit

- You keep fuckin' with me and I'll break both your arms

- Watch out or you're going to kiss concrete

Verbal abuse is unacceptable and constitutes grounds for being fired. Swearing at clients can constitute verbal abuse. Under no circumstances should direct service workers swear at clients.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Staff will not swear at clients.

2. Staff will not verbally abuse or threaten clients.

3. Verbal abuse of clients will result in disciplinary action by the supervisor.

4. Staff should consciously work to avoid swearing in the presence of clients and in the workplace. Swearing in the presence of clients is not necessarily verbal abuse but is unprofessional. Coworkers and supervisors should remind each other not to swear in the work setting in an effort to create a work culture that is free of profanity.

Staff Will Develop Awareness of Behaviors That Convey Disrespect to Clients

PERFORMANCE STANDARD 9

Sometimes the behavior of staff signifies or conveys disrespect to clients. Often disrespect is communicated without the staff person intending to do so. That is, most staff do not intentionally set out to behave in ways that disrespect clients. However, the fact remains that clients report many instances of being treated disrespectfully. Thus it is important for direct service workers to develop an awareness of situations and behaviors that hold the potential for communicating disrespect.

Examples of disrespectful behavior reported by clients and staff include:

1. A person in authority used to treat me like I was a child.
2. When staff talk down to me like a child or as if I'm not even in the room.
3. I've been ignored and not taken seriously.
4. Not being listened to or understood.
5. Staff telling me I'm paranoid and not believing me.
6. People telling me I imagined my children when I have three children.
7. I was overmedicated so I would do what they wanted me to do.
8. Staff pushing medications on me is disrespectful.
9. My doctor would never listen to what I wanted and didn't want to take for medications.
10. I feel disrespected when I'm standing with a staff person and another staff walks by and says "Hi" to the staff person and not me. They just look through me. That's just rude.
11. Some staff have been rude and have not shown up after promising to.
12. When staff are bad listeners — that shows disrespect.
13. Not being given choices and just being told what to do.
14. When staff show how they hate their jobs.
15. Staff turnover rate is disrespectful. I get to know someone, they want me to tell them about myself and then they're gone.
16. Arriving late for meetings with clients and not even apologizing.
17. Taking cell phone calls during a visit with a client.
18. Staff talking to each other and totally ignoring clients.
19. Looking in a client's refrigerator to see if they bought appropriate groceries without even asking first.
20. When staff do not return a client's phone calls.
21. When staff do not call to cancel appointments or visits.
22. Changing the TV channel without even asking the client.
23. Not informing clients of upcoming events (like conferences, trainings, work opportunities advisory board opportunities, etc.).
24. Staff closing the door to their office for extended times when all they are doing is chatting and clients need to gain access to them or to things in the office (meds, etc.).
25. Talking on cell phones when watching a movie with a group of clients.

Staff will become aware of the power of behavior to communicate respect or disrespect, and will refrain from behaviors that communicate disrespect.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. Being ignored, not listened to, not believed, treated like a child, told what to do, and staff acting as if the client is not in the room are common themes that emerge when clients were asked to describe staff behaviors that were disrespectful. Direct service workers will demonstrate an increased awareness of the power of these behaviors to convey disrespect to clients.
2. Situations involving greeting co-workers when in the presence of a client, being in public places with a client and assisting clients with medications are situations in which some clients have felt

disrespected. Direct service workers will demonstrate an increased awareness of how their behavior in these situations may affect clients.

3. If direct service workers are unhappy with their work, they should discuss this situation with their supervisor. Supervisors should help the staff person assess whether job dissatisfaction is affecting job performance such that clients are feeling disrespected, unworthy, or somehow the cause for the worker's unhappiness on the job.

4. Staff will strive to be on time for meetings with clients and if late, will apologize and offer an explanation as to why they are late.

5. When in client's homes staff will ask permission to open refrigerators, get a glass of water, use the bathroom or check for cleanliness.

