MentalPRAC

Training for practitioners who work with people with severe mental disorder

TRAINING GUIDE

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INTRODUCTION

In 2005 the World Health Organization divulged the Mental Health Declaration for Europe as a result of the Ministerial Conference in Helsinki that year. Following this milestone, the European Union initiated a series of responses to address mental health issues, such as the publication of 'Green Paper: Improving the mental health of the population: Towards a strategy on mental health for the European Union'. This report draws conclusions at the European level, finding there is a lack of support for mental health in general, a lack of interventions and solutions, a need to tackle stigma and discrimination, and a need for designing training programmes to create a sufficient and competent multidisciplinary workforce.

Taking these findings into account, the main goal of the project *'Mentalprac. Training for Practitioners who Work with People with Severe Mental Disorder'* is to improve the support for people with severe mental disorders through developing the skills of mental health care workers.

The lead partner of the Mentalprac project is Fundación Diagrama, with support from partners at several European organizations such as Diagrama Gemeinnützige GmbH (Germany), Action with Communities in Rural Kent (United Kingdom), Catching Lives (United Kingdom) and Groep Ubuntu (Belgium).

The **specific objectives** are:

- Filling the deficit of specific formal training among social and health care professionals who support people with severe mental disorders.
- Enhancing the knowledge and skills of professionals with low or medium qualifications who care for people with severe mental disorders, in order to also prevent burnout.
- Disseminating training materials for workers in the mental health field, particularly those who work with people with severe mental disorders.
- Raising awareness of specific support needs required by people with severe mental disorders and the importance of training professionals who work with them.

Therefore, the present training guide is a training tool to be used by care workers who need additional specialized training, and to boost the necessary skills to prevent burnout.

MODULE 1

MENTAL HEALTH AND SEVERE MENTAL DISORDER

WHY THIS SESSION

This module is the starting point for training care-giving professionals through the MentalPrac project. The aim of this module is to explain the basic concepts of the field of Mental Health work and to establish a common conceptual framework upon which the subsequent specialized training contents will be built.

This module is also intended to be an awareness raising tool for health and support workers who work with people who have mental disorders. To do this, it aims to facilitate the elimination of prejudice, discrimination and stigmatisation and to promote the acceptance, inclusion and social integration of people with severe mental disorders.

OBJECTIVES

- To provide basic knowledge for professionals who work with people with severe mental disorders.
- To raise awareness amongst participants of the needs of people with severe mental disorders.

KEY WORDS AND PHRASES

- **Health** is the 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.
- **Severe Mental Disorder:** A set of severe psychiatric disorders with long-term mental health disturbance, that involve varying degrees of disability and social dysfunction.
- People with severe mental disorders suffer **stigmatization and discrimination,** which cause negative social reactions, isolation and adjustment difficulties. The general population, and even professionals, often maintain stereotypes sustained by these misconceptions of people with mental disorders.

RESOURCES

- DSM-5 and ICD-10.
- Theoretical contents.
- Working Sheet 1: Myths of mental illness.
- Projector, computer, slides and board.

ESTIMATED LENGTH OF TIME **2 h.**

THEORETICAL CONTENTS

- Health and mental health.
- Mental disorders.
- Severe mental disorders.
- Causes of mental disorders.
- Theoretical models of mental disorders.
- Prevalence of mental disorders.
- Stigma, discrimination and the need for intervention.

ACTIVITIES SCRIPT

Activity 1: Why is this session important?

5 minutes. The first activity is an explanation of the purpose of this module within the training, using the information below.

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Activity 2: Health and mental health

5 minutes. Explanation of the most important theoretical concepts in relation to mental health, based on the following section of the theoretical manual: *1.1. Concept of health and mental health.*

Activity 3: Mental disorder concept

15 minutes. Explanation of the most important theoretical concepts in relation to mental disorders, based on the following section of the theoretical manual: *1.2. Mental disorders.*

Activity 4: Severe mental disorder concept

15 minutes. Explanation of the most important theoretical concepts in relation to severe mental disorders, based on the following section of the theoretical manual: *1.3.Severe mental disorders.*

Activity 5: Discussion on concepts related to mental health

10 minutes. Start a reflection on the concept of mental health and mental disorders based on mental health notions set out in paragraph 1.1. This exercise is intended to motivate the interest in the theoretical contents, unite the group and point out the two main conclusions on the first block of the module. The 2 topics to discuss are: mental health as a continuum and the clinical criteria defining mental disorders.

Activity 6: Causes of mental disorder

10 minutes. Explanation of the possible causes of mental disorder, based on the following section of the theoretical manual: *2.1. Causes of mental disorders.*

Activity 7: Prevalence of mental disorder

15 minutes. Explanation of data related to prevalence of mental health, based on the following section of the theoretical manual: *3. Prevalence of mental illness and severe mental disorder.*

Activity 8: Stigma and discrimination

20 minutes. The first part of the activity is the explanation of the following section of the theoretical manual: *4. Stigma, discrimination and intervention needs.*

The second part of the activity is an exercise on myths associated with mental disorders, listed in Worksheet 1. The activity will consist of a discussion about the myths associated with mental disorders. The professional responsible for training may decide to use each of the 10 myths or only those most suited to the characteristics of the group. The activity may be performed at the beginning of the session, to verify the initial ideas of the group around mental disorders, or the end of the session, to confirm the acquired knowledge.

Activity 9: Final practical exercise

15 minutes. Exercise on diagnostic classification of DSM-5 and ICD-10. The exercise is intended to ensure that participants know the manual diagnostic classification systems of the DSM-5 and ICD-10. For this, a superficial exercise on the process of diagnosing mental illness will be carried out. The manuals will be presented, the contents will be explained and groups will be created to discuss the following case:

"A 14 year old boy is brought to the psychiatrist because in recent months he has become uncommunicative and introverted. He seems to care about nothing, has little emotional response to emotional stimuli and is showing a loss of initiative and vitality. His parents say that this situation started about two years ago, when he failed in his studies and stopped working and engaging at school. Since then he has not performed any activity and dropped out of secondary school, completely. The disorder has progressed, leading to a very limited life, he has no friends and spends most of the time in his bedroom listening to music or doing nothing. When he is asked about his behaviour he says that it is ok, without giving more convincing explanations. Sometimes he states that he feels different from others and he hears a voice who wants to hurt him. He also believes that other people ignore him, but does not give a reasonable explanation as to what he means by this" (from Juan José Ruíz Sánchez, 2006).

Let the participants answer these questions:

Is this an episode of major depression or schizophrenia?
What are the criteria to consider these symptoms as a severe mental disorder?

THEORETICAL MANUAL

1. DEFINITION OF SEVERE MENTAL DISORDER

1.1. CONCEPT OF HEALTH AND MENTAL HEALTH

WHO defines health as a '*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*' (WHO, 2001).This definition includes mental health as part of the holistic health state of any person. Therefore, health and mental health are related concepts.

The definition of mental health is set in parallel with the definition established for overall health; it is not limited to the absence of mental illness, but includes **mental wellbeing** as a key element. A state of mental health would allow the person to be aware of his or her own abilities, to cope with the normal stresses of life, to work productively and to be able to contribute to his or her community (WHO, 2001).

Thus, welfare becomes a central concept both for health in general and for mental health in particular, and is defined as a positive and enthusiastic attitude to life, including the ability to manage emotions, behaviour and other elements like happiness, satisfaction and tranquillity. On the other hand, the concept of wellbeing and mental health is also associated with the ability to make a realistic assessment of limitations, the ability to effectively cope with stress and exert autonomy in decision-making.

Mental health is also related to successful interaction with one's immediate surroundings, including family, partners or peer groups. So, a person would enjoy good mental health if he or she is able to effectively adjust his or her behaviour and emotions to the demands of the environment.

Therefore, the concept of mental health is extensive, comprehensive, dynamic and attached to personal aspects of the individual, to life conditions and to relationships with others. This complex definition allows the concept of health to not only be focused on the absence of disease and biological aspects of the disease, but also includes issues related to the demands of the environment, interaction with the peer group and emotional and behavioural aspects of healthy states. These elements also include aspects such as lifestyle, health education and everything that may affect wellbeing.

The concept of mental health is part of one of the major fields of study in Psychology. Traditionally, the concept has been linked to personal maturity, the relationship with

the environment, emotional security, self-knowledge, perception of the environment adjusted to the reality or the presence of appropriate skills and competencies of task development (Allport, 1985).

Maslow (1982) notes the existence of a basic human tendency toward mental health, manifested through a process of self-actualization. People are characterized by accepting themselves and others, appearing spontaneous, focusing on problems and having sense of humour. Similarly, Rogers (1979) describes mental health as the process of becoming a person based on the capacity for self-direction, the desire for progress, openness to experience, the feeling of freedom, spontaneity and confidence in oneself.

As such, there are many concepts and theoretical developments associated with mental health. Therefore, the World Federation for Mental Health (Spanish Association of Neuropsychiatry, 2002) identified three main dimensions that systematize and characterize the approaches to the concept:

1. How we feel about ourselves.
2. How we feel about others.
3. How we respond to life situations.

Pacheco (2005) develops the dimensions presented by World Federation for Mental Health, establishing the main characteristics that define mental health:

DIMENSIONS OF MENTAL HEALTH
HOW WE FEEL ABOUT OURSELVES
• They are not overwhelmed by their own emotions (anger, fear, love, jealousy, guilt or concerns). • They can accept the disappointments of life without altering their behaviour dramatically. • They have a tolerant and relaxed attitude about themselves and others. • They are able to laugh at themselves.
HOW WE FEEL ABOUT OTHERS
• They are able to love and take into consideration the interests of others. • Their personal relationships are satisfying and lasting. • They are able to rely on others and want others to trust them. • They respect difference and diversity amongst other people.
HOW WE RESPOND TO LIFE SITUATIONS
• They accept their responsibilities to face problems. • They modify their environment whenever is possible and conform to it when necessary. • They plan in the present for the future, facing problems, rather than avoiding them, despite the possible fear they may feel.

The generality of the various elements that define mental health demonstrates that there is no clear dividing line that separates mentally healthy people from those who are not. This ambiguity does not allow a dichotomous classification, but the establishment of a quantitative continuum relative to the degree of mental health. In addition, each of the elements is dynamic and can change in the course of life: the mental health of each individual varies depending on events, situations and experiences.

On the other hand, the absence of any of the above elements cannot be admitted as evidence or indicator of a mental disorder. The items described are associated with mental health and wellbeing, while mental disorder is defined based on clear and specific diagnostic criteria and the potential for disability.

1.2. MENTAL DISORDER

To properly understand the concept of mental abnormality in mental health, and thus mental disorder, it is important to understand, first, what mental health is. As explained above, mental health involves adaptive functioning, and considers someone that shows sufficient capacity to interact with their environment in a constructive, flexible, productive and adaptive way to be mentally healthy. Thus, the perception of self and the environment are adjusted and promote a cognitive-affective balance, healthy relationships and patterns of functional behaviour.

As opposed to mental health, mental disorders are specific patterns of dysfunctional behaviour and are classified in the DSM-5 manual and ICD-10. These instruments for classification are intended to assist mental health professionals in the diagnosis, study and research of the different mental disorders.

In this way, DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) has been created by the American Psychiatric Association and it presents the clinical criteria accepted for the diagnosis of each mental disorder. On the other hand, ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 10th Revision) has been published in Europe by the WHO, focusing its 5th chapter on mental disorders.

The aforementioned diagnostic classifications are not rigid. They change depending on successive updates of the manual as result of scientific, social and cultural developments that require reworking the classification of mental disorders.

The DSM-5 identifies mental disorders in section II, stating that '*A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning*'. Thus, mental disorder is defined based on emotional, cognitive and behavioural functioning, affecting the basic psychological processes such as emotion, motivation, cognition, consciousness, behaviour, perception, learning and language, making it difficult to adaptat to the environment and producing some form of subjective distress.

Section II of the DSM-5 sets out the different mental disorders, the main categories of which are neurotic disorders and psychotic disorders. Neurotic disorders, in general, are characterized by an alteration in the perception that the individual has of himself and the ongoing process of review of his skills and abilities. This condition does not

represent a distortion of reality nor does it generally lead to social isolation. Anxiety disorders and depression are among neurotic disorders.

The symptoms of psychotic disorders, however, include delusions, strong affective difficulties, isolation, serious distortions of the environment and hallucinations. Among these disorders are schizophrenia, psychosis and bipolar disorder. In the next module, a more comprehensive analysis of the different mental illnesses will be performed.

1.3. SEVERE MENTAL DISORDER

Severe mental disorder refers to a distinct theoretical construct to 'common mental disorder' that brings together the clinical characteristics of chronic, high prevalence and significant impact on clinical practice.

The definition of severe mental disorder with the greatest consensus is the one made by the National Institute of Mental Health, USA (NIMH) in 1987. This organization characterizes individuals who suffer from severe mental disorders as '*a group of heterogeneous people who suffer from severe psychiatric disorders together with long-term mental disturbances, which entail a variable degree of disability and social dysfunction, and who must be cared for by means of different social and health resources of the psychiatric and social healthcare network*' (Ministerio de Sanidad y Política Social, 2009).

For a diagnosis of severe mental disorder, there are many factors that are used to evaluate the patient and to establish a diagnosis in order to plan services and performances required. Among these factors are clinical diagnosis, evolution time, the degree of dysfunction, the severity of associated clinical factors, the degree of disability, the characteristics of the demands of the patient's condition and the complexity of managing the disorder, including psychopathological instability, the importance of functional deficits, the lack of an adequate social support network, low awareness of disease and decoupling of health and social services.

Apart from taking into account the above information and definitions, the DSM-5 and ICD-10 establish a series of diagnostic criteria for defining severe mental disorder. These factors are set based on scales that define and quantify the presence of a number of specific symptoms (Ministerio de Sanidad y Política Social, 2009).

For the diagnosis of severe mental disorders, according to criteria of **ICD-10** or **DSM-5**, there are the following categories:

- The usual diagnostic categories in the definition of severe mental disorders are schizophrenia and other psychotic disorders, bipolar disorders, severe recurrent major depressive disorder, severe obsessive-compulsive disorder and severe personality disorder.

- Those disorders whose main diagnoses include:

    A. Dementia and other organic mental disorders.
    B. Moderate to severe intellectual impairment.
    C. Eating disorders.
    D. Disorders related to substances.

For proper diagnosis of severe mental disorder it is also necessary to take into account the duration of the symptoms. A minimum of 12 months is necessary for a classification of mental disorder, and a minimum of 24 is needed for a classification of severe mental illness. Also, a significant degree of dysfunction must be present (as measured by different scales).

