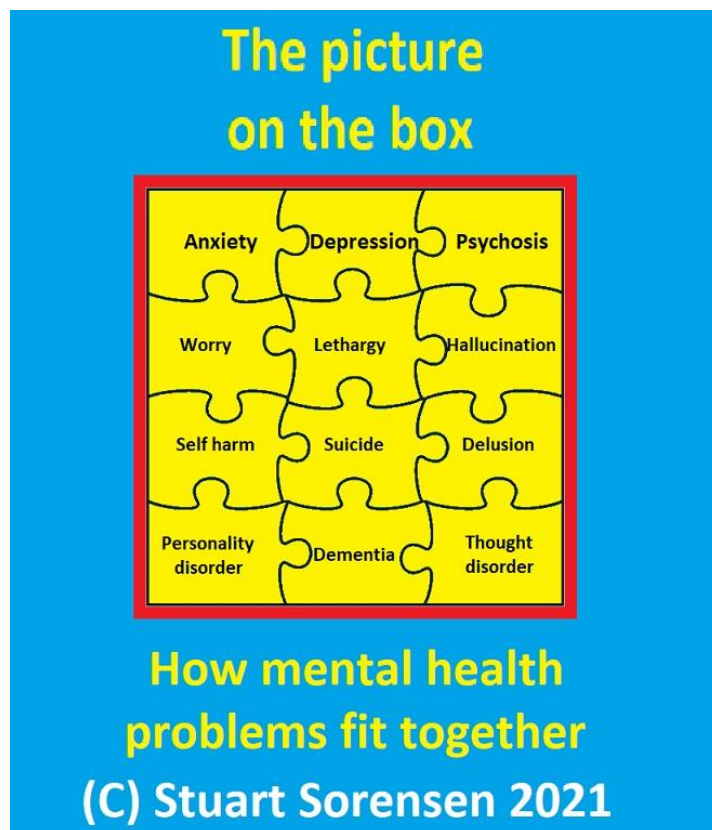


The picture on the box

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An introduction to Mental Health & Disorder



About your trainer

Stuart Sorensen is a registered mental health nurse with over 25 years post registration experience working in various social care settings. He began working in social care as a volunteer in the early 1980s and has since worked in residential and community settings with a wide variety of populations. Stuart qualified as a registered mental nurse in 1995



In addition to his nursing registration Stuart also holds a diploma in counselling, a diploma in nursing studies and a post graduate diploma in Psychosocial interventions. His main interests include working with people diagnosed with serious and enduring mental disorders like schizophrenia or bipolar affective disorder, people with personality disorders and those whose life choices have left them unsure where to turn to get their lives back on track. Stuart is particularly interested in issues relating to deliberate self-harm and is passionate about the possibility of recovery from mental disorders of all kinds.

As a trainer Stuart is keen to help staff 'at the coalface' to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. Based upon his years of experience as a worker and clinical specialist Stuart's training has the feel of reality about it rather than the 'ivory tower' presentations that come from simply reading a book. Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.

Training and consultancy work includes contracts for ARC (Scotland), Impact Health & Social Care Training, The Commission for Social Care Inspection (Now the 'Care quality commission'), East Training & Consultancy Ltd., Public Sector Providers, The National Health Service, The Rising Sun Trust, Linksworld and various other, regional and national organisations.

Welcome

This course, 'The picture on the box', covers various aspects of mental health and disorder from first definitions to recovery and much more in between.

Click the first video link to get started:

'Introduction'



Welcome back.

We'll begin with a questionnaire.

This isn't just to be cruel, asking questions about all the stuff we haven't covered yet. It's actually intended to set you up to learn. It's designed to generate your own questions and basically to get your head into gear.

People learn best when they have questions and they remember best when they have a 'schema', a 'picture on the box' to help make sense of what they're taught. That's what this training is all about and the questionnaire is the beginning of that process. Basically, I'm going to play with your head so that you learn more efficiently.

Click the second video link, 'Introductory questionnaire' and use the following page to record your answers.



The picture on the box

Introductory questionnaire

No	Statement	True	False
1	Mental illnesses are more difficult to cure than physical illnesses		
2	People who hear voices are mentally ill		
3	Schizophrenia is caused by 'bad' parents		
4	Depression is a normal human experience		
5	Alcohol causes depression		
6	'Symptom' means.....		
7	Which of these are symptoms of depression (please tick)? <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Dietary disturbance <input type="checkbox"/> Delusions <input type="checkbox"/> History of childhood abuse <input type="checkbox"/> Panic attacks <input type="checkbox"/> Over-active (manic) behaviour		
8	'Psychotic' means.....(please complete the sentence)		

Once you've completed the questionnaire please click the next video, the 'answers' video to see how you did.



What is Mental Illness?

This is a difficult question to answer. Different people interpret mental illness differently. These differences can be cultural, social, or to do with assumptions and expectations about how people ought to be. In general terms, 'mental illness' means problems with thinking, feeling and behaving.