6. Staff will knock before entering a client's room or apartment.

7. If a staff person is meeting with a client and is not on call, then cell phones and beepers should be turned off. If it is not possible to turn off cell phones and beepers, then at the beginning of the meeting with the client, the staff person should inform the client that they may be interrupted. If interrupted by a call, the worker should politely excuse themselves, take the call and then apologize to the client for the interruption.

Silence Can Communicate Disrespect

PERFORMANCE STANDARD 10

Silence can be a powerful communicator. If a staff person is silent when a client is weeping over the loss of a loved one, that silence can communicate respect. When a staff person is silent while a client is speaking, that silence can communicate a listening and receptive attitude. However, in certain situations, staff silence may communicate disrespect. Below are five examples given by Advocates staff:

1. During a treatment planning meeting when a client was present, most of the senior staff began to speak about the client as if the client were not there. The client's staff advocate, who was a more junior member of the team, felt this was disrespectful. However, the staff advocate did not speak up at the meeting for fear of getting into trouble with the senior staff. The staff advocate remained silent even though it went against his conscience. In this situation, silence could have communicated disrespectful messages to the client such as "My good standing with senior staff is more important to me than your feelings" or "My need to be well regarded is more important to me than your right to be treated with respect."

2. A staff person was accompanying a client to a doctor's appointment. They were a few minutes late for the appointment due to traffic. When they sat down in the waiting area, the physician came out and scolded the client for arriving late. The physician said the client had to learn to plan her time more efficiently and that this lack of planning had been a chronic problem. The client cowered in silence during the public scolding in the waiting area. The staff person wanted to speak up but remained silent instead. The staff person was afraid of confronting the authority of the physician and feared the physician's wrath might be turned on her. In this situation the message conveyed to the client might have been, "Better you get yelled at than me!" or "Don't challenge authority."

3. At a meeting a senior staff person made a joke about how a client had pulled his pants down in the community. Everyone laughed at the joke. No one spoke up about the demeaning way the client was portrayed. The group's silence might have conveyed the message that, "In this agency, when clients are not present, we can be disrespectful" or "Don't rock the boat in this agency, just laugh along or you might get fired."

4. The police were involved in helping to deal with a client in crisis. During the intervention the police officer said (with the client present), "I don't know why they let these people out anyway. Shouldn't they just stay in the hospital?" The staff person did not respond and remained silent, even though he thought the comment was disrespectful. The staff person feared alienating the police. In this situation staff silence might have conveyed the message, "It is more important to stay on the good side of the police than to speak up for your right to live in the community."

5. A staff person accompanied a client to her monthly appointment with a psychiatrist. The staff person spoke about what was going on at the residence and the client also spoke up. The psychiatrist eventually turned to the staff person and said, "She'll be okay. Just give her a Pop-Tart and she'll be fine." The staff person wanted to speak up but did not. The staff person feared that if he spoke up,

his supervisors would not support him. He was tired of always fighting and getting in trouble for it. Better to let the comment slide. In this situation staff silence might have conveyed the messages 'Clients are used to this crap and it just slides off their back" or "There is nothing we can really do to change things so why try?"

There are many reasons that staff people remain silent. Some of the reasons cited by Advocates supervisors were:

- Fear of retribution from hierarchy that has money for contracts
- Fear of being labeled a trouble-maker
- Fear of getting a bad reputation and being slandered in the rumor mill in the agency
- Lack of role-models who speak up regularly
- Fatigue, bum-out and a desire to choose battles wisely
- Fear of authority, of making waves, and of being seen as an outsider who does not "support the team"
- Fear of being wrong or being different than others around us
- Fear of getting into trouble or of getting fired for speaking up
- Fear that it is not our place to say anything and deference to senior staff to speak up
- Fear of what supervisors might say or do
- Fear of humiliating oneself or being humiliated by others
- A pervasive sense of powerlessness on the part of staff and the feeling of "why stick my neck out when nothing good will come of it anyway"
- Fear that supervisors will not support the staff person if he/she speaks up

Despite all the reasons listed above, the Advocates performance standard regarding silence that communicates disrespect is that we seek to break that silence while maintaining valued relationships with other mental health programs and staff. The standard is also that supervisors will support staff in speaking up in such situations.

