ASAL

ADVANCED SKILLS FOR ACTIVE LIVING

MODULE 1
Understanding Mental Health

FUNDACIÓN intras

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COURSE CONTENTS & TOPICS

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UNIT 1: Mental health and mental illness

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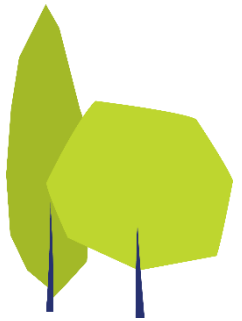
UNIT 1: Mental health and mental disorders

Learning objectives

- Knowing the current most accepted concepts of mental health and mental disorders.
- Learning about the incidence of mental health disorders in EU.
- Understanding that mental health disorders are caused by a combination of factors.
- Learning about the stages of mental health disorder.
- Understanding how mental disorder affects daily life
- Learning about the stigma suffered by people with mental health disorders
- Promote respect of people with mental health disorders
- Learning how professionals can address stigma



1. MENTAL HEALTH & MENTAL DISORDER (I)

Mental health is currently understood as wellbeing

The World Health Organization (WHO, 2001) defines mental health as a welfare state in which everyone realizes his/her own potential, can face with the normal stresses of life, can work productively and fruitfully, and he/she is able to contribute and participate in his/her community.

Mental health is **an integral component for health and well-being** in general (WHO, 2013).

It should be treated with the same urgency and consideration than physical health is treated:

"There is no health without mental health".

(The Comprehensive Mental Health Action Plan 2013-2020, WHO, 2013 a)

Mental health is not the absence of mental illness.

The absence of a recognized mental disorder is not necessarily an indicator of mental health. In regards to this statement, mental health or a state of well-being protects against the development of disorders, while mental disorders increase the risk of mental discomfort.

1. MENTAL HEALTH & MENTAL DISORDER (II)

Mental disorders

Mental disorders comprise a broad range of problems, with different symptoms.

However, they are generally characterized by some combination of abnormal thoughts, emotions, behavior and relationships with others.

Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse.

Most of these disorders can be successfully treated. (WHO, 2001)

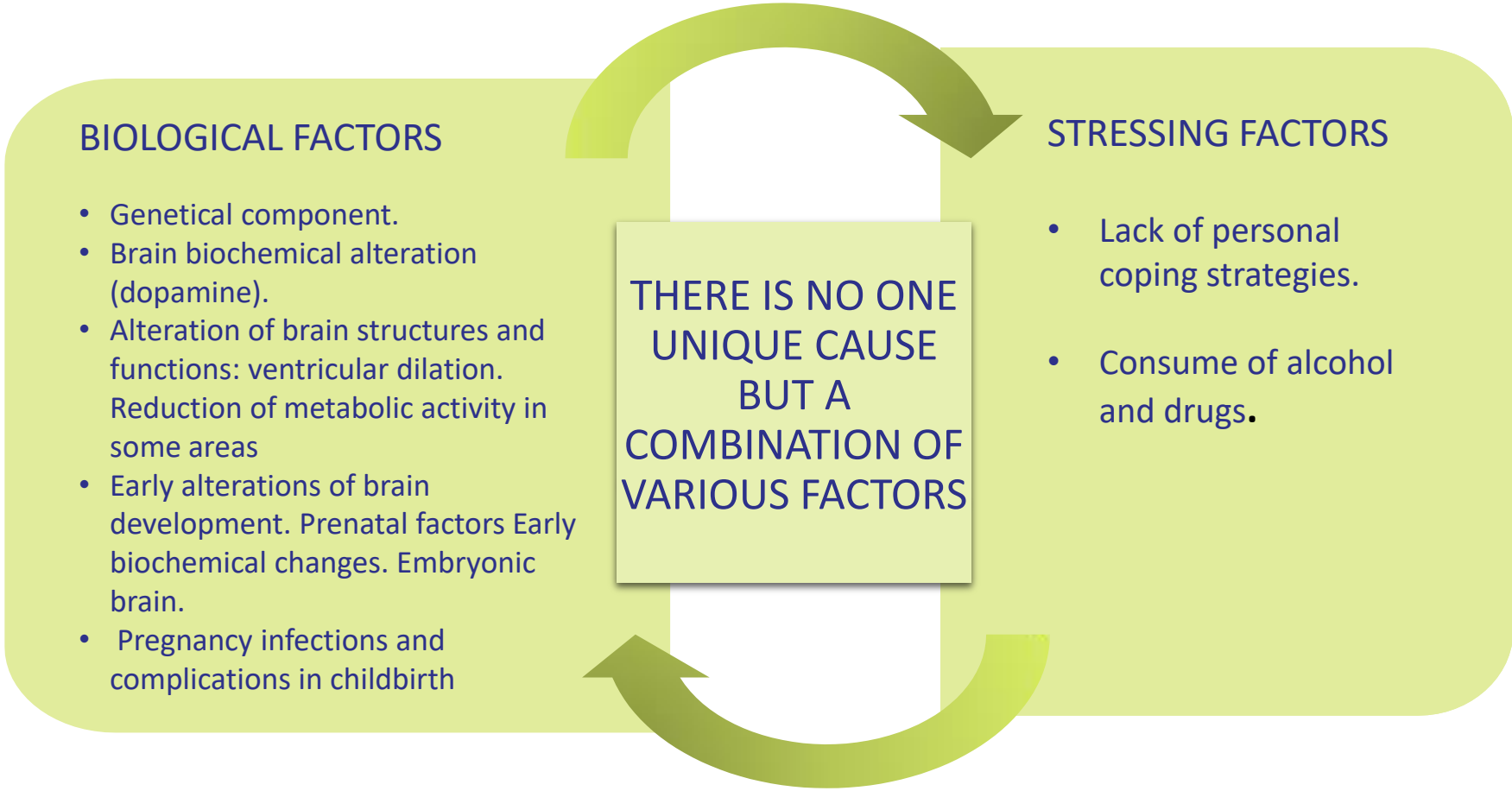
1. MENTAL HEALTH & MENTAL DISORDER (III): MH in Europe