Mental Health vs Mental Illness

Physical illnesses can be serious or trivial and the same is true for mental health problems. They can be life-long, prolonged or very short-term. People with mental disorders often find their level of mental health changes backwards and forwards over time. Often people suffering from mental disorders go long periods without diagnosis (perhaps never being diagnosed) because their problems are not severe enough to stop them coping with life.

Diagnosing Mental Illness

This is easier said than done. There are no blood tests or simple examinations to identify mental disorders. Diagnosis is a matter of clinical judgement taking into consideration the person's behaviour (including what they say) and whether or not they conform to the norm for their culture.

The problem with this idea of 'normality' is that it's very hard to define. Before we can know whether or not a person behaves 'normally' we must first decide what we think is normal for their particular society and culture. We must decide what causes that behaviour (and it may not be down to mental disorder). We must decide whether the abnormality is actually a problem. We must then decide if the problem matches any known category of mental disorder. This can be very tricky, particularly since the guidelines for what makes up a diagnosis differ in different parts of the world.

Have a look at the next video, 'What is mental disorder'?



The picture on the box

Exercise

Up until the middle of the twentieth century homosexuality was considered to be a mental disorder. Treatments included castration, hormone therapy or aversion therapy (now thought of as a form of torture by many people).

What do you make of this 'diagnosis'?

How could mental health professionals have made this assumption about 'mental illness'?

What might future generations have to say about current psychiatric diagnoses and practices?

Diagnosis and social values

There are many ways to define psychiatric diagnoses but they all have one thing in common. They all reflect the social and cultural norms of society. For example, in the late nineteenth century one common diagnosis was 'moral defective'. The usual fate of the unfortunate 'moral defective' was lifelong incarceration in a lunatic asylum.

In order to be diagnosed as a 'moral defective' a person had to:

1. Be female or an habitual criminal of either sex
2. Be unmarried
3. Be a mother or pregnant
4. Be unable to pay for the maintenance of herself and her children

This diagnosis clearly reflected the male, middle class values of the Victorian era. Freud coined the term 'hysterical' as a word to describe irrational and emotionally unstable people. It's root is the Greek word

The picture on the box

'hyster' meaning 'uterus' or 'womb'. In Freud's opinion you couldn't be hysterical unless you had a womb.

Nowadays of course we question many of these assumptions but it's still worth remembering that almost everything we know in psychiatry (or think we know) is based upon assumptions about what society thinks is appropriate. This is the heritage of the modern mental health system and so it's extremely important for us all to keep an open mind.

Models of mental health and disorder

The medical model (biological hypothesis)

The medical (biological) model is the dominant view of mental disorder in Western society. The basic notion is that mental disorders are rooted in physical problems and that they require physical treatments to alleviate them.

To make sense of this we must bear in mind that psychiatrists are trained as medical doctors first. All medical doctors, from General Practitioners to anaesthetists and gynaecologists treat physical disorders with physical cures such as medications and surgery. Psychiatrists come from the same basic perspective and psychiatry itself has developed from that same, physical root.

So, according to the biomedical model of mental disorder all psychiatric problems are caused by physical imbalances or abnormalities. That's why psychological problems attract physiological treatments like medications (chemicals used to change physical processes) or even surgery.

This is the opposite of the popular view that there is a difference between the 'mind' and the body. Many people, if asked, will insist that mental life is very different from physical life. However these people often do not think through their objections to the basic idea of the medical model.

Most people accept that hallucinogenic drugs like magic mushrooms and LSD affect perception. Drugs such as cannabis and ecstasy affect mood and substances such as amphetamine sulphate (speed) can cause psychological problems such as paranoia as well as major emotional problems relating to anger and paranoia. These are psychological problems caused by physical (chemical) changes. If we accept that these things happen we must also accept that physical changes cause psychological and emotional difficulties.

The medical model tells us that the fabled 'mind:body' split does not exist. Both are part of the same, single system. That is why physical interventions are used to make psychological and emotional changes. That is the essence of the biomedical model of mental disorder.

The social model

Many people argue that the social model is the opposite of the more familiar and traditional medical model. Whereas the medical model places the cause of problems in the individual affected the social model is

The picture on the box

interested in the way that society at large reacts to people. It places responsibility for people's problems as much in the lap of society as it does in the lap of the person themselves.

This does not mean that social perspectives deny the effects of physical or chemical processes such as drug use or disability. Rather it maintains that many of the problems people face are caused and/or maintained by social pressures.

People may have physical problems but the real impact of those problems is caused by the way that society responds to them. This is why we have laws governing discrimination and ensuring fair access to services and employment.