The *objective* of breaking oppressive silence is to preserve our own humanity in the workplace and to move the culture of mental health programs toward a more respectful way of communicating about clients.

Silence should be broken in situations *when:*

- Clients are insulted
- Slurs are used
- Nicknames are used
- Behavior is disrespectful
- Language devalues or disrespects clients
- Language promotes negative stereotypes of mental health clients
- Clinical language is used to disrespect clients
- Verbal abuse occurs

All of the above have been detailed in standards 1-9.

The *means* we use to break the silence that sometimes follows disrespectful language is important. There is no room for a double standard here. We must communicate respectfully with other staff when breaking silence, just as we hold ourselves to the standard of communicating respectfully with clients.

When breaking silence, staff are encouraged to be assertive, respectful and direct. Staff can use a "boiler plate approach" and explain that "at Advocates we are working on using person-first language and I would appreciate it if we all stopped talking about borderlines and started talking about people diagnosed borderline personality disorder". Another straightforward approach is to simply speak up and say, "I am uncomfortable with the way we are talking in this client's presence. Let's direct our comments directly to the client." Supervisors will always support staff when they respectfully and directly break silence. Staff will not be disciplined or fired for breaking silence in a manner that is assertive, respectful and direct. It is not insubordination to speak up, even to senior staff or to people outside of the agency.

The following are *unacceptable* ways to break silence:

- Name calling i.e., "You jerk, how could you say something like that?"
- Character assassination i.e., 'You really are the most insensitive person I have ever met and I suggest you learn to respect clients."
- Belittling someone i.e., "You are just ignorant to say that about clients"
- Intimidating someone i.e., "If you say something stupid again I'm going to report you."

Breaking silence in ways that insult, humiliate, belittle or intimidate other staff is unacceptable, no matter how egregious the situation is/was. In such situations supervisors may discipline staff, request that apologies be made, and help the staff person learn more effective ways to communicate.

Learning to speak up and break oppressive silence is a skill that can be developed over time. If staff feel too overwhelmed by the power differential when at a meeting with senior staff, then it is acceptable to talk with your supervisor about the situation later and ask for help. It is expected that in such instances supervisors will take up the issue at their level in the hierarchy.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

1. It is expected that staff will grow in their awareness of disrespectful communication and will feel tension when in a meeting where insults, stereotypes, slurs, etc. are being used. The emergence of this tension is not a bad thing. It signals that you are growing in your awareness and feel prompted to speak up. Share these experiences with your supervisor or trusted colleagues.

2. Supervisors will work with staff to develop their skills in assertively, respectfully and directly breaking silence. Two tools have been developed to help supervisors work with staff in this area. The first is called, *"A Tool to Learn About My Silence and What I Could Do Differently"* and the second is a series of role-plays. Both tools can be found in Appendix B.

3. Supervisors will support staff when they do break silence. This support will take the form of listening to staff, dealing with senior staff or other agency staff who may have taken offense and reiterating Advocates standards with regards to respectful communication.

Exercises to Help Sensitize Staff to Respectful and Disrespectful Communication

PERFORMANCE STANDARD 11

Creating a culture where clients are respected by staff in both word and deed is a process that will require ongoing consciousness raising and sensitivity training. All staff, no matter how skilled or experienced, can grow and learn to be ever more mindful of the clients' point of view and how to communicate respectfully with clients. Exercises that reinforce this mindfulness must be done on a routine basis in programs.

HOW TO IMPLEMENT THIS PERFORMANCE STANDARD

The following exercises are suggested for routine use during staff meetings.

EXERCISE 1

This exercise helps increase staff awareness of the power of labels to shape expectations and behaviors.