1 / 4 persons in Europe suffers mental health disorders in EU and 7% of the population Worldwide)

Mental disorders are **the most significant of the chronic conditions in EU** affecting near the **40%** of the population

- The percentage of persons who reported having consulted a psychologist, psychotherapist, or psychiatrist is higher among women (6,3 %) than men (4,2 %). This pattern was apparent across almost all EU Member States (Eurostat).
- **Depressive disorder**: the most extended disorder in EU (30 million people in EU). It is twice as common in women as in men.
- **Anxiety and specific phobias** are the second most frequent disorders in EU (WHO 2015)
- **Psychotic disorders**: about 1–2% of the population is diagnosed with, men and women equally.
- **Substance use disorders** (alcohol and drugs): 5,6% of men and 1,3% of women.
- **Dementia**: there is an increasing prevalence among the ageing population, typically 5% in people over 65 and 20% of those over 80.
- In all countries, mental disorders tend to be more prevalent among those who are **most deprived**.

1. MENTAL HEALTH & MENTAL DISORDER (IV): CAUSAL FACTORS



1. MENTAL HEALTH & MENTAL DISORDER (V): STAGES

BEGINING

- Starts between 14 and 25 years old (approximately).
- It can happened both in a sudden or slow way.
- The first episode can happened during a strong stress period
- Acute phase or outbreak

STATE PHASE

- Evolution in form outbreaks or crises: variable number, duration and intensity
- Periodical instability-stability phases
- Important: the medication and avoid stressful situations

RESIDUAL PHASE

- Advanced phases of the illness
- Usually predominate Negative symptoms and / or decreased intensity of positive symptoms

1. MENTAL HEALTH & MENTAL DISORDER(VI): ASPECTS OF DAILY LIFE

Mental illness **affects to daily life tasks**

- **Self care:** not caring for personal hygiene, dressing…
- **Autonomy:** difficulties in home cleaning, money handling, mobility, job performance…
- **Self control:** inability to stress handling, personal competences, mood…
- **Interpersonal relationships**: lack of social skills, social relationships…
- **Leisure:** isolation, apathy, inability to enjoy, passivity…
- **Cognition:** difficulties for keeping attention and concentration, memory, reasoning…

Affects **to their socio-economic status**

- People living alone or with their parents
- Low income
- Usually do not work

MENTAL HEALTH & MENTAL DISORDER(VII): ASPECTS OF DAILY LIFE

Affects **to their general health**

- They use to have worse physical health.
- Frequent use of health services
- Frequent hospital admission

Affects **to their family**

The burden of care falls on the parents and especially on the mother. This carry on other issues for the families/carers:

- Parent aging problems
- Unpaid care tasks
- Reduction of the time available for work, social and leisure activities.
- Overwhelming feeling of carers cause:
  - Criticism: Critical comments about the behavior of the person with MH. Negative evaluation of the behavior, both in the content (dislike and discomfort) and intonation of what was said.
  - Hostility: Generalized negative evaluation (directed more at the person than at the behavior) or a manifest rejection towards the person
  - Emotional overplay: Attempt to exert excessive control over the person's behavior. Refers to despair, self-sacrifice, overprotection and intense emotional manifestation

MENTAL HEALTH & MENTAL DISORDER (VIII): STIGMA

Affects also **to social inclusion**: People with severe mental health issues suffers **social stigma**

- They are one of the most historically stigmatized groups: Especially schizophrenia
- They are perceived as dangerous, aggressive, estrange, unpredictable, vague , etc. They are seem with fear
- There is a great ignorance and lack of awareness about mental disorders.
- Media, films, literature…had also created a negative image of mental disorders
- Families use to feel embarrassment, guilt and use to hide the illness.
- They find difficulties to find a job, a house, a couple, friends…
- It is difficult for the person with MHD to reach the status of citizen with full rights.
- Stigma worsen their situation: social maladjustment, low self-esteem, depression, increased family burden, integration into the community.

MENTAL HEALTH & MENTAL DISORDER (IX): STIGMA

What impact stigma have? Stigma has serious and long lasting consequences.

1. It brings the experience of:
   - Shame
   - Blame
   - Hopelessness
   - Distress
   - Reluctance to seek or accept help
   - Fear
   - Isolation

2. Emotional state: Affects sense of self-worth, self-steem.

3. Sypmtoms:
   - Contributes to shorten life expectancy
   - Slows recovery

4. Access and quality treatment: Limits access and quality of health.

5. Human rights: can lead to abuse.

6. Family: Disrupts relationships.

MENTAL HEALTH & MENTAL ILLNESS (X): PROMOTING RESPECT AND DIGNITY

What can sport professionals do to address stigma?.

- Change your own perception and attitude towards people with MH disorders.
- Understand that most of the people (including us) can suffer or have suffered MH disorders like anxiety, depression…
- Reaffirm that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms.
- Play a large part in fulfilling these rights.
- Respect and advocate for the implementation of relevant international conventions, such as the **United Nations Convention of the Rights of Persons with Disabilities** (CRPD) New York, 2006*

*Check if your country has ratified the Convention here: https://www.un.org/disabilities/documents/maps/enablemap.jpg

MENTAL HEALTH & MENTAL ILLNESS (XI): PROMOTING RESPECT AND DIGNITY

CRPD in brief

PURPOSE:

To promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity

PARADIGM SHIFT:

The Convention marks a major shift in the way societies view persons with disabilities, with the person being the key decision-maker in his or her own life. It makes persons with disabilities **"rights holders"** and "**subjects of law**", with full participation in formulating and implementing plans and policies affecting them.

- The Convention marks a 'paradigm shift' in attitudes and approaches to persons with disabilities.
- Persons with disabilities are not viewed as "objects" of charity, medical treatment and social protection; rather as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.
- The Convention gives universal recognition to the dignity of persons with disabilities.

MENTAL HEALTH & MENTAL ILLNESS (XI): CPRD

CRPD in brief

KEY CONCEPTS:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Art 1).

Disability results from an **interaction** between a non-inclusive society and individuals:

"Disability is an evolving concept, and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others".

- Person using a wheelchair might have difficulties gaining employment not because of the wheelchair, but because there are environmental barriers such as inaccessible buses or staircases which impede access
- Person with extreme near-sightedness who does not have access to corrective lenses may not be able to perform daily tasks. This same person with prescription eyeglasses would be able to perform all tasks without problems.

*Check if your country has ratified the Convention here: https://www.un.org/disabilities/documents/maps/enablemap.jpg

MENTAL HEALTH & MENTAL ILLNESS (XII): PROMOTING RESPECT AND DIGNITY

CRPD GENERAL PRINCIPLES

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

CRPD TERMINOLOGY

- YES: 'persons with disabilities' NO: 'handicapped' , 'physically or mentally challenged'

- Note: Preferences for terminology among persons with disabilities and among geographic regions may vary. The individual wishes of persons with disabilities should be respected as much as possible.