Have a look at the next video



The Stress & vulnerability model

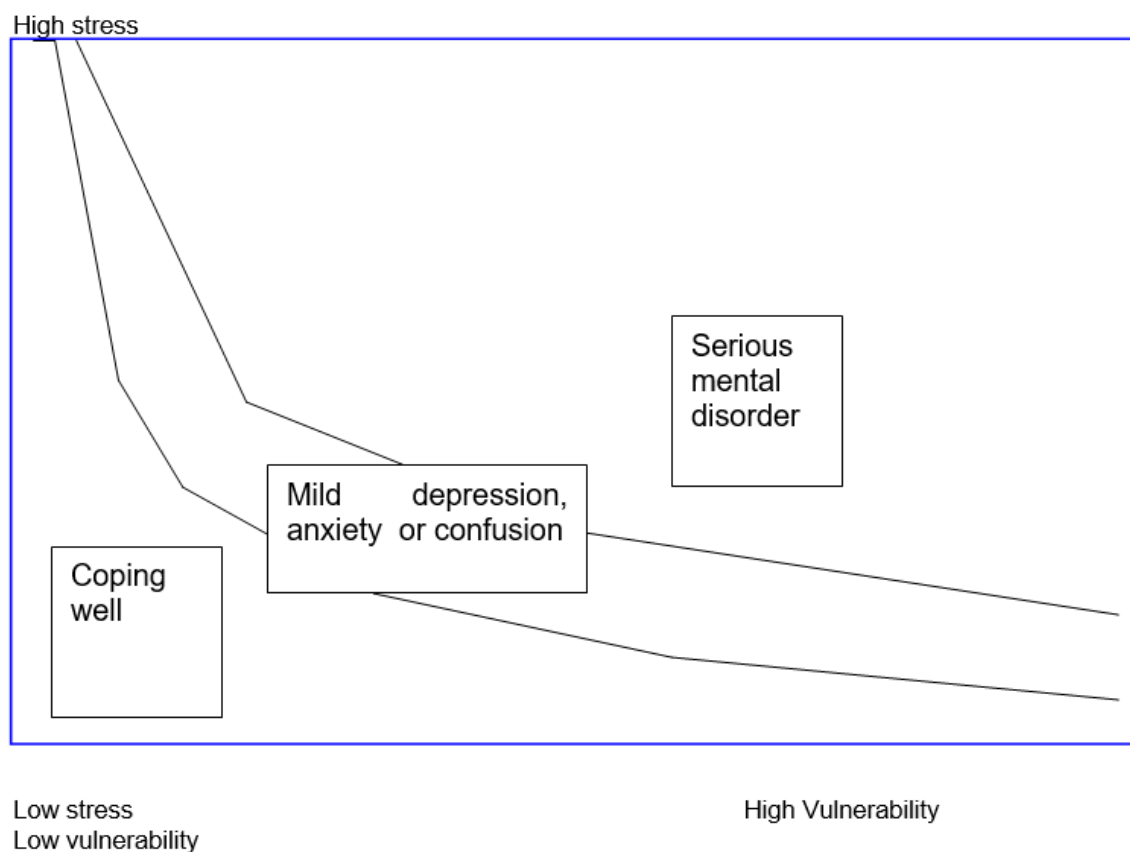
The 'Stress & Vulnerability model' postulates that a biological vulnerability is a necessary element of mental disorder. This is in agreement with the traditional medical model of mental disorder.

In addition to the biological factor, however it may arise, trauma of one kind or another does appear to be vital.

The model seems to occupy the middle ground in the 'nature versus nurture' debate and acknowledges the validity of both sides. For this reason many people are happy to work with it. It states that all people are vulnerable to stress but that the amount of stress they can cope with is variable. So one person may become disordered because of problems that another would simply shrug off but ultimately all people, if given enough stress, will develop similar problems.

We can see from the graph that people with low vulnerability need to experience a great deal of stress before they become distressed whereas those people with high vulnerability need only a small amount of stress to 'tip them over the edge' into serious mental disorder.

The picture on the box



Types of vulnerability include:

- Biological
- Psychological
- Social/cultural
- Environmental
- Developmental

The picture on the box

Jonathon is 22 years old. He has just started the third year of his organic chemistry degree course at university and is very worried about the exams he knows he will have to sit in a few months. As a child he was always the 'high-flyer' of the family and did well at school and also on the sports field. Coming to university was a real challenge for him. For the first time in his life he wasn't the best in the class and this was very difficult for him to come to terms with.