In addition, to assess the severity of a mental disorder, it is important to know if there is comorbidity with other physical and/or mental disorders, drug abuse, self-harm or assault, membership in a high-risk group (marginality, immigrants, ethnic minorities, elderly, family history or living with severe mental disorder) or whether the person is in a high-risk situation (pregnancy and teen pregnancy, postpartum, disability, unemployment, economic insecurity, misuse, abuse, etc). The presence of each of these elements compounds the initial diagnosis and requires the implementation of specialized care interventions.

On the other hand, the Spanish Association of Neuropsychiatry (Asociación Española de Neuropsiquiatría, 2002) establishes a set of common characteristics of patients with severe mental disorder:

- High vulnerability to stress, difficulties coping with environmental demands.
- Deficit in skills and autonomy.
- Difficulties in social interaction, loss of social support networks that, in many cases, are limited only to the family, and situations of social isolation.
- High dependence on others and health and/or social services.
- Difficulties to obtain and maintain a job, which is an obstacle to full social integration, facilitating economic dependency, poverty and marginalization.

2. THEORETICAL MODELS OF MENTAL ILLNESS

2.1. CAUSES OF MENTAL DISORDER

The desire to understand "abnormal" behaviour has led to theories and explanatory models to clarify the origin and treatment of mental health disorders. The first definitions generated on abnormal behaviour were supernatural explanations, blaming demons or spirits as causes of disorder; the same people advocated agents such as magnetic fields, the moon and the stars as influencing behaviour, thoughts and emotions.

Further theories sought rational causes for disorders, based in biology and psychology. The biological framework, originated by Hippocrates in the 5th Century BC, holds that mental disorders are biologically determined diseases of the body, and are caused by an organic imbalance, trauma or genetics. Nineteenth century German psychiatrist Emil Kraepelin, founder of modern psychiatry, was the great advocate of this idea, being the first to identify and classify mental disorders and provide a systematic explanation of the physiological causes of the disease.

By contrast, the psychological tradition explains mental disorders as a result of learning and the influence of social and cultural environment. These explanations take into account the personality of the individual and the environment in which it operates, accepting that mental disease is associated with unhealthy modes of life or negative social experiences, such as exclusion and violence (WHO, 2005).

Different treatments were proposed by the different schools of thought; the supernatural treatments included exorcism or witchcraft, biology was focused solely on the use of drugs or surgery, and psychological approaches used psychosocial treatments and modern psychotherapy.

However, despite all of the above, it is clear that mental health disorders do not fit simple explanatory and treatment models, but require complex approaches that assume that the causes of mental illnesses are multiple and sometimes unknown.

Currently, a full explanation of mental disorder involves accepting that there is a multi-causal correlation of biological, psychological and social explanations. When these three elements appear in a healthy, fully functional way, they enable a positive state of mental health. However, if the nature of any of these elements is negative, whether

because of an organic problem, a traumatic experience or an unstructured environment, the probability of suffering a mental illness will increase.

Thus, based on these varied causes, there is a possibility that any person may suffer from mental illness at some point. Hereditary or genetic causes only constitute one of the elements associated with mental disorder, and in addition to these, there are elements not determined biologically, as environment and experiences that increase individual's chances of developing a mentally disordered condition.

Thus, biological, psychological or social factors interact with and influence each other.

A disorder can develop, not only based on the presence of one factor, but any of them in combination. For example, an adverse situation that produces mental distress can activate a particular biological circuit that results in disease disorder; early symptoms can then trigger reactions of rejection by friends and family, increasing the isolation of the person and thus the symptoms of the disorder.

2.2. THEORETICAL MODEL OF MENTAL DISEASE

▶ MEDICAL MODEL

For the medical model, the concept of disease is seen from two perspectives: the first is related to the symptoms (perceptions or experiences of the patient and client), and the second is related to the signs or manifestations of the disease, as observed by the practitioner.

Thus, psychiatry interprets mental disorder as a medical condition located in the brain and the central nervous system. Therefore, in this model, professionals try to discover the organic cause of the disease with the help of diagnostic techniques such as MRI, PET, neurophysiological procedures and laboratory tests. Once the exact cause is known, a medical solution can be proposed to eliminate the symptoms and thus the disorder.

Technological advances have allowed the development of this model, showing evidence, for example, that many mental disorders, where the cause has previously been unknown or uncertain, may have originated in a neurotransmitter deficit.

This model is best applied to schizophrenia.

BEHAVIOURAL MODEL

The behavioural model understands mental dysfunction through experimental psychology. The symptoms are a patient's behaviour and this behaviour has developed through a process of learning or conditioning. Most learning is useful because it helps us to adapt to our environment, for example, by learning new skills. However, some learning is maladaptive and behaviour therapy aims to reverse this learning.

The different therapeutic approaches that form the basis of this approach have created different useful therapies for mental disorders. In addition, today, the behavioural processes that underlie certain disorders are better known, indicating that the learning factor is an essential element in understanding mental disorder.

This model is best applied to phobias.

COGNITIVE MODEL

The cognitive model understands mental disorder as being a result of errors or biases in thinking (cognition). Our view of the world is determined by our thinking, and dysfunctional thinking can be related to mental disorder. This model is intended to explain pathological mindsets, negative automatic thoughts and inner chatter that are typically symptomatic of behavioural disorders.

Therefore, to correct mental disorder, under this model, it is necessary to change thinking. To do this, some techniques are used to identify maladaptive cognitions or automatic thoughts, and once recognized they are corrected, most commonly through Cognitive Behavioural Therapy.

This model is often applied to depression and anxiety.

PSYCHOANALITIC MODEL

The psychoanalytic model is also known as intra-psychic or psychodynamic model. This model indicates that the determinants of mental disorder depend on the nature of childhood experiences, changes in the instinctive or sexual development, interpersonal relationships and control of these elements through defence mechanisms. From this perspective, an explanation for mental disorder is sought through therapy which addresses various unconscious mechanisms underlying the maladaptive behaviour.

This model is applied broadly but is often used for the most severe mental disorders.

NEW THERAPEUTIC MODELS

At present, without rejecting the classical models of intervention, there are new proposals emerging that involve not only a change of therapeutic strategies, but a change in the theory of the causes, effects and behaviour of disorders, and therefore, the expected results as well.

These include therapies that are not aimed at avoiding or reducing symptoms, but at encouraging clients/patients to acquire an acceptance of their symptoms and a commitment to coping with them. This group of therapies includes acceptance and commitment therapy, in which the main objective is to increase the psychological strength of the person using basic procedures such as acceptance, thinking and acting in the present and a commitment to personal values.

On the other hand, systemic family therapy focuses its activities on family functioning, focusing less on the person with a mental disorder and more on the system of family relationships. This approach is based on the theory that a person's disorder develops within the context of a family unit with maladaptive patterns of interaction, leading to mental disorder in one or more of its members. Therefore, to achieve the recovery goal of the person with the disorder, the therapeutic treatment starts with the family and looks to the behaviour and relationships within the family unit.

These new intervention models encourage the introduction of innovative techniques in the treatment of mental disorder and break new ground in understanding the causes. There is a need to combine each of these theories and their specific techniques into integrated models that allow for a wider intervention to address the multiple needs of the person with mental disorder. However, such a task is too much for an individual practitioner. Therefore, today, it is common to create multidisciplinary teams composed of nursing, psychology, social work or occupational therapy.

So, despite the importance of pharmacological interventions for mental disorders and severe mental disorders, much of the work done with people with mental disorders is currently about psychosocial interventions. The partial and limited control of symptoms provided by pharmacology, the short and long term side effects and the poor adherence to treatment has led to a gradual increase in psychotherapeutic and psychosocial interventions instead.

Caring for people with severe mental disorders requires the integration of different levels of care and different types of intervention. Goals for the individual with a mental disorder often include autonomy, quality of life, wellbeing, and social participation (Ministerio de Sanidad y Política Social, 2009). Thus, the treatment of mental disorder from an integrative perspective is not limited to the reduction of symptoms but variables directly related to the recovery of the wellbeing.

3. PREVALENCE OF MENTAL ILLNESS AND SEVERE MENTAL DISORDERS

Mental disorders affect many people around the world, causing significant distress to the individual and his/her immediate surroundings. The following compilation collects data on statistics relating to mental health.

Mental Health Prevalence

General data

- 1 in 4 people will suffer from mental illness throughout his or her life. Around 450 million people worldwide suffer from mental illness. Mental illnesses account for 40% of chronic diseases and the leading cause of long term disability (World Health Organization, 2005).
- The impact of mental disorders on quality of life is higher than other chronic diseases, such as arthritis, diabetes or heart and respiratory diseases (Ministerio de Sanidad y Consumo, 2006).
- It is expected that by 2020 depression will be the first cause of disease in the developed world (Commission of the European Communities, 2020).
- Neuropsychiatric disorders account for the second highest expenditure on diseases in the health system, after cardiovascular disease. (WHO, 2005).
- Unipolar depression is the third leading cause of disease burden, behind ischemic heart disease and stroke, accounting for 6.2% of the burden caused by all diseases (Ministerio de Sanidad y Consumo, 2006).
- 83% of the general population doesn't know what schizophrenia is (World Psychiatric Association, 2007).

European data

- In the EU, 18.4 million people aged between 18 and 65 suffer from major depression each year (European Parliament, 2006).
- 20% of the expenditure in the health systems of the European Union is used for the treatment and rehabilitation of mental illness (Junta de Andalucía, 2007).
- The social and economic costs of mental illness are estimated at around 4% of GNP of the European Union, about 182,000 million euro (Ministerio de Sanidad y Consumo, 2006).
- In many European countries, mental illness is the cause of 45-55% of absenteeism (WHO, 2005).

SEVERE MENTAL DISORDER

The prevalence of severe mental disorder is difficult to determine because of the difficulty of defining the term and the heterogeneity of the criteria. Thus, among the scientific research, the National Institute of Mental Health in the United States highlights (Asociación Española de Neuropsiquiatría, 2002):

- 40% of psychotic disorders meet the criteria for severe mental disorder.
- 9% of non-psychotic disorders also meet these criteria.

4. STIGMA, DISCRIMINATION AND INTERVENTION NEEDS

People with mental illness suffer stigmatization and discrimination which can lead to negative social reactions, isolation and adaptation difficulties (Comunidad de Madrid, 2006).

People in the environment of the person with mental disorder reproduce stereotypes, exhibit discriminatory behaviour and often have an avoidant reaction to people with mental illness. In fact, even family members react to illness with concealment or overprotection. Such attitudes increase stigma and deprive the person with mental disorder of his or her basic rights as citizen.

Along these lines, in a study conducted by the Government of the Region of Madrid (2006), people with mental illness noted that there is a lack of knowledge about

mental illness and a strong stigma focused on stereotypes relating to dangerousness, incompetence and inability to work.

The stigma around people with mental disorders is defined as the social construction of disapproval of personal characteristics or beliefs about people with mental disease. The characteristics of people with mental disorders are seen as contrary to the established norms, and thus penalized and excluded. The stigma against people with mental illness is based on thoughts (Ledesma, 2008). For example:

- Thought related to beliefs: **They are violent**.
- Thought related to feelings: **They scare me**.
- Thought related to actions: **I do not want them to work with me**.

Because of the stigma and discrimination, people with mental disorders can suffer human rights violations; economic, social and cultural rights are denied to many of them, and some restrictions on work and to education are imposed on them (WHO, 2011). Among the rights violations are difficulty in accessing the labour market, homelessness and incarceration. These three characteristics are more common among people with mental disorders and this enhances their marginalization and vulnerability. On the other hand, they can also suffer inhumane and unhygienic life conditions, harmful treatment practices and degrading treatment in health centres (WHO, 2011).

This situation has shown that assistance for people with mental disorders should not be limited to meeting their medical treatment needs, but should entail interventions oriented to allowing them full access to all of their rights of citizenship. In addition to addressing the symptoms of the illness and functional impairment of the patient, it is necessary to reduce the social difficulties that make the disease even more disabling. A comprehensive intervention for people with mental disorders should include actions aimed at reducing rejection, exclusion or difficulties in finding work, changing social barriers to the full integration and ensuring respect for their rights.

Worksheet 1

MYTHS ON PEOPLE WITH MENTAL DISORDERS **(From FEAFES: Spanish Confederation of Associations of people with mental disorders and their families)**
THEY ARE VIOLENT OR DANGEROUS PEOPLE
In fact they are more likely to be victims of a violent act than to commit one. This distorted image is closely related to the image portrayed by the media, tabloid headlines and movies, linking the disease with violent or criminal acts, using pejorative terms like "crazy" or "disturbed". Of course, these are not scientific sources and there is no scientific basis for this claim.
THEY HAVE A DOUBLE PERSONALITY
This is a false belief that has also been promoted in movies, leading the public to believe that people with schizophrenia have a split personality or multiple personalities. Schizophrenia is a term that describes fragmentation of thoughts and feelings, not the person.
THEY CANNOT LIVE WITH OTHERS
They can live together if they want, of course, or with their families, with a partner, or alone. Everyone is different, but we all need support in order to have an independent and autonomous life.
MENTAL DISORDERS ARE INCURABLE, THEY WILL NEVER HEAL
They can improve, and in fact they often do. People with mental illnesses can live a full life. The best option would be to receive holistic treatment that combines pharmacological treatment, socio-employment rehabilitation measures and psychological and family support.
SCHIZOPHRENIA IS CAUSED BY DRUG ABUSE
Drugs alone do not cause schizophrenia. However, drug misuse can be a precipitating factor of schizophrenia in those people who are predisposed to develop it.
MENTAL DISORDERS CAUSE INTELLECTUAL DISABILITY
A mental disorder is not an intellectual disability, and it is not the cause of one. People with a mental health diagnosis do not necessarily have diminished cognitive abilities or skills. Mental disorder and intelligence are different things.
PEOPLE WITH A MENTAL DISORDER HAVE A WEAK CHARACTER
People are not guilty of having a mental illness. Mental disorders can be developed as a result of multiple biological, psychological and social factors.

IT WILL NOT HAPPEN TO ME
One in four people develop some kind of disorder associated with mental health during their lifetime. Multiple factors are involved, and changes in mental health are not always predictable.
THEY ARE LAZY, UNRELIABLE AND UNPREDICTABLE
We must distinguish between what can be a personality trait or an acquired habit from what is a symptom of a mental disorder. No mental disorder has among its symptoms laziness or tardiness.
THEY ARE NOT ABLE TO WORK
Society discriminates against people who are different because it is not prepared to integrate them. It is not ready to give the necessary resources to enable them to function differently and integrate into the community. The key is giving the necessary support to people with mental disorders in order to allow them to have a full life, integrated into society, their environment and their community.