*Check if your country has ratified the Convention here: https://www.un.org/disabilities/documents/maps/enablemap.jpg

MENTAL HEALTH & MENTAL ILLNESS (XIII): PROMOTING RESPECT AND DIGNITY

DOs and DON'Ts to promote respect and dignity *

DOs

- Treat people with MNS conditions with respect and dignity.
- Protect the confidentiality of people with MNS conditions.
- Ensure privacy in the clinical setting.
- Always provide access to information and explain the proposed treatment risks and benefits in writing, if possible.
- Make sure the person provides consent to treatment.
- Promote autonomy and independent living in the community.
- Provide persons with MNS conditions with access to supported decision making options.

DON'Ts

- Do not discriminate against people with MNS conditions.
- Do not ignore the priorities or wishes of people with MNS conditions.
- Do not make decisions for, on behalf of, or instead of the person with MNS conditions.
- Do not use overly technical language in explaining proposed treatment.

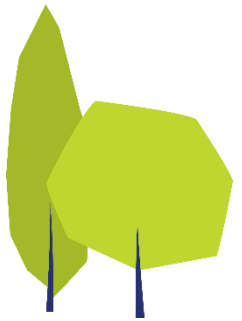
* SOURCE: WHO Mental Health Gap Action Programme (mhGAP), mhGAP Training Manual for the mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings – version 2.0

UNIT 2: Mental health disorders and symptoms

UNIT 2: Mental health disorders and symptoms

Learning objectives

- Learning about the two most widely systems of classification of mental health disorders
- Identifying the characteristics of most common mental health disorders.
- Understanding how persons with mental health disorders feels.
- Learning that diagnoses are based on symptoms but are not pure
- Learning the different type of symptoms
- Promote respect and dignity for people with mental health disorders



2. MENTAL HEALTH DISORDERS & SYMPTOMS

CLASSIFICATION OF DISORDERS

PSYCOSIS	NEUROSIS	ANSIETY DISORDERS	MOOD DISORDERS	PERSONALITY DISORDERS
• SCHIZOPHRENIA • BIPOLAR DISORDER • PSYCOSIS	• OBSESIVE NEUROSIS • HYSTERIA • PHOBIAS	• OBSESIVE-COMPULSIVE DISORDER • PANIC • POST-TRAUMATIC STRESS	• DEPRESSION	• BORDERLINE • DISSOCIATIVE IDENTITY DISORDER (DID)

There are several classifications of mental health issues.
The two most widely established systems of psychiatric classification are:

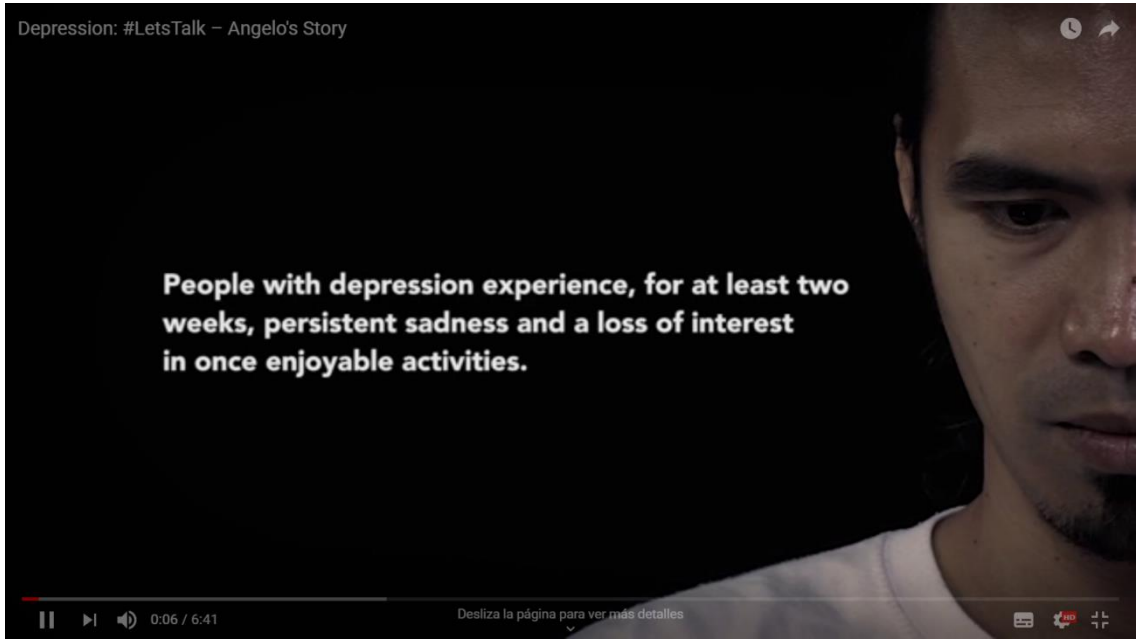
- DSM (Diagnostic and Statistical Manuel of Mental Disorders)
- ICD (International Classification of Diseases)

https://www.mentalhealthtoday.co.uk/innovations/an-introduction-to-the-classification-of-mental-disorders-the-dsm-and-the-icd