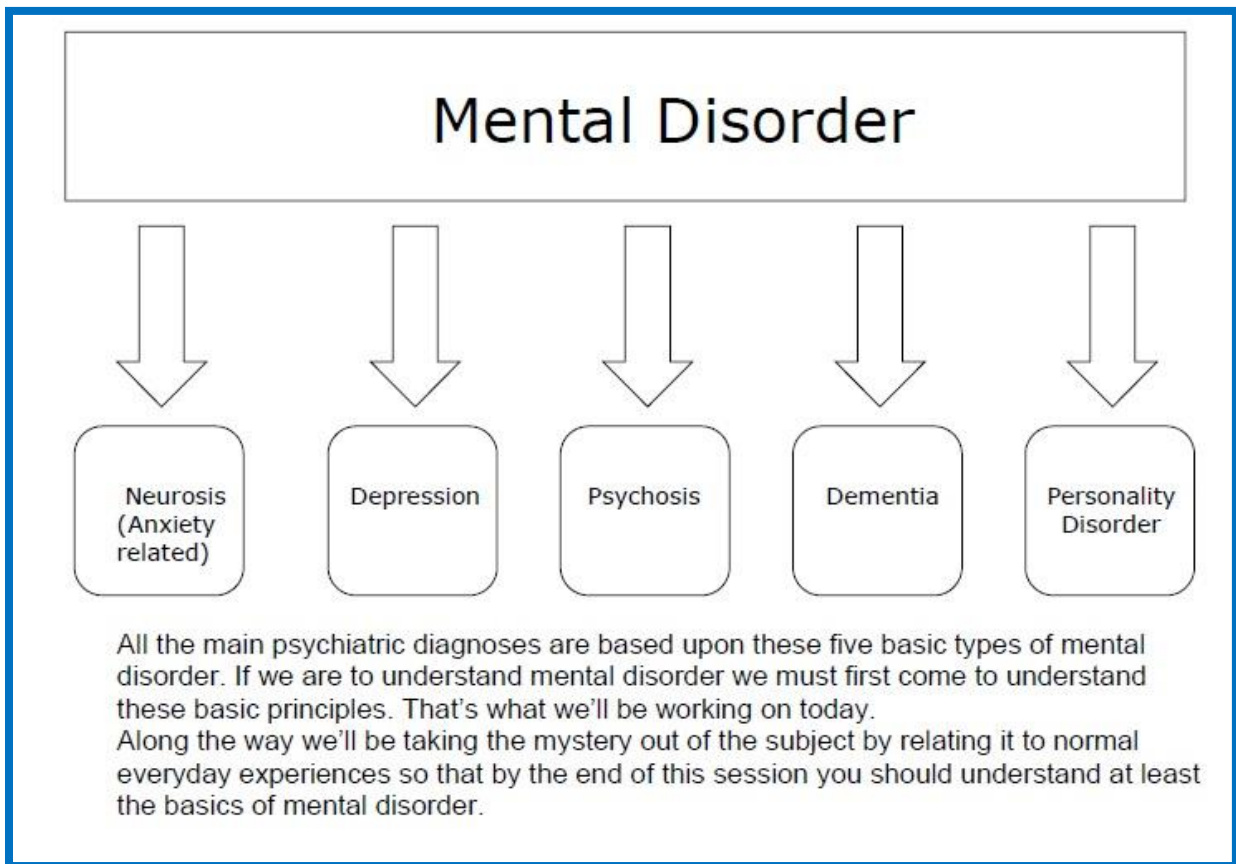
Jonathon began drinking and neglected his studies last year so he has a lot of catching up to do. His father expects him to do well and has promised him a high-flying job in the family business (industrial chemicals) once he gets his degree. The possibility of Jonathon failing to get a 'first' has never been considered.

Jonathon knows he has a lot of catching up to do but he can't seem to get it done. He is experiencing low mood, feelings of guilt and inadequacy as well as anxiety and difficulty concentrating. Bearing in mind the Stress and vulnerability model, what would you suggest to help Jonathon?

-
-
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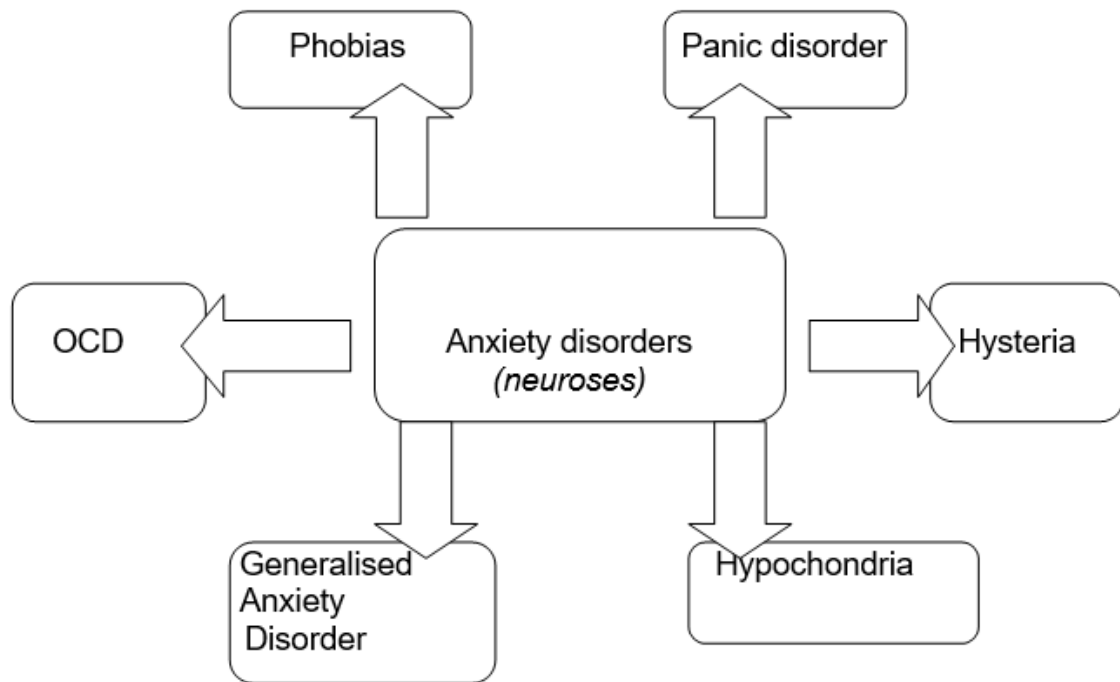
Five groups of mental disorder