SELF-ASSESSMENT TEST

1. The World Health Organization defines health as:
    a. A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.
    b. A complete physical, mental and social wellbeing.
    c. The absence of disease or infirmity.
2. Regarding the conception of mental health, the World Health Organization:
    a. Includes mental wellbeing as a key element.
    b. Supposes the absence of mental illness.
    c. Both answers are correct.
3. Mental disorders:
    a. Are specific patterns of dysfunctional behaviour determined by the consensus of psychiatric professionals.
    b. Are specific patterns of dysfunctional behaviour and are classified in the DSM-V manual and ICD-10.
    c. None of the answers is correct.
4. Neurotic disorders:
    a. Are characterized by an alteration in the perception that the individual has of himself and the ongoing process of review of his/her skills and abilities.
    b. Includes delusions, strong affective difficulties, isolation, a distorted relationship with the environment and hallucinations
    c. Among these disorders are schizophrenia, psychosis and bipolar disorder.
5. Psychotic disorders:
    a. Are characterized by an alteration in the perception that the individual has of himself and the ongoing process of review of his/her skills and abilities.
    b. Includes delusions, strong affective difficulties, isolation, a distorted relationship with the environment and hallucinations
    c. Among these disorders are anxiety disorders and depression.
6. According to the National Institute of Mental Health (NIMH), a severe mental disorder is characterized as:
    a. Being untreatable.
    b. Severe psychiatric disorders, independent of their duration.
    c. Severe psychiatric disorders together with long-term mental disturbances, which entail a variable degree of disability and social dysfunction.

7. A full explanation of mental disorder:
    a. Involves accepting that there is a multi-causal correlation of biological, psychological and social explanations.
    b. Involves accepting genetics as the main cause of mental disorders.
    c. Involves the pre-eminent role of social conditions.
8. According to the World Health Organization:
    a. One in one hundred people will suffer from mental illness during their lifetime.
    b. Everybody will suffer from mental illness almost once in their life.
    c. One in four people will suffer from mental illness during their lifetime.
9. The stigma around people with mental disorder is defined as:
    a. The unfair laws and social norms affecting their rights.
    b. The struggle in getting a job and accessing social and educational resources due to the traits of the disorder.
    c. The social construction of disapproval of personal characteristics or beliefs about people with mental disease.
10. Which of these sentences is a myth on mental disease?
    a. People with mental disorders are violent and dangerous.
    b. Mental disorders cause intellectual disability.
    c. Both options are correct.

Keys: 1:a; 2:c; 3:b; 4:a; 5:b; 6:c; 7:a; 8:c; 9:c; 10:c.

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MODULE 2
TYPES OF MENTAL DISORDERS

WHY THIS SESSION IS IMPORTANT?

This module describes the main factors that help to identify and treat mental illnesses that are usually defined as severe mental disorders.

The module will provide some specialised knowledge intended to clarify some of the tasks carried out by professionals, ensuring safety and promoting transparency with patients.

This increased knowledge of the main features of mental disorders can also help to reduce stereotypes, encourage empathy and promote positive interaction between caregiver and patient.

OBJECTIVES

- Improve knowledge of participants in relation to mental disorders, in order to improve their relationship with patients.
- Develop a basic understanding of what constitutes a severe mental disorder and how to identify different types.

KEY WORDS

- The major international diagnostic classifications include schizophrenia, bipolar disorder and borderline personality disorder as examples of severe mental disorders.
- Schizophrenia, bipolar disorder and borderline personality disorder are considered severe mental disorders because of their high prevalence, significant impact on the welfare of the patient and their disabling potential for the individual.
- An explanation of the origin of mental disorders will include genetic factors and environments, but will also analysis of other elements, including protective factors, precipitating factors and maintenance factors.
- The main treatments for severe mental disorders require the implementation of comprehensive interventions that include pharmacology, psychosocial rehabilitation, family support and teamwork.

RESOURCES

- Theoretical Module.
- Projector, PC, slides and whiteboard.
- Card symptoms of mental disorders described.

ESTIMATED LENTH OF TIME **3 h.**

THEORETICAL CONTENTS

- Schizophrenia.
  - Causes.
  - Symptomatology (signs and symptoms).
  - Typologies (different types and classifications).
  - Treatment.
- Bipolar disorder.
  - Causes.
  - Symptomatology.
  - Typologies.
  - Treatment.
- Borderline Personality Disorder.
  - Causes.
  - Symptomatology.
  - Typologies.
  - Treatment.

ACTIVITIES SCRIPT

Activity 1: Explanation of the main characteristics of schizophrenia

40 minutes. The activity consists of the description of 4 elements related to schizophrenia as a mental disorder: causes, symptomatology, typologies and treatment. To support this activity the trainer may use the following section of the theoretical manual: *2. Schizophrenia.*

Activity 2: Practical exercise for schizophrenia

20 minutes. The activity implies watching interviews with patients in order to identify the main symptoms and hear about the experience of people living with schizophrenia. This will support the theoretical content and should incorporate discussion and the sharing of ideas.
Videos from YouTube could be used for this activity, such as:

Spanish:

https://www.youtube.com/watch?v=tu-wg4SR6Gk

https://www.youtube.com/watch?v=95ijVA9mTQE

English:

https://www.youtube.com/watch?v=i4b-_bNsajY

https://www.youtube.com/watch?v=JPxZYvUfOFg

Questions to be discussed after watching the video:

- What signs and symptoms did you hear about and observe?
- Are there any other symptoms that might make us think of another disorder?
- What did you observe about the non-verbal language? What does this nonverbal language indicate about the disorder?
- Does this disorder impact on the life of the person giving the testimony? If so, how? (Think about what you have seen and heard)

Activity 3: Explanation of the main characteristics of bipolar disorder

40 minutes. The activity consists of the description of 4 elements related to bipolar disorder as a mental disorder: causes, symptomatology, typologies and treatment. To support this activity the trainer may use the following section of the theoretical manual: *3. Bipolar disorder.*

Activity 4: Practical exercise for bipolar disorder

20 minutes: Watching interviews with patients in order to identify the main symptoms and hear about the experience of people living with bipolar disorder. This will support the theoretical content and should incorporate discussion and the sharing of ideas.

Videos from YouTube could be used for this activity, such as:

Spanish:

https://www.youtube.com/watch?v=CAOfHPDvneU

https://www.youtube.com/watch?v=bb-l2GWrkos

English:

https://www.youtube.com/watch?v=4Hp3Qk1ahqo

https://www.youtube.com/watch?v=mpE-oaix5kA

Questions to be discussed after watching the video:

- What signs and symptoms did you hear about and observe?
- Are there any other symptoms that might make us think of another disorder?
- What did you observe about the non-verbal language? What does this non verbal language indicate about the disorder?
- Does this disorder impact on the life of the person giving the testimony? If so, how? *(Think about what you have seen and heard)*

Activity 5: Explanation of the main characteristics of borderline personality disorder

40 minutes: The activity consists of the description of 4 elements related to borderline personality disorder as a mental disorder: causes, symptomatology, typologies and treatment. To support this activity the trainer may use the following section of the theoretical manual: *4. Borderline personality disorder.*

Activity 6: Practical exercise for borderline personality disorder

20 minutes. Watching interviews with patients in order to identify the main symptoms and hear about the experience of people living with borderline personality disorder. This will support the theoretical content and should incorporate discussion and the sharing of ideas.

Videos from YouTube could be used for this activity, such as:

Spanish:

https://www.youtube.com/watch?v=2KQsiIgpN7M

https://www.youtube.com/watch?v=7T2OUR7M9wg

English:

https://www.youtube.com/watch?v=eOphgCJX1FY

https://www.youtube.com/watch?v=At0cLgyZtXM

Questions to be discussed after watching the video:

- What signs and symptoms did you hear about and observe?
- Are there any other symptoms that might make us think of another disorder?
- What did you observe about the non-verbal language? What does this non verbal language indicate about the disorder?
- Does this disorder impact on the life of the person giving the testimony? If so, how?*(Think about what you have seen and heard)*

THEORETICAL MANUAL

1. INTRODUCTION

The National Institute of Mental Health in the U.S. (1987) provides diagnostic criteria for defining severe mental disorders. In its classification, psychotic disorders and some personality disorders are included as fundamental diagnoses that establish the definition of severe mental disorders.

Beside these two diagnostic groups, this module includes bipolar disorder within severe mental disorders. WHO (2003) included this illness in its ranking of severe mental disorders because of its chronic nature and potential for severe behaviour alterations. Additionally, the high prevalence of bipolar disorder and the serious consequences for the well-being of the patient mean that it fits the criteria for severe mental disorders.

The following sections will describe the main characteristics of the mental disorders listed below:

- Schizophrenia.
- Bipolar disorder.
- Borderline personality disorder.

2. SCHIZOPHRENIA

Schizophrenia is one of the most common psychiatric disorders and one of the major serious mental disorders, affecting 1 in 100 people (WHO, 2003), with no significant differences in gender, culture or social class.

This disorder is chronic and severe, and in many cases, results in varying degrees of disability and social dysfunction. The disorder is characterized by an altered perception of reality involving a range of problems with thinking, behaviour and emotions.

Onset of the illness is usually between 15 and 35 years old, typified by slow and gradual behavioural changes. The most common behaviours displayed are:

- Withdrawal from friends and family.
- A drop in performance at school or work.
- Sleeping problems.

- Irritability or depressed mood.
- Lack of motivation.
- Out of character or odd behaviour and sudden outbursts.

2.1. CAUSES

There is no single explanation for schizophrenia and its exact cause is unknown. However, many authors suggest a multi-causal origin. The most widely accepted model to date for the explanation of the disorder is the vulnerability stress model. This model indicates that there is an inherited vulnerability to the disorder and that there must be a genetic predisposition and stressful or traumatic events may then trigger the condition. Maintenance factors also need to be considered.

▸ Underlying Factors

The risk of developing the condition increases significantly if there is a family history. Thus, the overall risk of the disorder, at 1% for the general population, rises to 10% in cases where one parent has suffered from it, and up to 40% if both parents have suffered from it. There are additional factors to be considered, such as changes in the levels of certain neurotransmitters or complications during pregnancy.

▸ Precipitating and Trigger Factors

Trigger factors in people with a genetic predisposition to schizophrenia are, most commonly, stressful or traumatic life events, such as the loss of a relative, a change of address, entry into university, military service or losing a job.

▸ Maintenance Factors

The progression of the disorder depends on both maintenance factors which can contribute to the development and persistence of the disease, as well as on protective factors which can reduce vulnerability to it.

Among the protective factors known to reduce both vulnerability to and symptoms of the disease are: compliance with medication, the existence of positive family and social support, recognition and acceptance of symptoms and maintaining a healthy lifestyle.

The maintenance factors of the disorder include stressful life events, stopping medication, troubled relationships, substance misuse and a chaotic lifestyle.

- **Evolution**

Schizophrenia is a disorder whose course and development is unpredictable, being strongly influenced by social and family factors. Often patients have had a fairly normal life prior to the first presentation of the symptoms of psychosis. It is often not until the appearance of the most striking symptoms, such as hallucinations or delusions, that the disorder is properly identified.

Moreover, the evolution of the disease is characterized by following the three thirds rule. Under this rule, a third of people diagnosed with schizophrenia have a favourable prognosis and will see complete remission of symptoms; a third show a steady progress over time, with relapses and periods of stability; and the last third spiral chaotically toward personal and social deterioration.

2.2. SYMPTOMATOLOGY

Schizophrenia presents with a wide variety of symptoms, none of which are specific to the illness, and can be present in many different disorders. However, most of these symptoms are subjective, and it depends on what elements the patient explains and the practitioner's awareness of the disease. This situation makes the diagnosis more difficult and requires the collaboration of the family and the professional expertise to ensure an accurate diagnosis.

The symptoms of schizophrenia are divided into two blocks of symptoms: positive and negative.

- **Positive Symptoms**

Positive symptoms are psychotic symptoms involving the loss of contact with reality and include:

- **Delusions**: These are false beliefs that are not based in reality. For example, you're being harmed or harassed, certain gestures or comments are directed at you, you have exceptional ability or fame, another person is in love with you, a major catastrophe is about to occur, or your body is not functioning properly. Delusions occur in as many as 4 out of 5 people with schizophrenia.

- **Hallucinations**: These usually involve seeing or hearing things that don't exist. Yet for the person with schizophrenia, they have the full force and impact of a

normal experience. Hallucinations can be in any of the senses, but hearing voices is the most common hallucination.

- **Disorganized thinking** (speech): Disorganized thinking is inferred from disorganized speech. Effective communication can be impaired, and answers to questions may be partially or completely unrelated. Rarely, speech may include putting together meaningless words that can't be understood, sometimes known as word salad or schizophasia.

- **Extremely disorganized or abnormal motor behaviour**: This may show in a number of ways, ranging from childlike silliness to unpredictable agitation. Behaviour is often chaotic and not focused on a goal, which makes it hard for those affected to perform any jobs, tasks or activities. Abnormal motor behaviour can also include an inability to comply with instructions, inappropriate or bizarre posture, a complete lack of responsiveness, or useless and excessive movement.

  Each of the positive symptoms of schizophrenia can be subject to an irregular or even imperceptible pattern of development. The intensity and regularity of appearance will depend in part on whether the patient is taking medication or not.

Negative Symptoms

Negative symptoms refer to a reduced ability or lack of ability to function normally. For example: appearing to lack emotion (such as not making eye contact, not changing facial expressions, speaking without inflection or in a monotonous way, or not adding hand or head movements that normally provide the emotional emphasis in speech), interest, initiative or enthusiasm. The person may also have a reduced motivation to plan or carry out activities; for instance, neglecting personal hygiene, a loss of interest in everyday activities, social withdrawal and a reduced ability to get pleasure from pastimes that were previously enjoyed.

These symptoms are harder to recognize as part of the disorder, as they are more subtle. They are typical of people diagnosed with depression and may also be found in the general population. But it is this group of symptoms that really limit the life of the patient, impeding the very activities and tasks that can help in recovery.

These symptoms do not necessarily manifest at the same time or have the same intensity in all patients. There are also different types of schizophrenia, diagnosis of which depend on which symptoms are most frequent and prevalent.