Before the meeting the supervisor will make up signs or labels for 1/3 of the staff who will be in attendance. Signs or labels could include things like "party animal", "smart", "shy", 'boring", "hostile", "poor", "deaf', "exconvict', "88 years old", etc. During the exercise put the labels on the backs of 1/3 of the staff (preferably staff who volunteer). Do not let the volunteers read what is on their label. Then instruct the whole group to act like they are at a social engagement and give some ideas of what people should talk about. Instruct the people who are not wearing labels to treat people with labels in a stereotyped fashion. Have people mingle in this way for 15 minutes. Then ask people what they think their label is. Did people with labels begin to act in ways that are characteristic of others with a similar "label"? What did people learn from this exercise and how does it apply to our daily work with people labeled with mental illness and/or substance abuse?

EXERCISE 2

This exercise is intended to help people develop descriptive writing skills.

In this exercise have two people act out a skit and then have the rest of the staff write clinical notes about what they observe. For instance have two staff people act out a skit in which one person is angry and is demanding an apology from another person. Then have staff compare their notes. How was the situation described by different people? Did staff avoid making judgments? Did staff pathologize the behavior? Did staff remember to note any strengths or positive qualities in the actors? What does this exercise teach us about writing progress notes and clinical notes about clients? A variation on this exercise would be to have staff watch a 5 minute portion of a movie. Each staff person writes notes on what they observe. Then they compare notes and discuss.

EXERCISE 3

This exercise *is intended to help sensitize staff to how* easy *it is to misinterpret behavior.*

In this exercise you give one person a task that they have to act out i.e., tell a staff person to go through the motions associated with putting up a small tent. This is the only person to hear about the task of putting up the tent. Then ask another staff person to come into the room to watch the first. Let the staff person observe the first for two minutes, and then have the second person carry on the act as they understand it (but do not tell them they are supposed to be putting up a small tent!). The first person should sit down, the second takes over the acting and you invite a third person into the room to observe, take over the action, etc. At the end of the exercise ask each person what they thought they were doing. Ask each how they came to that conclusion. Allow group members to challenge each other i.e., "How did you come to that conclusion?" or "What did I do to make you think that?" Then engage staff in a discussion of how this exercise pertains to the daily work. Has anyone had the experience of misinterpreting a client's behavior?

EXERCISE 4

Mental Health Monopoly.

The purpose of this exercise is to sensitize staff to some of the stress of living below the poverty level. Have staff develop a board game similar to Monopoly. In the game, each player starts with a basic SSI monthly income. As they move around the board, staff will have to pay rent, buy food, buy hygiene products, etc. and stay within budget. Players will draw cards for unexpected events like overdue payments on library books, past parking tickets, or maybe even an SSI refund windfall. The development of the game, or playing a similar game developed by others, will help staff learn how they would navigate the stressful terrain of poverty.

EXERCISE 5

Ask staff to recall a time when they made a self-defeating or "bad" choice in their lives.

Then have them imagine what it would be like to have that bad choice reflected on their resume for the rest of their lives. How would it impact their lives? How could they get the resume changed? What should they tell employers? What should they tell supervisors who know about it? After this exercise, ask staff to reflect on how a client's bad choice or a self-defeating choice lives on in an agency or program. The incident report gets written and years later staff may still refer to the same situation, as if the client has not changed or grown.

This page intentionally left blank.

Appendix A

In the introduction to this performance standard on respectful communication with/about clients, the following statement was made on page 1: **"The goal of this performance standard is not to save clients from oppression, but to save our own humanity."**

Many staff had difficulty with this statement. They saw it as part of their work to help liberate clients from oppression. They were disappointed with the idea that they did not have the power to liberate clients. Although this is understandable, the fact remains that professionals do not have the power to liberate clients who are oppressed. The statement on page 1 is grounded in an understanding that people diagnosed with mental illness are the only ones who can liberate themselves from oppression. Mental health professionals, no matter how well intentioned, cannot liberate clients from oppression. What professionals can do is save their own humanity by refusing to collude in dehumanizing language, attitudes and behaviors. This in turn helps to create opportunities for clients to learn to value themselves and seek their own freedom from oppression.