Click to play the next video



The picture on the box



Anxiety

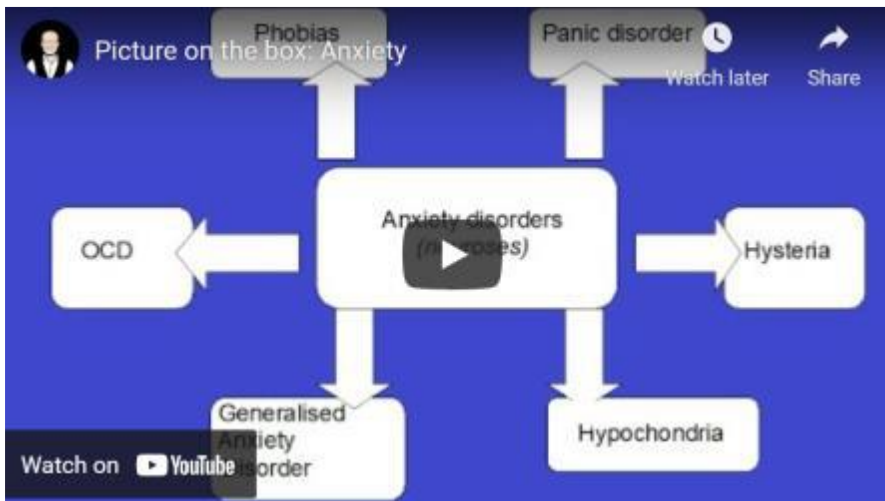
The main clinical features of anxiety are...

The physiological symptoms of anxiety are.....

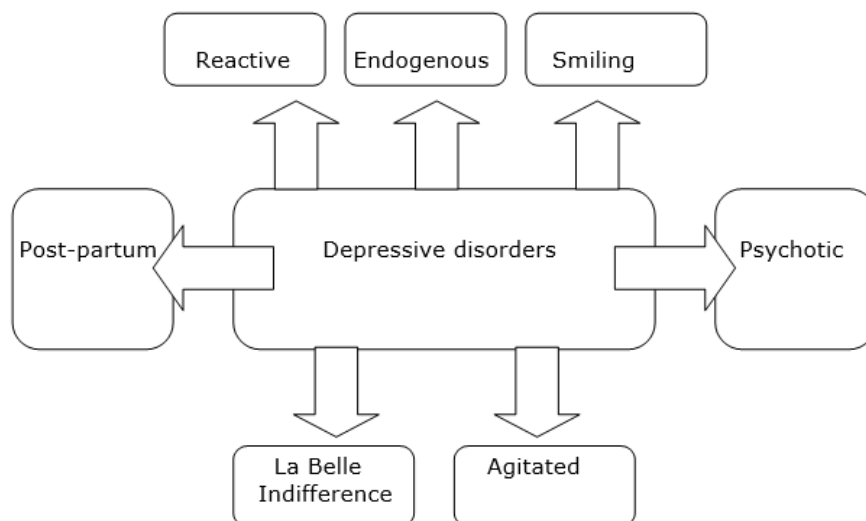
The psychological symptoms of anxiety are.....

The picture on the box

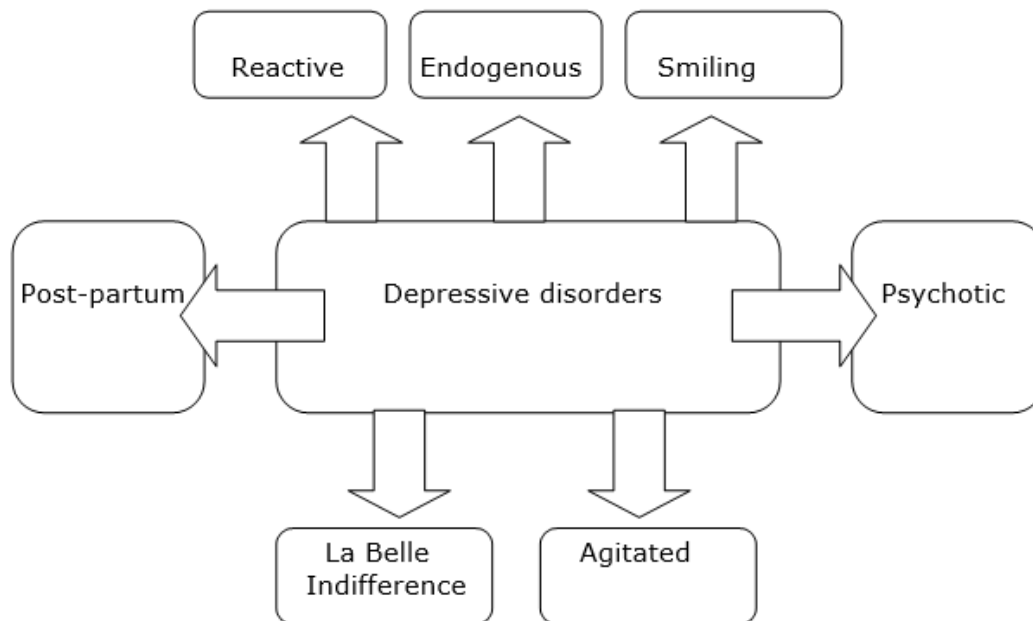
Now watch the video on anxiety and as you do so complete the exercise above by noting down the different features of anxiety in the categories provided.