2.3. TYPES OF SCHIZOPHRENIA

Schizophrenia shows different forms depending on the predominant symptoms at the time of evaluation. The main types of schizophrenia include:

- **Catatonic Schizophrenia**: People with catatonic type can assume peculiar postures and are usually unable or unwilling to speak. They can be both rigid and motionless, or they may seem agitated and move around excessively, but always without seeming to respond to any external stimulus. Catatonic people may also have strange facial expressions, may mimic the behaviour of others, and may repeat words that others say. Catatonic behaviour is also seen in mood disorders, like bipolar disorder and major depressive disorder; it can also, occasionally, occur in diseases of the central nervous system, like Parkinson's disease.

- **Paranoid Schizophrenia**: This type is typified, primarily, by delusions that follow a theme, for example, a belief that they are being persecuted or grandiose beliefs ('*I'm the real heir to the throne…*'). Auditory hallucinations may accompany a delusion and are therefore usually related to its theme. Symptoms common to other subtypes, like disorganized speech and flattened affect, are not usually prominent in episodes of paranoia, but anger, irritability, and extreme anxiety are. People suffering from paranoid delusions often become particularly preoccupied with them and may be especially prone to challenging behaviour such as irritability, sudden anger, fearfulness, and suspicion. Interestingly, people with paranoid schizophrenia may experience less dysfunction than people with other subtypes. They are often able to live, work, and care for themselves. The onset of paranoid schizophrenia is tends to be later in life than other forms.

- **Disorganized Schizophrenia**: This type is characterised by disorganized speech, behaviour, and flattened affect and is particularly disruptive to the lives of those affected. The disorganized episode (also known as hebephrenic schizophrenia) often features fragmented speech and inappropriate or unexpected behaviour that does not reflect ideas expressed verbally. Strange mannerisms, gestures, and surprising behaviour are also common. This type of schizophrenia typically causes significant dysfunction in daily life, self-care, and interaction with others, as well as notable thought disturbance and loss of goal-directed behaviour. People in the midst of a disorganized episode show no catatonic signs.

- **Residual Schizophrenia**: This type of schizophrenia is diagnosed when positive symptoms like delusions, hallucinations, and grossly disorganized behaviour have disappeared. The negative symptoms, as detailed earlier, remain and may be

interrupted only briefly by mildly disorganized speech or strange behaviour. When delusions or hallucinations occur, even if infrequently, they are not serious enough to cause severe dysfunction. Residual symptoms can last indefinitely, or they can disappear altogether, though this is rare.

- **Undifferentiated Schizophrenia**: This is the diagnosis for a person who is exhibiting symptoms which meet many of the criteria of schizophrenia, but does not fully or clearly fit one of the other types of schizophrenia (paranoid, catatonic, disorganized or residual). Undifferentiated schizophrenia can also be confused with other illnesses, including neurological disorders.

2.4. TREATMENT

The prevalent theoretical models of schizophrenia provide a multi-causal explanation for the origin and maintenance of the disorder, so a proper treatment plan is based on a methodology that combines the different elements, including pharmacological and psychosocial elements.

Drug therapy provides the basis for reducing symptoms and preventing relapse. Patients need to be matched to the right drug and the right dose, a process that often takes some time. Once this is in place, other interventions will be implemented aimed at improving patient functioning.

The main medications for the treatment of positive symptoms (hallucinations, delusions, disordered thinking) are antipsychotics or neuroleptics. But they often are prescribed in combination with other drugs to treat concomitant and secondary symptoms associated with antipsychotic or neuroleptic drugs (anxiolytics or tranquilizers, antidepressants, mood stabilizers and sleeping pills).

A combined prescription is often called for because of the significant side effects of the main drugs used in the treatment of symptoms of schizophrenia. Amongst them are dry mouth, restlessness, stiffness or decreased movement, constipation, blurred vision, tremors, nervousness, insomnia, drowsiness, involuntary movements or cramps in the face, etc. Some of these effects disappear over time, but others require an adjustment of the dosage to achieve more precise minimization of side effects while maintaining the therapeutic effect of the drug. However, in many cases, a combination of different drugs is necessary to control the side effects and to maintain the effect of reducing symptoms of the primary drug.

There are two main groups of drugs used for the treatment of schizophrenia. Firstly, the classic or typical antipsychotics (e.g., chlorpromazine) which are very effective in treating positive symptoms, but often with significant side effects; secondly, the atypical or new generation antipsychotics (e.g., risperidone), which, in addition to improving positive and negative symptoms, have fewer side effects. Atypical antipsychotics are prescribed to a greater extent at present, enabling the patient to reduce symptoms and control side effects.

The psychosocial element of treatment for schizophrenia will focus on the use of cognitive behavioural techniques, social skills training and psycho-education in order to increase capacity and functional abilities of the patient. By helping the patient to acquire these skills it is hoped that they will have the tools that they need to live independently, fully participating in their community and able to develop social support networks.

3. BIPOLAR DISORDER (BPD)

Bipolar disorder is defined as a chronic mental disorder included within the classification of mood disorders. BPD develops when the biochemical systems in the brain that regulate emotion and mood are altered. This is characterized by constantly changing moods between depression and mania. The mood swings are significant and excessive, and the experiences of the highs of mania and the lows of depression are usually extreme, with serious impacts on behaviour.

The main studies indicate that BPD occurs in 1.2% of the population, with the same frequency in both men and women. This disorder usually develops in adolescence or early adulthood (age 15 – 30), and is onset usually by a severe manifestation of symptoms.

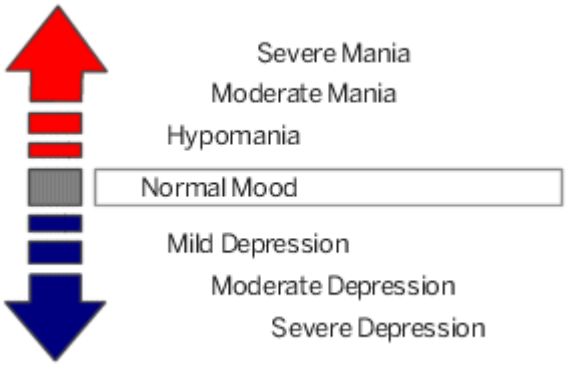
The disorder consists of several episodes that vary in intensity from person to person, including periods of stability between the manic, hypomanic and depressive episodes:

- **Manic episode**: Characterized by a period of elevated, euphoric, expansive or unusually irritable mood, as well as notably persistent, goal-directed, physical and mental activity.

- **Hypomanic episode**: Notable for the presence of manic symptoms of lower intensity.

- **Depressive episode**: Characterized by a depressed mood, sadness, discouragement and a loss of interest or pleasure in daily activities.

- **Mixed episode**: The person presents both manic and depressive symptoms during the same episode.



3.1. CAUSES

Genetic, neurochemical and environmental factors probably interact at many levels to play a role in the onset and progression of bipolar disorder. The current thinking is that this is a predominantly biological disorder that occurs in a specific part of the brain and is due to a malfunctioning of neurotransmitters (chemical messengers in the brain). As a biological disorder, it may lie dormant and be activated spontaneously or it may be triggered by stressors in life. Amongst these are predisposing factors that produce greater biological vulnerability to the disease, various precipitating factors that can trigger the condition and maintenance factors that worsen or maintain the symptoms.

▸ Underlying factors

Genetic: Genetic factors are the main explanatory cause of bipolar disorder: One in 3 children of parents with BPD develops the disorder, the risk increasing if both parents have had it.

Biochemical: Research indicates the existence of relationships between certain neurotransmitters such as norepinephrine with the depressive phase of the disorder. Recently it has been observed that steroids, hypothyroidism and hyperthyroidism can also relate to the onset of symptoms.

- **Precipitating and trigger factors**

The appearance of the disease is most often related to the occurrence of stressful life events, in people with a predisposition or vulnerability to the disorder. But even without clear genetic factors, other factors such as altered health habits, alcohol or drug misuse, or hormonal problems have been shown to trigger the disorder.

- **Maintenance factors**

After the onset of the disorder, there are factors that may worsen symptoms, as well as protective factors that may be able to improve the symptoms of the patient.

Among the factors that may worsen the disorder are stressful life events, lack of organization or daily routines, social isolation, unhealthy family relationships or substance misuse.

The main protective factors include medication, the existence of strong family and social support, maintenance of routines, self-awareness and the ability to recognize symptoms of the disorder and a healthy lifestyle.

- **Evolution**

Although BPD is a chronic disorder, suitable treatment can result in shorter, less frequent episodes and fewer relapses, leading to a considerable improvement in the patient's quality of life.

The onset of the disease is most often associated with a stressful life event, but subsequent eventsdo not need to be associated with external factors. In most cases, the condition first manifests as a depressive phase and is misdiagnosed as a unipolar condition.

Some recent research has demonstrated that there may be a seasonal aspect to both manic and depressive episodes; depressive episodes more often occur in autumn and winter, and manic episodes in spring and summer.

Finally, it is important to note that people with bipolar disorder tend to have an average of four episodes of varying intensity during the first 10 years of the disorder, the intervals between episodes shortening as the disease progresses.

3.2. SYMPTOMATOLOGY

BPD is difficult to diagnose since, because of the differing phases, it has a wide variety of symptoms and it manifests in a different way depending on the patient.

Many of the symptoms are common to other diseases and the development of each episode varies from person to person, but there are a number of symptoms that are common to all patients, in each manic-depressive episode.

- **Manic Episode:**

Characterized by a distinct period of abnormally and persistently elevated or irritable mood, and abnormally and persistently increased goal-directed activity or energy. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others. Some of the specific symptoms are:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- More talkative than usual or pressure of speech.
- Flight of ideas or subjective experience that thoughts are racing.
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

- **Depressive episode:**

This is characterized by some of the following symptoms that, as with a manic episode, cause clinically significant distress or impairment in social, occupational or other important areas of functioning:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g. appears tearful).
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.

- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- **Episodes of hypomania:**

Hypomania is characterized by a distinct period of abnormally and persistently elevated or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic, but the episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic. Some of the specific symptoms are:

- Inflated self-esteem or grandiosity.
- Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
- More talkative than usual or pressure to keep talking.
- Flight of ideas or subjective experience that thoughts are racing.
- Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

3.3. TYPES OF BIPOLAR DISORDER

BPD is classified, based on the intensity of the symptoms and the frequency and type of episodes, as follows:

- **Bipolar I disorder**

Bipolar I disorder is the classic and best known type, characterized by the presence of intense phases of mania and depression. The manifestation of episodes and their intensity varies from one patient to another. However, research has indicated that there is a higher probability that men start the cycle with a manic episode and women with a depressive episode.

- **Bipolar II disorder**

Bipolar II disorder is characterized by the presence of severe depression with hypomanic episodes. Hypomanic phases typically include more sociable relations and a state of mild euphoria, so the disease is often confused with simple changes in the patient's mood. The lack of full manic episodes is what differentiates Bipolar II from Bipolar I.

- **Mixed Phases**

Mixed phase bipolar, which occurs in approximately 30% of patients with a BPD diagnosis, is characterised by the occurrence of depressive and manic symptoms in combination. During one day a patient may have depressive symptoms, such as sadness, and also irritable mood or increased activity or energy.

- **Rapid-cycling**

Rapid-cycling is a term that describes having four or more mood episodes within a 12-month period. Episodes must last for some minimum number of days (normally 1 week) in order to be considered distinct episodes. Some people also experience changes in polarity from high to low or vice-versa within a single week, or even within a single day. The full symptom profile that defines distinct, separate episodes may not be present (for example, the person may not have a decreased need for sleep), making such "ultra-rapid" cycling a more controversial phenomenon. Rapid cycling can occur at any time in the course of illness, although some researchers believe that it may be more common at later points in the lifetime duration of illness. Women appear more likely than men to have rapid cycling. A rapid-cycling pattern increases risk for

severe depression and suicide attempts. Antidepressants may sometimes be associated with triggering or prolonging periods of rapid cycling. However, that theory is controversial and is still being studied.

3.4. TREATMENT

Treatment of BPD involves the use of a combination of medication and psychosocial intervention.

- **Medication**

Medication varies depending on the specific symptoms the patient is presenting with, but in the remission phases, lithium is most often used, in order to stabilize mood and prevent relapse. Lithium is a mineral that occurs naturally in our body, but people with BPD need an amount greater than that provided by food to maintain a stable mood.

Lithium is one of the most widely used and studied medications for treating bipolar disorder. Lithium helps reduce the severity and frequency of mania and it may also help relieve or prevent bipolar depression. However, there can be side-effects including tremors, thirst, need to urinate more than usual, diarrhoea, abdominal pain, dizziness and long-term problems with kidney and thyroid function.

Depressive episodes of disease are, for the most part, treated with tri-cyclic antidepressants but because this treatment can be the trigger for manic phase change, it is important to prescribe clinically and carefully.

To treat symptoms of a manic phase, patients are usually prescribed antipsychotics, neuroleptics or anti-manic drugs. Among the possible side-effects of these drugs are: drowsiness, stiffness of limbs, slowing, increased appetite and insomnia.

- **Psychotherapy and psychosocial intervention**

Cognitive Behavioural Therapy, social skills training and psycho-education have proven to be effective in stabilizing patients and helping with their psychosocial improvement.

The use of these techniques helps to increase the powers of the patient to cope with adverse situations; enhancing their autonomy, wellbeing and their capacity for involvement in the community. Strengthening psychosocial skills along with good social support network elements are particularly important to stabilize the patient and prevent relapses.

4. BORDERLINE PERSONALITY DISORDER (BoPD)

Borderline Personality Disorder is a subtype of the diagnostic family of Personality Disorders. These disorders are defined as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, that is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

A personality disorder is a pathological form of behaviour and a pervasive, inflexible and maladaptive failure in the social and personal functioning of the individual affected. To be considered a disorder, the behaviour should not to be associated with external factors or life events, but should be clearly outside of what is expected in a particular social and cultural context. A disorder, in this context, should be clearly distinguishable from a healthy personality (characterized by adaptability, flexibility and emotional stability).

BoPD is part of this group of disorders, having the same permanent, inflexible and maladaptive pattern of behaviour. But BoPD is distinguished by a pathological variable and unpredictable mood, of an uncontrolled intensity.

BoPD is one of the mental disorders with the highest prevalence, affecting about 2% of the general population. There is a higher occurrence in women than men (3: 1) and onset is usually in adolescence or early adulthood (age 19-34). It should be noted that because of the symptoms and the fact that BoPD often occurs alongside other conditions, diagnosis is often delayed by as many as 9 years.