Here are some quotes that help explain this position:

"Dehumanization, which marks not only those whose humanity has been stolen, but also (though in a different way) those who have stolen it, is a distortion of the vocation of becoming more fully human . . . This then is the great humanistic and historical task of the oppressed: to liberate themselves and their oppressors as well. The oppressors . . . cannot find in this power the strength to liberate either the oppressed or themselves. Only power that springs from the weakness of the oppressed will be sufficiently strong to free both . . . True generosity consists precisely in fighting to destroy the causes which nourish false charity. False charity constrains the fearful and subdued, the 'rejects of life', to extend their trembling hands. True generosity lies in striving so that these hands — whether of individuals or entire peoples — need be extended less and less in supplication, so that more and more they become human hands which work and, working, transform the world."

Paulo Freire, Pedagogy of the Oppressed, pp. 28, 29

"We know through painful experience that freedom is never voluntarily given by the oppressor; it must be demanded by the oppressed."

Martin Luther King, Letter From a Birmingham Jail

"The mission of Advocates Inc. Mental Health Division is to provide skills, supports and resources so that people who have been diagnosed with psychiatric disorders, chemical dependency or who have other problems in living can recover valued social roles, overcome obstacles imposed by oppression and regain control over their lives."

Appendix B

A TOOL TO LEARN ABOUT MY SILENCE AND WHAT I COULD Do DIFFERENTLY

In the performance standard on Communicating Respectfully With and About Clients, we discovered that sometimes silence can communicate a great deal of information to clients. Silence when a client is grieving can convey respect and empathy. Silence when a client is speaking can convey a listening and receptive attitude. However in certain situations a staff person's silence may convey disrespectful and disempowering information to clients. For instance, during a treatment planning meeting when a client was present, most of the senior staff who were present began to speak about the client as if the client were not there. The client's staff advocate, who was a more junior member of the team, sensed that to speak about the client in this way communicated disrespect to the client. However, the staff person did not speak up in the meeting. Why? There are many possible reasons why this staff person may have chosen not to speak up. These include: fear of being seen as a trouble-maker, fear of losing his/her job, fear of alienating people in supervisory positions, fear of being different, fear of challenging authority, fatigue and feelings of demoralization, not wanting to look foolish, fear of lack of support, etc.

This exercise is intended to help you begin to think about the times your silence conveys disrespect to clients and what you can do differently in the future.

TASK 1

Briefly describe a time when your silence or failure to speak up, communicated disrespect to a client(s) and/or briefly describe a time when you wanted to speak up to support a client but remained silent.

TASK 2

Complete the worksheet on the following page, **Exploring My Silence**.

TASK 3

Discuss your experience and reflections with your supervisor or training group.

Exploring My Silence Worksheet

Name _____ Date_____

1. In the situation described on page 76, what would I have liked to say?

_____

_____

2. What would the client have wanted me to say?

_____

_____

3. What is the worst consequence (real or imagined) that might have happened if I did speak up?

_____

_____

4. What was the barrier to my speaking up? (check the ones that apply)

- ☐ Fatigue
- ☐ Burnout
- ☐ Overwhelmed
- ☐ Lack of support from supervisors
- ☐ Fear that I would be devalued as a troublemaker , etc.
- ☐ Fear that I would be seen as insubordinate
- ☐ Fear that I was wrong and senior staff know more than me
- ☐ Fear that even if I said something, it really would not have mattered
- ☐ Fear of humiliation
- ☐ Fear that I was over-reacting
- ☐ Fear of challenging authority
- ☐ Fear that we might lose a contract or funding if I spoke up
- ☐ Fear of alienating important people like parents, police, etc.
- ☐ Fear that there were politics involved and that I might say the wrong thing
- ☐ Fear that the staff would see me as different and not a team player
- ☐ Other

Now review your answers with your supervisor and/or training group. Get feedback from the group on your situation. Problem solve. Reality check the consequences you feared. Think about how you might have responded differently and record your conclusions in number 5.

5. If a situation like this arises in the future, I will:

_____

_____

This page intentionally left blank.