Now watch the video on depression



The picture on the box



Note down the features of depression

The main clinical features of depression

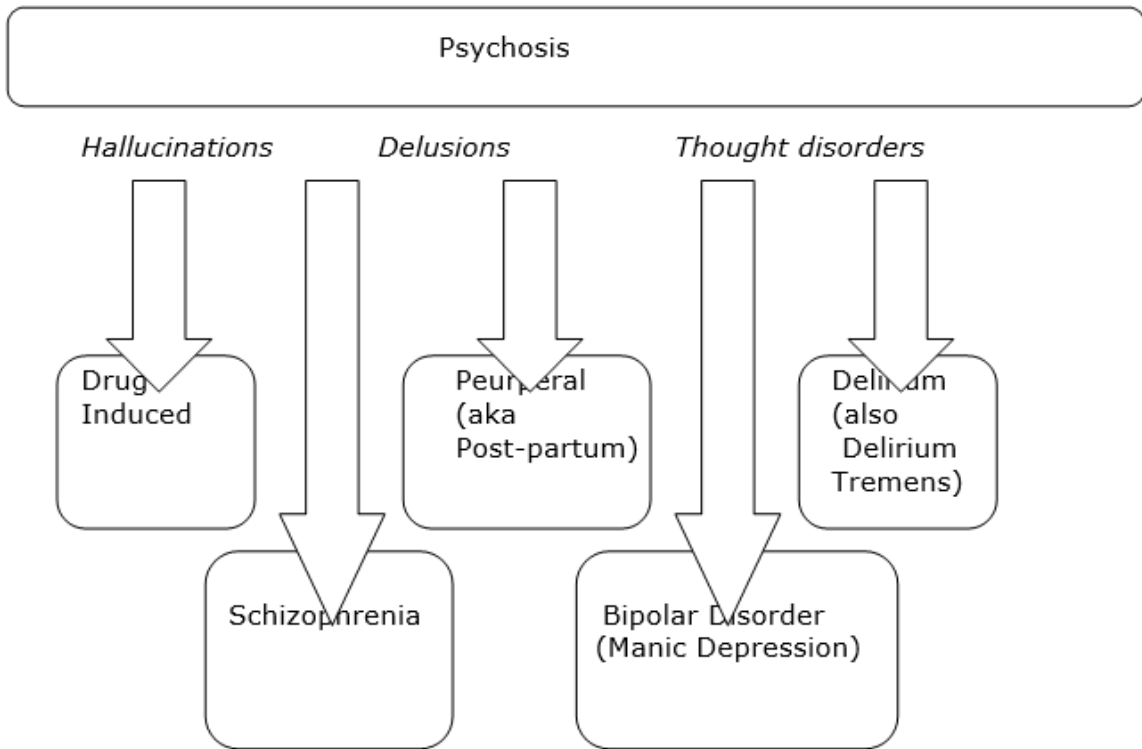
Biological symptoms of depression are.....

Psychomotor retardation means.....

Psychological symptoms of depression are.....

The picture on the box

Psychotic states



Watch the next 3 videos and complete the table on psychotic symptoms.



The picture on the box

The main clinical features of psychosis

Hallucinations means.....

Delusions means.....

Thought disorder means.....

What is psychosis?

Loosely defined, 'psychosis' might be described as 'loss of touch with reality'.

Positive symptoms are those symptoms, which exist 'in addition' to the norm. For example visual hallucinations are extra experiences, which most people do not have.

Negative symptoms are detractions from the norm. For example apathy is a negative symptom, which represents a lack of 'normal' interest in life. Lethargy is 'lack of energy'.

So positive symptoms represent 'extras' and negative symptoms represent 'absences'.

Hallucinations

Hallucinations are sensory experiences in any modality (sight, hearing, touch, taste, smell), which do not have any observable external source. For example an hallucination may be a voice which no one but the voice-hearer can detect or a vision which only they can see.

Many of the chief religious and political figures across the world achieved their status precisely because of experiences such as these. Jesus, Joan of Ark, Buddha, Sister Fatima, Moses, Saul, Samuel, Noah, Ghandi, Martin Luther King, Hitler, Alexander the Great, various Catholic saints including the virgin Mary, and of course her husband, Joseph all reported 'textbook' hallucinations.