4.1. CAUSES

Most experts agree that there is no single, clear cause of BoPD. It is likely to be caused by a combination of factors including:

- Genetic factors that can predispose a person to developing BoPD. It has been demonstrated that a high percentage of people with personality disorders have a family history of mood or personality disorders.
- Biological factors (some people with BoPD have a number of regions in the brain with abnormal structure and function)
- Environmental and social factors that influence the evolution of BoPD. Past events, including parental models, the family atmosphere, the presence of

addictive behaviour, substance misuse, learning and information processing patterns assimilated by the patient all appear to play an important role.

- **Evolution**

The evolution of BoPD varies, depending on the characteristics and experiences of the individual. There has been a general assumption that BoPD begins to manifest towards the end of adolescence or in early adulthood; however, recent research points to the possibility of an earlier beginning. The presence of childhood personality traits, such as impulsivity, emotional instability, hostility or hyperactivity in many patients with BoPD has demonstrated that early symptoms can be identified during childhood.

Generally, patients with BoPD become less impulsive as they get older, from around 30 years old. This change is reinforced if the patient accepts the illness, if personal and cognitive impairment has not been very pronounced during the early stages of the disease and if they have a good support network and a stable, structured environment.

There are mixed opinions on the possibility of recovery from BoPD. Some studies predict a major improvement if the medical treatment plans are followed, but other studies indicate continued deterioration of the patient. Any deterioration can also include depression, substance misuse, eating disorders, self-harm and suicide attempts, all of which can worsen the symptoms and hamper recovery.

4.2. SYMPTOMATOLOGY

Borderline personality disorder is characterized by a widely diverse range of symptoms. Characteristics of the patient, their personal circumstances and experiences will determine the development of the disorder and how it is expressed in interactions with others and the world around them. It is, therefore, not possible to make a definitive list of unique symptoms for the majority of patients.

Despite the heterogeneity in expression of symptoms in each patient, there are two main features present in all patients: **impulsivity** and **emotional and affective instability**.

In addition to these two main symptoms, other common symptoms include:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance misuse, reckless driving, binge eating).
- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

4.3. TYPE OF BORDERLINE PERSONALITY DISORDER

Four different subtypes of BoPD have been identified and described below:

- **Discouraged borderline**: This is a person who believes that no matter what, they just can't win. Consequently, he or she may avoid people, believing they will not want to be around him/her. The other extreme is he or she may be overly dependent on other people, hoping to find some sense of self-worth from them. This person may also suffer from symptoms of depression. This person is operating in an "abandoned child" mode. He/she believes that he/she is unworthy of love and affection. He/she believes no one will want anything to do with him/her, and behaves accordingly. This may include frantic efforts to avoid the end of or disturbance of any relationship, black-and-white thinking, or unstable sense of self.

- **Impulsive borderline**: This is what mental health professionals usually mean when they say "borderline". This type of person is in constant conflict with society. Bouts of violence are not uncommon. This person does not think before acting, and the result is chaos for everyone involved. This person may also have antisocial personality disorder as a co-occurring diagnosis. This person is operating in an "abandoned child" mode as well as an "angry child" mode. The angry child believes that other people deserve to be punished for his/her pain, and behaves accordingly. This type of person with BPD may have poor impulse control, abuse substances, or self-harm. On the other extreme, he or she may seek approval at any cost. In a way this is just as damaging as bouts of self-injurious behaviour. He or she may not care about himself/herself; it's all about what the other person thinks. This often results in extreme efforts to avoid disapproval and abandonment.

- **Petulant borderline**: This is a passive-aggressive person. He/she will injure himself/herself (either physically or emotionally) in an attempt to get needs met. This person has an unstable sense of self, a frantic fear of abandonment, and inability to express his/her needs. This person operates in an "angry child" mode. He/she is angry and will hurt friends and family as a result. He/she often does not recognize the anger (the world is the problem, not him/her). He/ she does not know how to express his/her needs in a healthy way, so relationships seem to be a game of 'If you really loved me' or 'You should know what I want'.

- **Self-destructive borderline**: This is the popular cultural image of a person with borderline personality disorder. This person often suffers from depression as a co-occurring diagnosis and is a self-injurer. Oftentimes, just these two criteria (emotional instability and self-injurious behaviour) are enough to merit a diagnosis. This is a person who feels that no one cares, and reacts by not caring about himself/herself. This person operates in an "abandoned child" mode. Since he /she does not feel loved, he/she reacts in self-destructive ways in an attempt to feel something instead of nothing. He/she lives in terror of abandonment, is self-loathing, and has no idea who he/she is inside. Thoughts of self-injury (or actions) are a given in this type.

4.4. TREATMENT

The characteristic emotional and behavioural instability of BoPD hinders successful treatment and favours neglect and inconstancy in following medication and guidelines set by the doctor. Therefore, to achieve the objectives of intervention it is necessary to involve each of the agents that can influence the person's health. The patient with BoPD needs a multimodal intervention that connects family and practitioners, while living in a stable environment, following the drug treatment plan, participating in psychotherapy and having access to specific treatment when facing a crisis.

▸ Medication

Borderline personality disorder is a chronic disease for which medication does not provide a cure, but can reduce the severity of symptoms. Thus, drug treatment is seen as a complementary intervention aimed at reducing certain symptoms, thus helping the patient to get better outcomes from the other parts of the treatment.

There is no specific drug treatment for this disorder; medication will be prescribed to

match specific symptoms. The three main groups of symptoms normally prescribed for are:

- Emotional and affective instability.
- Behavioural impulsivity and lack of control.
- Cognitive difficulties.

▸ Psychotherapy and psychosocial intervention

Psychotherapeutic intervention for BoPD normally consists of structured, multi-component, inclusive programmes, which include social skills training, psychotherapy and psycho-educational intervention, both individually and in groups.

The main objectives of psychotherapeutic intervention are to increase the level of daily functioning skills and social interaction, improve social competence and promote physical and psychological wellbeing.

It is also important that any treatment interventions take into account community inclusion. Participation in community programmes and activities allow patients to achieve goals, increase the feeling of self-sufficiency and create positive interpersonal relationships.

Involving family members in treatment can also be important in the treatment of BoPD. Particularly where the patient is living with family, they will need support to accept the diagnosis and its impact, as well as to adapt to the new challenges presented . It is essential to provide the family with the proper tools to improve and maintain relationships with the patient and to deal with their own feelings of anxiety, denial or impotence.

It should also be noted that the symptoms of BoPD will, almost inevitably, make the relationship between the practitioner or caregiver and the patient more difficult. It is not uncommon for an individual with BoPD to become disillusioned with the practitioner or caregiver and abandon treatment.

▸ Crisis intervention by hospitalization

BoPD can sometimes present a set of symptoms which the patient, caregiver and other supporters, including family, can't cope with. These situations will require a specialized hospital intervention where the client is placed, voluntarily or otherwise, into a specialised mental health ward designed to cope with suicide attempts, psychotic episodes, depression, self-harm and other behavioural issues.

In most cases, hospital stays during a crisis are usually short and aimed at stabilising symptoms. Once the situation is under control, the patient will be discharged and referred to the specific community resource that can give ongoing support.

SELF-ASSESSMENT TEST

1. Which of the following diagnoses is considered a severe mental disorder?
    a. Schizophrenia.
    b. Depression.
    c. Anxiety disorder.
2. What is true about schizophrenia?
    a. The onset of the illness is usually between ages 35 and 40.
    b. The onset of the illness is usually between ages 15 and 35.
    c. The onset of the illness is usually after age 40.
3. The vulnerability stress model for schizophrenia indicates that:
    a. There is an inherited vulnerability to the disorder and that there must be a genetic predisposition.
    b. Maintenance factors also need to be considered.
    c. Both answers are correct.
4. Compliance with medication, the existence of positive family and social support systems recognition and acceptance of symptoms and maintaining a healthy lifestyle are:
    a. Precipitating and trigger factors in the schizophrenia.
    b. Maintenance factors.
    c. Protective factors.
5. Which of the following are considered positive symptoms in the schizophrenia?
    a. Delusions, hallucinations, disorganized thinking, extremely disorganized or abnormal motor behaviour.
    b. A reduced ability or lack of ability to function normally.
    c. Disappearance of delusions, hallucinations and disorganized thinking and normal functioning recovery.
6. The main type of medication for the treatment of positive symptoms in schizophrenia is:
    a. Antipsychotics or neuroleptics.
    b. Lithium.
    c. Selective serotonin reuptake inhibitors.
7. Bipolar disorder is defined as
    a. A chronic mental disorder included within the classification of personality disorders.
    b. A chronic mental disorder included within the classification of mood disorders.
    c. A chronic mental disorder included within the classification of psychotic disorders.

8. A manic episode is characterized by:
    a. An excessive worry that blocks the ability to carry out normal life activities.
    b. A period of elevated, euphoric, expansive or unusually irritable mood.
    c. A period of feelings of unhappiness, fear, solitude and emptiness.
9. Treatment of bipolar disorder involves the use of:
    a. A combination of medication and psychosocial intervention.
    b. Only medical treatment.
    c. Only psychosocial intervention.
10. Which of the following is a borderline personality disorder symptom?
    a. Impulsivity.
    b. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.
    c. Both answers are correct.

Claves: 1:a; 2:b; 3:c; 4:c; 5:a; 6:a; 7:b; 8:b; 9:a; 10:c.

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MODULE 3

SOCIAL COMPETENCIES FOR CARE WORKERS

WHY THIS SESSION IS IMPORTANT?

In common with the rest of the training, having a clear idea of the skills and competencies that you need to be able to support people with complex mental health issues will help you to avoid burnout.

This session should help you improve on your existing skills and learn about new skills that may help you in your career. It should also help with developing new knowledge and help improve your practice in the future.

OBJECTIVES

- To increase awareness of your skills and knowledge.
- To increase awareness of the skills and knowledge you need to have for care work.
- To be able to map your skills to a recognised framework.

KEY WORDS

- **Burnout** is a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose the interest or motivation that led you to take on a certain role in the first place.
- **Competence** is the ability to do something successfully or efficiently.

RESOURCES

- PowerPoint Presentation.
- Theoretical Content and Module Structure.
- Handouts.
- Projector, Computer, Board, Flipchart Paper and Pens.

ESTIMATED LENGTH OF TIME

2 h.

THEORETICAL CONTENTS

- Purpose of competencies and occupational standards:
  - Personal development.
  - Person-centred care and support.
  - Effective communication.
  - Duty of care and safeguarding.
  - Multi-disciplinary working.
  - Information handling and confidentiality.
  - Equality, diversity and inclusion.

ACTIVITIES SCRIPT

This section is designed to be delivered in two hours, following a structured time table, and is based around the theoretical contents available in this manual, including a brief script. The activities are detailed in the script.

There is a sample competency list of each of the 7 areas of competency identified in the training, a list of key words and worksheets.

The trainer will need to spend some time familiarizing him/herself with the material before delivery of the training, and there may be a need to adapt and tailor the training to different national systems. The training is designed to be easy to adapt.

Activity 1. Introduction

5 minutes. Introduction from the trainer to include aims of the session. Look at paragraph *1.Introduction*.

Activity 2. What are social care competencies?

20 minutes. Discussion in small groups and feedback from discussions: What are social care competencies? What competencies do you have? What competencies do care workers need? What competencies do you feel you lack?

Activity 3. Why is it important?

10 minutes. Why is it important? Before bullet points are shown, ask why it is important to learn what the social competencies are. Below is some information for the discussion:

- *The care of people who have complex mental health needs is difficult and challenging work. The people who do the work need to have a minimum level of training, something that isn't always available to the support staff, health care assistants and auxiliaries who, increasingly, work alongside the many professionals (doctors, nurses, occupational therapists, etc.) involved in this care.*

- *With this in mind, a competency framework, or at the very least a knowledge of what competencies you need to have as a care worker, are vital so that you have a clear idea of the skills and knowledge that are needed.*

- *We are going to look at the competencies that we think are important but it isn't just what we think. The "Core Competences for Healthcare Support Workers and Adult Social Care Workers in England" (Skills for Health and Skills for Care 2013), was recently produced for the Department of Health in England. This document was based on research and consultation with those that are involved in the front line of this kind of support. It covers all of the areas of competency considered necessary for the role, but we will also be looking at the social elements.*

- *It should also be noted that this training module will only be able to look at the competencies in brief and to get the full benefit you will need to do a lot of follow-up reading. We will provide links for you to look at, to help build on this knowledge.*

Activity 4. Previous ideas

10 minutes. Activity- Before showing the competencies, create a mind map or list in groups, illustrating what the trainees think the 7 competency headings are.

Activity 5. Competencies

55 minutes. Detailed explanation of the 7 chosen competencies.

As previously mentioned, we have put together a set of competencies that apply to all of the work that you might be called upon to do as a care worker. This section is based on the theoretical contents from sections 2.1 to 2.8. Look at the categories of competency that you need to be aware of. Each of the categories is accompanied by a list of competencies that we have drawn up (worksheets 1 to 7), but there is far more to this subject and we will only be able to scratch the surface. You will need to look at the handouts and the links that we will provide afterwards.

10 minutes. Personal Development (paragraph 2.1 of the theoretical manual): The trainer gives an example of a mistake or experience that they struggled with. What did the trainer learn from this? How did he/she learn and what impact did this have on personal development? Ask trainees for an example. Conclude with an emphasis on the importance of evaluating and reflecting every day

10 minutes. Person-centred Care and Support Discussion (paragraph 2.2. of the theoretical manual): What does person-centred mean? How much input should a client/patient (with complex mental health needs) have into their care?

10 minutes. Effective Communication Discussion (paragraph 2.3. of the theoretical contents): Look at both elements of communication: with colleagues and clients/patients. How important are both? Look at eye-contact, tone and body language, briefly linking it to the section of training on Facing Crisis Situations.

10 minutes. Duty of Care and Safeguarding (paragraph 2.4. of the theoretical manual): Define the terms 'duty of care' and 'safeguarding' and look at how they underpin practice. Provide handout (worksheet 4).

5 minutes. Working in Multidisciplinary Teams Discussion (paragraph 2.5. of the theoretical manual): this will be looked at in more detail in the final module of the training, but have a brief discussion of the benefits: *Multidisciplinary teams convey many benefits to both patients and those working on the team, such as continuity of care, the ability to take a comprehensive, holistic view of the patient's needs, the availability of a range of skills, and mutual support and education.*

5 minutes. Information Handling and Confidentiality Discussion (paragraph 2.6. of the theoretical manual): a brief discussion on confidentiality and the importance of knowing organisational policies and your responsibilities.