Delusions

Fixed, false beliefs – not amenable to reason

Examples of delusions include:

'Persecutory' or 'paranoid' delusion

'Ideas of reference'

'Delusions of Guilt or of Grandeur'

'Hypochondriasis'

'Religiosity'

Passivity

Thought disorders

There are many types of thought disorder. These tend to be differences in the 'process' of thought itself rather than in the 'outcome' or 'content' of thought. Thought disorders include:

'Flight of ideas'

'Clang association'

'Poverty of thought'

'Knight's move thinking'

'Word salad'

'Neologism'

'Perseveration'

The picture on the box

Exercise

Consider the sort of beliefs or delusions you might have if you...

Hear a voice saying that you are the next Messiah and that the voice is 'well pleased' with you.

See fleas all over your house no matter how often you cleaned it and other people denied that they were there at all.

Are a WW2 spitfire pilot with a life expectancy measured in hours and no way to back out without being thought of as a coward.

Have a young daughter the same age that you were when your own abuse began.

The picture on the box

Watch the next video on Personality disorder



According to ICD-10, Personality Disorders comprise:

"....deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance."
"Personality disorders differ from personality change in their timing and the mode of their emergence: they are developmental conditions, which appear in childhood or adolescence and continue into adulthood."

(WHO 1992 p.200)

This seems to be quite straightforward in many ways. It's a description of lifelong problems that show up in all situations that individuals find themselves in. To put it another way...

Wherever you go – you always take yourself with you.

The notion of personality disorder is controversial however because it does not describe an illness so much as a faulty person. Many people think that this is inappropriate for medicine.

Exercise

1 Why might it be appropriate for doctors to concern themselves with personality?

2 Why might it be inappropriate?

The picture on the box

Click on the next video – Dementia



As you can see from the video there are many different types of dementia. What they all have in common is a physical deterioration in the brain and nervous system causing confusion, memory loss, disorientation to time, place and person and a worsening course. There are medications such as rivastigmine that can slow down the progress of some dementias and medication intended to prevent stroke can help with vascular dementia but there's no actual cure as yet.

As is the case with personality disorder the day to day task remains to alleviate the dementia sufferer's experience of anxiety, depression and psychosis.

It's easy to become demoralised when working with people diagnosed with dementia but it helps to understand that success is measured not in steps toward recovery but in the quality of life that can be maintained as the disease progresses.

Imagine you're designing a ward, care home or other living space for people suffering from Alzheimer's dementia. What features of the environment could you include that would make their lives easier?

What principles of everyday practice would you expect from the workers? Think about the Stress and vulnerability model to help you decide.

Three types of recovery

It's important to be clear about what we mean by recovery. Many people believe that there are actually three types of recovery and that if a person can achieve any two of the three then they have recovered.

The three types of recovery are:

Social recovery This is to do with community acceptance. If our friends, colleagues and neighbours don't have a problem with us then we have social recovery. We are productive, contributing members of society.

Psychological recovery If we are not distressed by our 'symptoms' then there is no psychological (or emotional) problem. This is known as psychological recovery.

Medical recovery If we are free of the medical symptoms of mental disorder then we can be said to have recovered – so long as the symptoms do not return. This is why mental health professionals who are interested in recovery work hard on 'relapse prevention'.

What this means

Many people argue that any two of the three is enough for meaningful recovery. What matters is that people have a place in the world, can function appropriately within society and are not distressed or incapacitated by their experiences.

Click to watch the next video



The importance of environment: Expressed emotion in action

Living with a mentally disordered relative is stressful. Many people find the stress of their situation difficult to cope with and this puts them at risk of mental disorder themselves. Remember that the stress and vulnerability paradigm works for relatives too.

Whether they develop mental disorders or not family members and carers often find themselves reacting in less than positive ways to their mentally disordered relatives. Unfortunately these essentially normal, human responses tend to make relapse more likely and so mitigate against recovery.

There are essentially three distinct types of interaction that seem to encourage relapse. These are known collectively as High Expressed Emotion or HEE. The three types of High Expressed Emotion are:

- 1. Criticism**
- 2. Hostility and Aggression**
- 3. Over Emotional Involvement**

It can be difficult to challenge these often deeply ingrained patterns of behaviour and yet recovery is much more likely in low expressed environments than in high expressed emotion households. A good rule of thumb is to approach the subject from the perspective of normal reactions to extremely difficult circumstances. Some practitioners see HEE as a way to blame families for their relative's problems which is rarely helpful and almost never entirely true.

Use this space for your own notes

The Invalidating Environment

Interestingly these principles of HEE are not only significant for psychotic disorders such as schizophrenia or bipolar disorder. Marsha Linehan, a psychologist once diagnosed with Borderline Personality Disorder and now working in Seattle has described the 'Invalidating environment' which mirrors the British notion of HEE almost exactly.

She reports that Invalidation contributes to the maintenance of Borderline Personality Disorder and the effects of Post-Traumatic Stress Disorder, another piece of evidence in support of Stress and vulnerability in favour of more traditional diagnostic models.

However we choose to describe it there is compelling evidence that reducing familial conflict has a major impact upon relapse and therefore improves the overall likelihood of recovery whatever the diagnostic label.

Exercise

How can we use the principles of HEE and IE at work in mental health and social care?

How can you apply the principles discussed so far in your day to day work?

What mental health workers can do

Therapeutic optimism

There's another really important principle here. It's to do with expectation. People don't work at things they don't believe in. Mental health recovery can be difficult – it takes work and before people are prepared to do that work they must first believe that it's possible.

That's why therapeutic optimism is so important. We need to believe recovery is possible for our service-users or we won't work toward it – and neither will they. The other side of this is the self-fulfilling prophecy that maintains illness and dependence. If we believe that people are beyond help we won't try very hard to help them.

Make sure that the self-fulfilling prophecies in your service are positive.

When to seek help & how to get it

When we talk to other professionals it's worth using the right language to make sure we're understood. Different professions use different terms but all statutory services should be familiar with the medical model, even if they don't always agree with it.

As we know the medical model places the cause of mental disorder within the physical body. That is why doctors rely upon physical treatments like medication which change how the physical body functions.

Before starting your referral, plan how you will describe the problems you're facing. This helps the doctor or other professional see the problems clearly. It also helps ensure that you don't miss anything. Just go through a quick checklist of biological, psychological, emotional and behavioural symptoms.

Also, be sure to point out clearly to the doctor what you're asking for and if you don't think that you can cope make a point of saying so. Never assume that the other person knows that you're struggling. Often if you don't spell it out like that they will assume that you are managing and will not give much assistance.

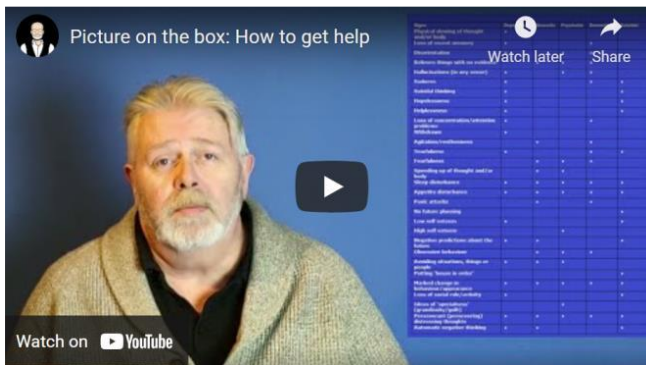
Present symptoms in the same categories that doctors do.

- • Physical (within the body)
- • Psychological (within the mind/emotions)
- • Psychomotor (speeding up or slowing down of mind & body)
- • Behavioural (what the person does)

The picture on the box

The more preparation you do the more likely you are to be listened to and taken seriously. Stamping your feet in the Doctor's surgery doesn't help and is likely to make the task harder for you next time. Overleaf are some of the more common diagnostic groupings for depression, anxiety and psychosis. Keep the list handy for reference. Those in bold may indicate suicidality – report them.

Click to watch the final video



The 'symptom sorter' checklist is on the next page...

The picture on the box

Symptom sorter – not to be used for actual diagnosis

Rough assessment checklist. Not for making diagnoses.

Signs	Depressive	Neurotic	Psychotic	Dementing	Suicidal
Physical slowing of thought and/or body	+				
Loss of recent memory	+			+	
Disorientation	+		+	+	
Believes things with no evidence		+	+	+	
Hallucinations (in any sense)	+		+	+	
Sadness	+			+	+
Suicidal thinking	+				+
Hopelessness	+				+
Helplessness	+				+
Loss of concentration/attention problems	+			+	
Withdraws	+				
Agitation/restlessness		+		+	
Tearfulness	+			+	+
Fearfulness		+	+	+	
Speeding up of thought and/or body		+	+		
Sleep disturbance	+	+	+	+	+
Appetite disturbance	+	+	+	+	+
Panic attacks		+		+	
No future planning					+
Low self esteem	+				+
High self esteem			+		
Negative predictions about the future	+	+			+
Obsessive behaviour		+	+	+	
Avoiding situations, things or people	+	+	+		
Putting 'house in order'					+
Marked change in behaviour/appearance	+	+	+	+	+
Loss of social role/activity	+				+
Ideas of 'specialness' (grandiosity/guilt)			+		
Perseverant (persevering) distressing thoughts	+	+	+	+	+
Automatic negative thinking	+	+			+

Physical symptoms of anxiety

Restlessness & tremor
Tension and headaches
Sweating
Tachycardia (heart rate increases)
Intestinal problems (constipation, diarrhoea, nausea etc)
Dizziness
Dry mouth

Psychological symptoms of anxiety

Worry
Fear

Negative predictions about the future

Biological symptoms of depression

Lethargy (tiredness and slowness)
Sleep & appetite disturbance

Psychological symptoms of depression

Reduced concentration and attention
Reduced self-esteem and confidence

Ideas of guilt and unworthiness

Bleak and pessimistic views of the future

Ideas or acts of self harm or suicidality

Helplessness and hopelessness

Symptoms of psychosis

Disturbances of:
Perception (hallucinations)
Belief (Delusions)
Thinking process (Thought disorder)