5 minutes. Equality, Diversity and Inclusion (paragraph 2.7. of the theoretical manual): If you are able to demonstrate to a patient that you respect their beliefs, culture, values and preferences, what impact is this likely to have on their experience of care? Provide Handout (worksheet 7).

Activity 6. Evaluation of the session

15 minutes. Evaluation of the session. Discussion: What have you learned from this session? What do you think would be most effective in practice? What one key piece of advice would you use? What do you think is the most important skill in your work? Feedback to the group.

Activity 7. Final questions

10 minutes. Opportunity to ask questions and make trainees aware of resources.

THEORETICAL MANUAL

1. INTRODUCTION

According to Skills for Health (SfH), a UK based non-profit organisation set up by the UK national government to improve working standards in the UK health sector, all health and social care professionals should be educated to deliver client-centred care as members of an interdisciplinary team, emphasising evidence-based practice, quality improvement approaches, and the latest information. We believe that these are the basic tenets of becoming a good care worker.

Although SfH (and their sister organisation, Skills for Care) value classroom-based academic learning, they champion the benefits of work-based learning and development based on a set of standard competencies; competencies that can be addressed and assessed in the work place. With this in mind, they have drawn up a set of National Occupational Standards (NOS), for staff and employers to use. We have based our lists of competencies on those of Skills for Health and Skills for Care.

NOS describe the skills, knowledge and understanding needed to undertake a particular task or job at a recognized level of competence. They focus on what the person needs to be able to do, as well as what they must know and understand to work effectively. They cover the key activities undertaken within the particular occupation, under all the circumstances the job-holder is likely to encounter.

Each Occupational Standard contains an agreed set of knowledge and understanding and performance criteria that must be met before someone can be deemed competent. They describe the minimum standard to which an individual is expected to work in a given occupation and a variety of benefits:

- Provide managers with a tool for a wide variety of workforce design, management, succession planning and quality control.

- Offer a means to manage performance, increase productivity, identify and fill skills gaps.

- Act as a framework for recruitment, selection and induction.

- Supply a tool for personal, career and team development.

- Present a framework for training and education design, assessment and accreditation.

2. PURPOSE OF COMPETENCIES AND OCCUPATIONAL STANDARDS

But our focus here is on your development as a care worker, on how a set of competencies or occupational standards, as set out in this section of the training, describe the skills, knowledge and understanding you need to undertake the challenging work of supporting people with complex mental health needs, in a social care environment. They focus on what the care worker needs to be able to do, as well as the level of understanding and knowledge needed to work effectively.

This will help the individual care workers feel more confident in their practice and offer a means to identify strengths and areas that need to be improved upon. It should also enable the individual to become more reflective of their practice. We will be looking at competencies under the 7 headings below; these groups of competencies, we believe, cover all of the key areas of the work and will give all of the trainees food for thought and reflection.

2.1. PERSONAL DEVELOPMENT

As workers in the social care field, we have a responsibility to keep our knowledge and skills up to date. This sort of learning is called personal development. The aim of personal development is to make us more effective at what we do.

The first step is to think about the demands of your job: its purpose, how the tasks listed in your job description relate to that purpose and, most importantly, what it means to do the job well. Ask yourself what knowledge, skills and attitudes are required for this.

The next stage is to reflect on and evaluate your own performance. Try and identify the parts of the job that you enjoy and the parts you find difficult. How fully do your knowledge, skills and attitudes match those that the job requires? How could you improve your ability as a care worker?

From this you can develop a plan, either informally for yourself, or formally, as a personal development plan, with your line manager. The plan details what knowledge,

skills and attitudes you aim to develop and how you will develop them. The final stage is to carry out the learning activities in your plan and then evaluate the results. What new knowledge and skills have you gained and how has this improved the way you work?

2.2. PERSON-CENTRED CARE AND SUPPORT

Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.

Person-centred care is not just about giving people whatever they want or providing information. It is about considering people's desires, values, family situations, social circumstances and lifestyles, seeing the person as an individual, and working together to develop appropriate solutions.

Being compassionate, thinking about things from the person's point of view and being respectful are all important. This might be shown through sharing decisions with patients and helping people manage their health, but person-centred care is not just about activities. It is as much about the way professionals and patients think about care and their relationships as the actual services available.

In the past, people were expected to fit in with the routines and practices that health and social service professionals felt were most appropriate.

But in order to be person-centred, services need to change to be more flexible to meet people's needs in a manner that is best for them. This involves working with people to find the best way to provide care. This partnership can occur on a one-to-one basis, where individual people take part in decisions about their health and care, or on a collective group basis whereby the public or patient groups are involved in decisions about the design and delivery of services. The underlying philosophy is the same: it is about doing things with people, rather than 'to' them.

There is no one definition of person-centred care. People might also use terms such as patient-centred, user-centred, individualized or personalized. Regardless of the terms used, a lot of research has looked into what matters to patients and how to provide person-centred care to make sure people have a good experience.

But we also need to consider that in these times of austerity, services may not have the resources, and therefore the time, to provide truly person-centred care. But we should try to involve patients in as many decisions as possible, because it is very easy for services to become un-responsive and rigid, without the flexibility to treat people as individuals.

2.3. EFFECTIVE COMMUNICATION

Effective communication is vital to working in health and social care. An important part of communication is the giving and receiving of information, between patients and their care workers and among staff team members. Health, care and support workers also need an understanding that these skills need to be adapted to different circumstances (e.g., a nurse trying to take blood from a patient who has a fear of needles needs to use their voice and body language to reassure the patient and control the situation, a social worker writing a report on a child in their care must be accurate, clear and sensitive to the child's needs).

There are different forms of communication, each with their own advantages and disadvantages; for some individuals, conventional forms of communication are inappropriate. People who access services do so because they have needs that have to be expressed by the individual and understood by the practitioner; communication facilitates this. It is not always easy to communicate effectively, and factors that inhibit and support communication also need to be understood by support workers and carers. These factors include slang, cultural references, environmental conditions, positioning and body language. Many of these factors can have a negative impact on communication and will need to be overcome in order to communicate effectively.

Communication between team members, whether verbal or written, can be used to reduce and eliminate risk; the more information that you have about clients and their needs, the better equipped the team is to support them in a safe way. This also includes gaining consent from patients to act on their behalf and to share information where necessary.

2.4. DUTY OF CARE AND SAFEGUARDING

Duty of care is defined simply as a legal obligation to always act in the best interest of individuals and others and not to act or fail to act in a way that results in harm. It also refers to the necessity to always act within your competence and not take on anything you do not believe you can safely do, carrying out duties only for which you are competent and are in your job description and declining those which are not. It

extends to being accountable for your own decisions and actions and following standard procedures in all aspects of work, including use of resources and equipment. A duty of care means that you have to provide standards of care in line with principles and codes of practice that apply to your setting or service, including a need to observe confidentiality, to be observant, to report any concerns and the importance of induction and regular updating of knowledge and skills.

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

Safeguarding vulnerable adults includes:

- Protecting their rights to live in safety, free from abuse and neglect.
- People and organizations working together to prevent the risk of abuse or neglect, and to stop them from happening.
- Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account.

Safeguarding training is provided, as a standard, in all environments that have a duty of care for vulnerable adults. This training generally includes how to spot and report different types of abuse.

Abuse is a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

2.5. MULTI-DISCIPLINARY WORKING

Like families, multi-disciplinary teams can work brilliantly together, or be totally dysfunctional. It's hardly surprising that when you assemble a diverse group of people with varied skills into a team, things don't always go smoothly. But multi-professional teams are a fact of life in health and social care, with integration between professions set to get ever closer. The team working module of this training will explore the issues involved in team working in greater detail, but environments, particularly those involved in the care of people with mental health problems, include social workers,

nurses, psychiatrists, and teachers, all of which have different training, ways of working and culture. Social care, health and education are all sectors which have undergone huge change, restructuring and reorganization. Evolving roles and boundaries consequently affect how professionals work together and can cause confusion. Everyone needs clarity on their own role and to be clear about what other team members do.

2.6. INFORMATION HANDLING AND CONFIDENTIALITY

Confidential information about clients or patients should be treated respectfully; service providers always have legal responsibilities about how they keep, store and share this information. In the UK one of the most important pieces of legislation relating to information is the Data Protection Act 1998. All members of a care team should have an awareness of their responsibilities under this legislation, or the legislation that applies in their country. These responsibilities would normally be set out in policies and procedures drawn up by the organization for which they work.

Personal information will have to be handled in particular ways depending on the format it is held in (paper, video, computer, etc.) and this will usually be set out in the law or the organizational policy. A sample confidentiality policy can be found in Worksheet 10.

2.7. EQUALITY, DIVERSITY AND INCLUSION

Equality, diversity and inclusion are all key parts of social care (Definitions can be found in Appendix K). They relate to areas such as race, gender, disability, age, sexual orientation and religious beliefs. People have the same right to receive care whatever their background or beliefs. A care worker needs not only to be aware of this but also to be active in promoting these concepts in their practice. Equality and inclusion apply not only to the people you support but also to your work colleagues. They are two of the essential values which underpin social care.

Every care worker needs to understand the value and importance of equality and inclusion and what this means for them personally. Often it will mean reflecting on their own views and behaviour and how they impact those around them, particularly patients.

A care worker also needs to be able to identify discrimination and to be able to challenge it.

2.8. SUMMARY

The areas of competency that we have covered in the section above, and those that we have listed in the appendices are a good starting point for any competent care worker who wants to know how to improve their skills, be better at their job and provide better care for their clients and patients. We have deliberately not gone into too much detail because there is far more information available than we could cover in 2 hours. The reference section at the end of this module provides links for you to look into in much more detail.

Worksheet 1. Personal Development of Social Competencies

- Describe the duties and responsibilities of own work role.
- Explain expectations about own work role as expressed in relevant standards.
- Be able to reflect on practice.
- Explain the importance of reflective practice in continuously improving the quality of service provided.
- Demonstrate the ability to reflect on practice.
- Identify your own values, interests and priorities in relation to health and social care.
- Describe how own values, belief systems and experiences may affect working practice.
- Be able to evaluate own performance and identify the ways in which your own work can be improved.
- Evaluate own knowledge, performance and understanding against relevant standards.
- Incorporate new knowledge and learning, based on evidence and reflection, into practice.
- Demonstrate use of feedback to evaluate own performance and inform development.
- Be able to agree to a personal development plan.
- Identify sources of support for planning and reviewing own development.
- Demonstrate how to work with others to review and prioritize own learning needs, professional interests and development opportunities.
- Demonstrate how to work with others to agree to own personal development plan.
- Be able to use learning opportunities and reflective practice to contribute to personal development.
- Evaluate how learning activities have affected practice.
- Demonstrate how reflective practice has led to improved ways of working.
- Show how to record progress in relation to personal development.

Worksheet 2. Person-Centred Care and Support Competencies

- Define person-centred values.
- Explain why it is important to work in a way that embeds person-centred values.
- Explain why risk-taking can be part of a person-centred approach.
- Explain how using an individual's care plan contributes to working in a person-centred way.
- Be able to work in a person-centred way.
- Find out the history, preferences, wishes and needs of the individual.
- Apply person-centred values in day to day work, taking into account the history, preferences, wishes and needs of the individual.
- Be able to establish consent when providing care or support.
- Explain the importance of establishing consent when providing care or support.
- Establish consent for an activity or action.
- Explain what steps to take if consent cannot be readily established.
- Be able to encourage active participation.
- Describe how active participation benefits an individual.
- Identify possible barriers to active participation.
- Demonstrate ways to reduce the barriers and encourage active participation.
- Be able to support the individual's right to make informed choices.
- Use agreed risk assessment processes to support the right to make choices.
- Explain why a worker's personal views should not influence an individual's choices.
- Describe how to support an individual to question or challenge decisions concerning them that are made by others.
- Be able to promote individuals' wellbeing.
- Explain how individual identity and self-esteem are linked with wellbeing.
- Describe attitudes and approaches that are likely to promote an individual's wellbeing.
- Support an individual in a way that promotes a sense of identity and self esteem.
- Demonstrate ways to contribute to an environment that promotes wellbeing.

Worksheet 3. Effective Communication Competencies

- Identify the different reasons and ways that people communicate.
- Explain how communication affects relationships in the work setting.
- Be able to meet the communication and language needs, wishes and preferences of individuals.
- Demonstrate how to establish the communication and language needs, wishes and preferences of individuals.
- Describe the factors to consider when promoting effective communication.
- Demonstrate a range of communication methods and styles to meet individual needs.
- Demonstrate how to respond to an individual's reactions when communicating.
- Be able to overcome barriers to communication.
- Explain how people from different backgrounds may use and/or interpret communication methods in different ways.
- Identify barriers to effective communication.
- Demonstrate ways to overcome barriers to communication.
- Clarify points and check that you and others understand what is being communicated.
- Demonstrate strategies that can be used to clarify misunderstandings.
- Explain how to access extra support or services to enable individuals to communicate effectively.
- Maintain confidentiality of information where appropriate to do so.
- Understand the importance of communication within staff teams.

Worksheet 4: Duty of Care and Safeguarding Competencies

- Define the term 'duty of care'.
- Explain what it means to have a duty of care in own work role and how it affects that role.
- Explain how duty of care contributes to the safeguarding or protection of individuals.
- Describe dilemmas and conflicts that may arise between the duty of care and an individual's rights and know how to address them.
- Describe how to manage risks associated with conflicts or dilemmas between an individual's rights and the duty of care.
- Explain where to get additional support and advice about how to resolve such conflicts and dilemmas.
- Know and describe how to respond to complaints.
- Explain the main points of accepted procedures for handling complaints.
- Describe and be able to recognize factors, situations and actions that may cause or lead to harm and abuse.
- Describe and be able to recognize signs and symptoms that may indicate that an individual has been, or is in danger of being, harmed or abused.
- Demonstrate that you know your role in safeguarding individuals and how this fits with local procedures and agreements.
- Know the role of different agencies and multi-agency working in the safeguarding of individuals.
- Show that you know the actions you need to take and those you must avoid, when harm or abuse is suspected or has been disclosed, in line with the responsibilities of your role and local procedures.
- Ensure your own actions and attitudes do not contribute to situations, actions or behaviour that may be harmful or abusive.
- Support practices that help to safeguard individuals from harm or abuse.
- Know where to seek support in situations beyond your experience or expertise.
- Use supervision and support to deal with your own reactions to possible harm or abuse, within confidentiality requirements.

Worksheet 5. Multi-disciplinary Team Working Competencies

- Understand and describe the role and purpose of the team and its individual members.
- Ability to recognize the strengths and adapt to the needs of individual members.
- Willingness and ability to cross-cover between disciplines and role-blur within the limits of own skills.
- Knowledge of how to work in partnership with service users, carers and social networks.
- Understand the sources of conflict and development of basic teamwork skills including negotiation and conflict resolution.
- Understand the need for, and willingness to participate effectively in, multi-disciplinary team supervision.
- Understand how good leadership can improve outcome for individual service users.
- Knowledge of the importance of clear communication between team leaders and individual members.
- Respect for service users and caregivers as individuals and understanding of the rights of users and caregivers.
- Respect for and understanding of the different training, skills and perspective of other team members.
- Understanding of multidisciplinary team working and commitment to this, as a means of delivering mental health treatment and care.
- Positive attitude to those with mental illness, including a commitment to a holistic approach to mental health.
- Understanding of, and belief in, the philosophy and background behind mental health recovery principles.

Worksheet 6. Information Handling and Confidentiality

- Identify and summarise the main points of the legislation and codes of practice that relate to handling information in health and social care for your organization, in your country.
- Be able to implement good practice in handling information.
- Describe features of manual and electronic information storage systems that help ensure security.
- Demonstrate practices that ensure security when storing and accessing information.
- Maintain records that are up to date, complete, accurate and legible.
- Be able to support others to handle information.
- Support others to understand the need for secure handling of information.
- Support others to understand and contribute to records.
- Demonstrate an understanding of the confidentiality policy that relates to your organization.
- Shows an ability to discuss, in an appropriate way, any dilemmas and tricky situations that may occur.
- Demonstrate an understanding of the importance of patient consent where disclosure of information may be necessary.

Worksheet 7. Equality, Diversity and Inclusion Competencies

- Explain what is meant by diversity, equality and inclusion.
- Describe the potential effects of discrimination.
- Explain how inclusive practice promotes equality and supports diversity.
- Be able to work in an inclusive way.
- Explain how legislation and codes of practice relating to equality, diversity and discrimination apply to own work role.
- Show interaction with individuals that respects their beliefs, culture, values and preferences.
- Be able to promote diversity, equality and inclusion.
- Demonstrate actions that model inclusive practice.
- Demonstrate how to support others to promote equality and rights.
- Describe how to challenge discrimination in a way that promotes change.

SELF ASSESMENT TEST

1. Using learning opportunities and reflective practice to contribute to personal development belongs to the group of competencies called:
    a. Person-centred care.
    b. Effective communication.
    c. Personal development.
2. Person-centred care and support is:
    a. A way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs.
    b. A way of thinking and doing things that sees the people using health and social services as co-therapist.
    c. A way of thinking and doing things that sees the people using health and social services as beneficiaries of a care that meets their needs
3. Effective communication, understood as a competency for healthcare workers, consists of:
    a. A suitable understanding of medical directions.
    b. An important part of communication is the giving and receiving of information, between clients/patients and their caregivers or support workers and among staff team members
    c. Both answers are correct.
4. Duty of care and safeguarding, understood as a competency for healthcare workers, consists of:
    a. A legal obligation to always act in the best interest of individuals and others and not to act or fail to act in a way that results in harm
    b. It refers to the necessity to always act within your competence and not take on anything you do not believe you can safely do
    c. Both answers are correct.
5. A multidisciplinary team:
    a. Is composed of professionals who perform different functions.
    b. Is composed of professional from different disciplines.
    c. Gathers several professionals from the same discipline.
6. As far as information handling and confidentiality is concerned:
    a. Only doctors and psychologists should deal with confidential information.
    b. Talking about a client to somebody who isn't involved in their care doesn't violate client's right to be treated confidentially and respectfully.
    c. All members of a care team should have an awareness of their responsibilities regarding information handling and confidentiality.

7. Equality, diversity and inclusion:
    a. Relate to access to the same treatment for all the clients.
    b. Relate to the right to be treated according to the personal preferences of the client.
    c. Relate to areas such as race, gender, disability, age, sexual orientation and religious beliefs.
8. Which of the following competencies is not included within the *Effective communication* competencies*?*
    a. Demonstrate a range of communication methods and styles to meet individual needs.
    b. Demonstrate how to respond to an individual's reactions when communicating.
    c. Explain the main points of accepted procedures for handling complaints
9. Which of the following competencies is not included within the *Duty of care and safeguarding* competencies*?*
    a. Explain the main points of accepted procedures for handling complaints
    b. Describe and be able to recognize factors, situations and actions that may cause or lead to harm and abuse
    c. Respect for and understanding of the different training, skills and perspective of other team members.
10. Which of the following competencies are not included within the competency called *Information handling and confidentiality?*
    a. Respect for and understanding of the different training, skills and perspective of other team members.
    b. Demonstrate an understanding of the confidentiality policy that relates to your organization.
    c. Demonstrate an understanding of the importance of client/patient consent where disclosure of information may be necessary.

REFERENCES AND LINKS

Skills for Health (2016). *Standards.* From: http://www.skillsforhealth.org.uk/standards

Skills for Care (2016). *National Occupational Standards.* From: http://www.skillsforcare.org.uk/Standards-legislation/National-Occupational-Standards/National-Occupational-Standards.aspx

Skills for Care y Skills for Health (2013). *Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England*. United Kingdom: SfC y SfH. Recuperado de http://www.skillsforcare.org.uk/document-library/standards/national-minimum-training-standard-and-code/codeofconduct.pdf

Skills for Care y Skills for Health (2013). *Core Competences for Healthcare Support Workers and Adult Social Care Workers in England*. United Kingdom: SfC y SfH. From: http://www.skillsforcare.org.uk/document-library/standards/national-minimum-training-standard-and-code/codeofconduct.pdf

MODULE 4
FACING CRISIS SITUATIONS

WHY IS THIS SESSION IMPORTANT?

Mental health crises affect many people and if not dealt with quickly and appropriately, can have very detrimental consequences to the long term mental health of individuals.

So, it is particularly important for care workers who work with individuals with complex mental health needs and diagnoses of long term conditions to understand what a crisis is and to have clear strategies to deal with one in order to keep both the patient and themself safe.

OBJETIVES

The purpose of this section is to prepare care workers to respond to and manage care for persons experiencing mental health crises and emergencies, in particular those associated with the conditions discussed earlier in the training.

At the end of this section you should have:

- An understanding of what constitutes a crisis.
- An understanding of some of the most common causes of mental health crises.
- A clear idea of how crises can develop.
- An understanding of possible intervention strategies.

KEY WORDS

- **Crisis** is a situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown.
- **Intervention** is an action taken to improve a situation/condition/disorder (sometimes taken without consent).
- **Rapport** is a close and harmonious relationship that enables those concerned to understand each other's feelings or ideas and to communicate well.
- **Coping** consists of facing and dealing with difficulties in a calm or adequate manner.
- **Psychological Factors** are thoughts, feelings and other characteristics that affect the attitude, behaviour and functions of the human mind.
- **Social Factors** consist of lifestyle, economic and educational issues that may affect development and the ability to cope.
- **Empower** means to give someone power or enable them to feel powerful, particularly in making decisions for themself or taking control of their own life.

- **Active Listening** means demonstrating to the speaker that you have heard and processed what they have said.

RESOURCES

- PowerPoint Presentation.
- Theoretical Contents and Module Structure.
- Handouts.
- Projector, Computer, Board, Flipchart Paper and Pens.

ESTIMATED LENTH OF TIME **2 h.**

THEORETICAL CONTENTS

- Introduction and history.
- Caplan's four stage model.
- Roberts' seven step crisis intervention model.

ACTIVITIES SCRIPT

This section is designed to be delivered in two hours and is based around the theoretical contents available at the next section and following a structured time table, which includes a brief script. The activities are detailed in the script.

The trainer will need to spend some time familiarizing himself/herself with the material before delivery of the training and there may be a need to adapt and tailor the training to different national systems. The training is designed to be easy to adapt.

The two scenarios have been chosen at random; please feel free to substitute any scenario that fits with the working environment of the care workers you are training. The application of the 7 stage model should allow everyone involved to identify the best interventions, so we have not supplied any "correct" answers. The response to these, and similar situations, will be affected by the environment and the individual, so each group is likely to come up with different solutions.

Activity 1. Introduction

5 minutes. Introduction from the trainer to include aims of the session (paragraph *1. Introduction an History*, in the theoretical contents).

Activity 2. What is a crisis?

15 minutes. Discussion in small groups: What is a crisis and what are the factors that could lead to a crisis?

Feedback:

- *A crisis is a state of imbalance that may escalate into an emergency if it involves self-harm, suicide or threats to self or others.*
- *A hazardous or traumatic event that challenges a person's ability to cope with feelings of helplessness and a lack of control.*
- *A crisis can be the beginning, deterioration or relapse of a psychiatric condition.*

Activity 3. Risk factors

15 minutes. Presentation and discussion about the physical, psychological, emotional and social events which can cause and contribute to the crisis. Here you have a brief guide to work with:

Physical Causes

- *Poor sleep.*
- *Changes in medication.*
- *Illness.*
- *Poor nutrition.*
- *Developmental stages (adolescence, menopause).*
- *Serious injury.*
- *Non-compliance with medication in someone with pre-existing severe mental illness.*

Psychological and Emotional Causes

- *Anxiety.*
- *Depression.*
- *Cognitive Distortions.*
- *Bereavement.*
- *Post-traumatic stress.*
- *Loneliness.*
- *Conflict/Cognitive Dissonance (usually due to a difficult choice where neither alternative is acceptable).*
- *Relationship problems - e.g., with partners or a child.*

Social Causes

- *Living conditions (Deprivation).*
- *Loss of job.*
- *Poor relationships.*
- *Lack of education etc.*
- *Becoming homeless.*
- *Changes of role - e.g., getting married or divorced, having a child, starting a more demanding job.*

Activity 4. Phases of a crisis

15 minutes. Presentation and discussion about the phases of a crisis based on the contents set out in point *2. Caplan's four stage model* of the theoretical manual.

Activity 5. Facing a crisis

15 minutes. Discussion in small groups and feedback: What steps and strategies do you use when faced with crises? Can they be used to help others?

Activity 6. Roberts' 7 stage model

25 minutes. Presentation and discussion: Look at the 7 stage model of crisis intervention, based on the work of Albert Roberts, a professor at Rutgers State University. Roberts based his work around the early work of Caplan. For developing theoretical contents, look at paragraph *3. Roberts' seven step crisis intervention model.*

Activity 7. Scenarios

15 minutes. Group discussion: Divide into groups to look at the two scenarios (Worksheet 1 and Worksheet 2) and decide how they would deal with them based on the 7 stage model.

Activity 8. Evaluation of the session

10 minutes. Partner discussion: What have you learnt from this session? What do you think would be most effective in practice? What one key piece of advice would you use? Feedback to the group.

Activity 9. Final questions

10 minutes. Opportunity to ask questions and make trainees aware of resources

THEORETICAL MANUAL

1. INTRODUCTION AND HISTORY

Mental health crisis intervention has developed into a discipline of its own, since the mid 1940s, ased on the pioneering work of two community psychiatrists, Erich Lindemann and Gerald Caplan. In the 1940s, Erich Lindemann, while working at Massachusetts General Hospital as a community psychiatrist, conceptualised crisis theory based on his work with the traumatized survivors and relatives of 493 dead victims of a night club fire. Gerald Caplan, a psychiatry professor at Massachusetts General Hospital and the Harvard School of Public Health, expanded Lindemann's pioneering work. Caplan was the first clinician to describe and document the four stages of a crisis reaction: *initial rise of tension from the emotionally hazardous crisis event, increased disruption of daily living because the individual is stuck and cannot resolve the crisis quickly, tension rapidly increases as the individual fails to resolve the crisis through emergency problem-solving methods, and the person enters a depression or mental collapse or partially resolves the crisis using new coping methods (Caplan 1964).*

A number of crisis intervention practice models have been put together over the years, but Caplan's model still seems the most apt and the simplest to put into practice. So we have based our training on Caplan's work on the stages of a crisis, and on a model of crisis intervention that was developed from Caplan and Lindemann's early work: the Roberts Seven Stage Crisis Intervention Model (R-SSCIM). This was developed in the 1990s and 2000s by Albert Roberts, a professor at Rutgers State University. It represents a practical, stepped blueprint for responding to crises and is applicable across a wide variety of situations and environments, not just mental health.

2. CAPLAN'S FOUR STAGE MODEL

Gerald Caplan was the first to describe the main stages of a crisis reaction. The contributions of later theorists have been based on Caplan's work and have basically consisted of a restatement of his phases. According to Caplan (1964), most crisis reactions follow 4 distinct phases:

- **Initial Threat or Triggering Event**

In the initial phase, the individual is confronted by a problem that poses a threat to, what Caplan termed, his/her homeostatic state. Faced with this threat and feelings of

increased tension, the person, in an effort to lower the level of anxiety (fear), will employ various defence mechanisms, such as denial, displacement (particularly anger) or projection (attributing own thoughts, motivations and feelings onto another person). If the problem is resolved, the threat disappears, and there is no crisis.

- **Escalation**

If the problem continues and the usual defensive response fails to deal with the situation, anxiety will continue to rise to serious levels, causing extreme discomfort. The person becomes disorganized and has difficulty thinking, sleeping, and functioning. Trial-and-error efforts are initiated to solve the problem and restore emotional equilibrium.

- **Crisis**

When trial-and-error attempts fail, anxiety intensifies to a severe level and then to panic, and people will mobilize automatic relief behaviours (flight or fight). Some form of resolution may be made, such as redefining the problem, attacking it from a new angle, and trying again to find a solution.

- **Personality Disorganization**

If the problem is not resolved and new coping skills are ineffective, anxiety may overwhelm the individual and lead to a major breakdown in the individual's mental and social functioning (this could include serious disorganization, confusion, depression, or violence against themselves, such as suicide, or against others).

As you can see, Caplan sets the process out clearly, making the experience and behaviour of the patient who is suffering the crisis easier to understand.

2.1. OTHER FACTORS TO CONSIDER IN THE DEVELOPMENT OF A CRISIS

In her work on crisis, Donna Aguilera (1998) noted that the equilibrium of people in crisis is significantly affected by three balancing factors: perception of an event, support system, and coping mechanisms.

Perception of an event refers to the importance of a problem to the individual in crisis and includes such things as health, career, financial status and reputation.

Support system refers to the resources possessed by the person in crisis, such as other people the individual trusts who can provide support and assistance during a time of need.

Coping mechanisms are skills or methods people use to reduce anxiety and solve problems, such as reasoning, meditation, physical exercise, sleep and denial.

2.2. ROBERTS' SEVEN STEP CRISIS INTERVENTION MODEL

Once the crisis has developed and taken hold, intervention will be required. Roberts' (2005) model was developed to help with effective intervention. It does so because it follows clear steps allowing for rapid assessment of the patient's problem and ability to cope. It includes collaborating with the patient on goal-setting and achievement, finding more constructive (less destructive) coping mechanisms, the development of a working alliance with care staff and others involved in support and building upon the client's strengths.

The R-SSCIM is a series of guideposts that makes it easier to consider a variety of techniques, making the management of crises much more flexible and person-centred. This links very clearly with the process of recovery. By learning about each stage of the model, care workers can support the work of the mental health professional involved in the care of those in crisis and better understand how each state relates to client recovery, goal achievement, problem solving and crisis resolution.

In conceptualizing the process of crisis intervention, Roberts' (1991, 2000, 2005) seven critical stages have been identified, through which clients typically pass on the road to crisis resolution and recovery. These stages, listed below, often overlap:

1. Plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment.
2. Make psychological contact and rapidly establish the collaborative relationship;
3. Identify the major problems, including crisis precipitants.
4. Encourage an exploration of feelings and emotions.
5. Generate and explore alternatives and new coping strategies.
6. Restore functioning through implementation of an action plan.
7. Plan follow-up and booster sessions.

You will note, when looking at the steps of Roberts' Crisis Intervention Model, in more detail below, that we have tried to simplify the process, so that we can get a clear picture, without over-complicating or over-intellectualising.

Step 1: Risk Assessment

Examples of points to consider:

- Is the person safe?
- Is the person alone?
- Is the person substance affected?
- What is the person's history? (violence, previous suicide attempts, etc.)
- Does the person intend to harm themselves or others?

The care or support worker should conduct a quick and thorough assessment. This should cover the client's available support, stressors and triggers, any medical needs and medications, any recent substance use (drugs or alcohol) and all of the techniques and behaviours that the client uses to cope, both internal and external.

The initial focus of any assessment, in these circumstances, is suicide and suicidal ideation. If the client has actually initiated a suicide attempt, any necessary emergency steps should be taken. If no suicide attempt is in progress, the worker should inquire about the client's "potential" for self-harm.

This assessment requires:

- Asking about any thoughts or feelings about suicide.
- Assessing the patient's intent. The question often posed is 'Is this a serious attempt to end life or is it a cry for help and attention?'
- Gauging the level of suicidal ideation and planning, because how far the person has progressed in the planning is a clear indicator of level of intent. Have they thought about how they would do it? Do they have access to what they need (drugs, alcohol, rope, firearm)? Have they decided when?
- Finding out about any previous suicide attempts or other times that they have seriously considered suicide.
- Taking into consideration other factors that might elevate the level of risk (social isolation, loss of job, bereavement, divorce, etc.).

Step 2: Establish Rapport and Communication

What you can do to achieve this:

- Listen actively to the person in crisis.
- Help make sense of what happened.
- Validate their emotions, concerns and fears.
- Try to provide hope.
- Empower the person to take action.
- Reflect on what the person is saying.

The establishment of rapport can be facilitated by using basic counselling skills, demonstrating to the person that you care, by actively listening, paraphrasing and repeating back what the client says to you, making consistent eye contact, etc. This is also the stage in which the personality, motivation and strengths of any care worker can come to fore in order to instil trust and confidence in the client. The best of these are a non-judgmental attitude, creativity, flexibility, a positive mental attitude, the ability to reinforcing small gains and the worker's own personal resilience. It should be noted that any care worker who does not possess these traits, or who finds it hard to care or empathize, is probably in the wrong job.

Step 3: Identify Major Problems

Examples of points to consider:

- What led up to the precipitating event?
- Who was involved in the situation?
- Identify and remove triggering stimuli.
- Ask one question at a time.
- Leave the person enough personal space.
- Take threatening statements seriously.

Current problems of the client should be the focus of crisis intervention, which may be the ones that caused the crisis. As has been evidenced in research, the care worker's focus should be on finding out just what in the client's life has led him or her to require help at the moment.

Roberts (2005) suggests, in his model, not only asking about the precipitating event but also examining all of the client's problems, finding out which have had the most significant impact, those being the ones that need the most immediate attention. In the course of understanding how the event has caused the crisis, the worker can develop an idea of the client's most common coping style in a crisis. This coping style is likely to require changes for resolving the present crisis and preventing future crises. These coping styles and mechanisms can include: always focussing on past mistakes and problems, self-isolation from other people to avoid distressing situations, self-medication with alcohol or drugs, taking feelings out on other people or engaging in self harm (cutting, burning, hair pulling, etc.).

Step 4: Dealing with Feelings and Providing Support

Examples of how you can go about this:

- Reassure the person they can cope with the crisis.
- Reassure the person that it is ok to need and ask for help.
- Ask the person to slow down.
- Help the person find a quiet and safe place.
- Allow the person to vent his feelings.
- Support reality-based statements.

There are two points to highlight in Stage 4. In the first stage, a care worker should allow the client to express their feelings and to explain his or her experience of the current crisis situation. This would be done using skills like paraphrasing, reflection, open questions and empathy (Egan, 2002). In the second stage the worker should, seamlessly, start gently challenging the client. Challenging responses can include giving correct information and giving possible alternative explanations for events. Challenging can help to change clients' maladaptive beliefs and lead them to consider other ways of thinking and behaving.

Step 5: Explore Alternatives

Examples of issues to examine:

- What is the most important issue the person feels he/she is facing?
- What is the person hoping for?
- What has the person tried in the past?
- Does the person have a network of support?
- Offer alternatives the person might not have been able to identify.

In crisis intervention, this stage can be the most difficult to carry on with. Clients in crisis often do not have the ability to see the bigger picture and tend to be firmly attached to their usual ways of coping even when they are not working. Nevertheless, it is possible that the client may have re-established some emotional balance if he or she has worked through enough feelings. Now, caregiver and client can start to discuss what can be put in place, both to alleviate the crisis and to help in recovery. Possible options include: a no-suicide contract, accessing extra community based support, counselling and psychotherapy, a voluntary stay in a residential mental health facility or a residential drug or alcohol recovery/rehabilitation unit. When they are generated collaboratively and when the choices are "owned" by the client, the alternatives are positive. The care worker can make the process collaborative by asking about what the client has found works in similar situations. The client is the "expert" on themselves and their own experience. This can be particularly relevant if the trigger for the crisis has any cultural factors. Clients from other cultures can find that family and community expectations can clash with those of western societies. They will need to educate the care worker about how this affects them.

Step 6: Structure a Crisis Plan

Examples of possible actions:

- Identify and propose actions that help the individual gain a sense of control.
- Propose alternative coping strategies to replace harmful ones (where that person might normally cope through substances or angry outbursts).
- Make referrals if necessary.
- Is there anything you can do to help?

Stage 6 is where coping strategies become integrated into a treatment or crisis management plan. Jobes, Berman, and Martin (2005), who wrote about high-risk crisis intervention, drew up the following list from their experience and research with young people:

- *"Removing the means - involving parents or significant others in the removal of all means of suicide and safeguarding the environment.*
- *Negotiating safety - time-limited agreements during which the client will agree to maintain his or her safety.*
- *Forward planning - scheduling phone calls, subsequent clinical contacts, events to look forward to.*

- *Decreasing anxiety and sleep loss - if acutely anxious, medication may be indicated but would need to be carefully monitored. Other methods of decreasing anxiety and regularising sleep patterns should also be explored.*
- *Decreasing isolation - friends, family and neighbours can be mobilised to keep ongoing contact with the person in crisis.*
- *Hospitalisation - a necessary intervention if risk remains unabated and the patient is unable to contract for his or her own safety".*

At stage 6, the actions taken are important for the psychological balance of the client. However, Roberts indicated that there is another element that is vital at this stage, the client's thinking, particularly about the triggering or crisis event. For instance, recovering from a divorce or death of a child, hinges on making some meaning out of the crisis event: "*Why did it happen? What does it mean? What are alternative constructions that could have been placed on the event? Who was involved? How did actual events conflict with one's expectations? What responses (cognitive or behavioural) to the crisis actually made things worse?*" To be able to cope with difficult situations in the future is important to work through the meaning of the event.

Step 7: Follow-up Measures

How can this be followed up?

- Telephone calls.
- Face-to-face contact.
- These measures should be included in the crisis plan.
- Both the person and care worker should agree with the time frames of the follow-ups.

There should always be a follow-up contact with the client after the first intervention to make sure that the client is okay and continuing to recover. This post crisis evaluation of the client can include (Roberts and Ottens, 2005):

- Physical condition of the client: how are they sleeping and eating? Are they looking after themselves?
- Does the client have a better understanding of what happened and why it happened?
- An assessment of overall functioning within their usual environment. Are they seeing friends? Are they going to school, college or work?
- Are they happy with the help they are getting to recover (medication, counselling, etc.)?
- How are they coping with stress and any stressful events?

- Do they need any more help or referrals to other specialised agencies?

Follow-up can also include the scheduling of another meeting, one month after the crisis intervention has been terminated. All of the above points can be looked at again and progress in recovery can be monitored.

2.3. WHAT TO AVOID DOING DURING CRISIS SITUATIONS

- Over-reassurance:
  Too much reassurance can backfire. For example, when people are angry, reassurance can increase their anger because they can think that you are either not telling them the truth or you are not taking their concerns seriously.
- Confrontation:
  If your body language and tone mirror theirs, this might be perceived as a threat and make the situation worse. Always try to keep your voice calm (and body language passive) and this will, in most cases, reduce the agitation exhibited by the client.
- Failure to acknowledge fears and concerns:
  Even when the fear that the client is expressing is totally unjustified, people do not respond well to this being ignored, nor do they respond well to criticism. Instead, acknowledge people's fears even while giving them the information they need to put those fears into context. Giving people permission to be alarmed about a perceived threat, while still telling them why they need not worry, is far more likely to reassure them.
- Panic:
  If you are panicking, you are very unlikely to be able to think of useful solutions for the current crisis situation.
- Making promises you may not be able to keep:
  If you are able to help and reduce stress and concerns for the client, this should be done. But don't say you can do something unless you are sure you can, and don't promise anything that you can't deliver. The client may realise that you are doing this (making the situation worse) or you can give them a false expectation which will have a negative impact later on, when the promised outcome doesn't happen.

3. RESOLUTION

When a crisis is resolved and emotional equilibrium is restored, our clients still have to face the normal, everyday issues that life throws at us. Ideally, as a result of a crisis, they learn new coping skills, gain greater self-confidence, increase their support network, and increase their ability to function.

The goal of crisis intervention is to restore the pre-crisis level of functioning and, where possible, raise it to a higher level than it was before the crisis. An important part of all crisis interventions, wherever they take place, is the learning that can come from the crisis. Working together, carer and patient/client can ensure that more effective coping mechanisms are put in place for future crisis events. If possible, this psycho-education should continue for as long as the care worker is involved in supporting the client.

4. CONCLUSION

Every one of us will have situations in our lives that we struggle to cope with, situations that could be categorized as crises. And every one of us will have a slightly different method of coping. But for the most part, those of us who do not suffer from mental health concerns manage to cope without resorting to mechanisms that are destructive and unhelpful. This is often only possible with the help and support of our friends, family and loved ones.

So that is what we, as care and support professionals, have to provide for our clients, and the foregoing models give us a clear process and model to follow in structuring that support. Caplan and Roberts have set the process out simply, with clear steps to follow, and this should form the basis of the support that we offer our clients. They are incredibly adaptable and have been designed to work, with a minimum of adaption, in a wide range of environments. Links and references have been provided at the end of this module, to facilitate those of you who would like to look into it further.

SELF ASSESMENT TEST

1. Caplan's model of a crisis reaction is composed of:
    a. Three stages: initial threat, escalation and personality disorganization.
    b. Five stages: initial threat, triggering event, escalation, crisis and personality disorganization.
    c. Four stages: initial threat or triggering event, escalation, crisis and personality disorganisation.
2. Roberts' process of crisis intervention has:
    a. Seven steps.
    b. Four steps: initial threat or triggering event, escalation, crisis and personality disorganization.
    c. Five steps.
3. The initial step in Roberts' process of crisis intervention is:
    a. Establish rapport and communication.
    b. Identify major problems.
    c. Risk assessment.
4. If we want to establish rapport and communication we should:
    a. Listen actively to the person in crisis.
    b. Help to make sense of what happened.
    c. Both answers are correct.
5. In Roberts' process of crisis intervention, the question *What led up to the precipitating event?* belongs to:
    a. Step 2: establish rapport and communication.
    b. Step 3: identify major problems.
    c. Step 4: dealing with feelings and providing support.
6. Within Roberts' process of crisis intervention, step 4 says that:
    a. The care worker strives to allow the client to express feelings, to vent and heal and to explain their story about the current crisis situation.
    b. The care worker strives to prevent the client to express feelings, to vent and heal and to explain their story about the current crisis situation.
    c. The care worker should call emergency services, who will allow the client to express feelings, to vent and heal and to explain their story about the current crisis situation.
7. According to Roberts' crisis intervention process, dealing with feelings and providing support implies:
    a. Reassuring the person they can cope the crisis.
    b. Allowing the person to vent his feelings.
    c. Both answers are correct.

8. Step 5 in Roberts' model called *explore alternatives:*
    a. This stage can often be the easiest to accomplish in crisis intervention.
    b. This stage can often be the most difficult to accomplish in crisis intervention.
    c. It is not recommended to ask the client what happened in similar situations.
9. An example of possible actions in Step 6: *Structure a crisis plan* is:
    a. Removing the means - involving parents or significant others in the removal of all means of suicide and safeguarding the environment.
    b. Decreasing isolation - friends, family and neighbours can be mobilised to keep ongoing contact with the person in crisis.
    c. Both answers are correct.
10. Step 7 in Roberts' model is called:
    a. Hospitalization.
    b. Follow-up measures.
    c. None of the answers is correct.

Claves: 1:c; 2:a; 3:c; 4:c; 5:b; 6:a, 7:c; 8:b; 9:c; 10:b.

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