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

DEPRESSION

WATCH ANGELO'S STORY: https://www.youtube.com/watch?v=PYbuB-Ateus

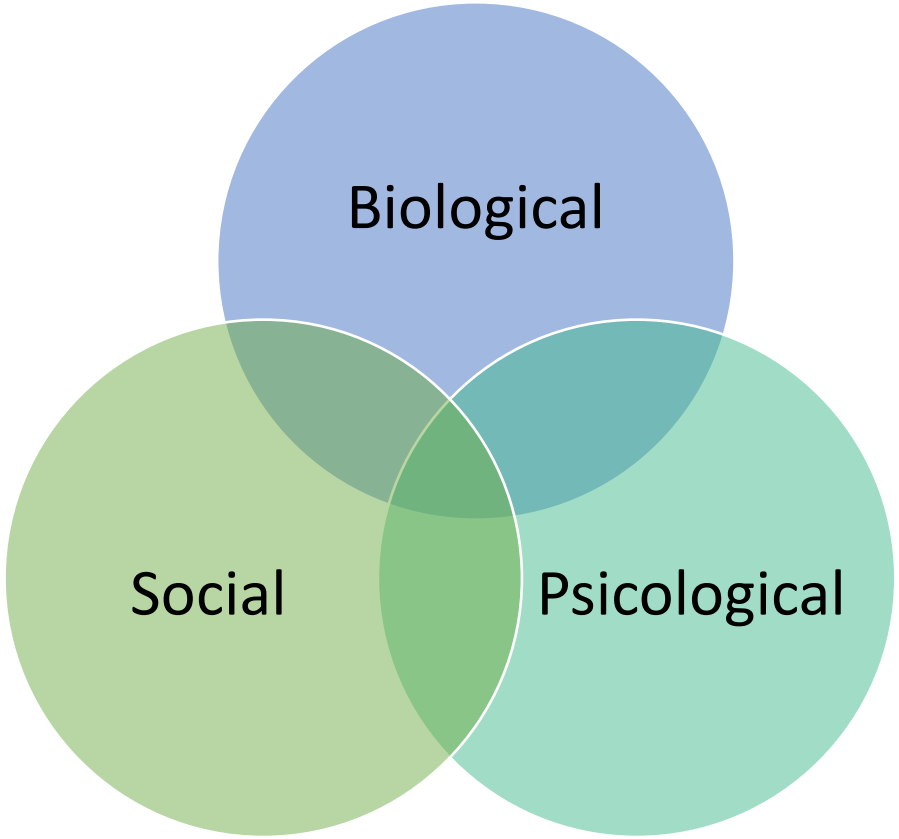


2. MENTAL HEALTH DISORDERS & SYMPTOMS: DEPRESSION

DEPRESSION

- Depression is the most common mental disorder (322 million people worldwide).
- It is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration.
- People with depression may also have multiple physical complaints with no apparent physical cause.
- Depression can be long-lasting or recurrent, substantially impairing people's ability to function at work or school and to cope with daily life.
- At its most severe, depression can lead to suicide.
- Symptoms of depression are lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DEPRESSION



Depression results from a complex interaction of social, psychological and biological factors.

- For example:

People who have gone through adverse life events (unemployment, bereavement, psychological trauma) are likely to develop depression.

Their depression can, in turn, lead to the person experiencing more stress and dysfunction (such as social isolation, indecisiveness, fatigue, irritability, aches and pains), thus worsening the person's life situation and the depression itself.

Biological factors may contribute to a person developing depression, such as a person with a family history of depression.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DEPRESSION

LOW MOOD ≠ DEPRESSION

- **Low mood** is normal and transient; many people can experience low mood from time to time.
- **Depression** lasts longer and has a profound impact on a person's ability to function in everyday life. Symptoms must be present for at **least two weeks**.

  In many cases depression can reduce a person's ability to carry out **daily tasks** such as cooking, cleaning, washing etc. Those with depression may struggle with getting out of bed and/or engaging in any activities of daily living.

  If a person is experiencing persistent low mood but continues to function in their everyday life then they have symptoms not amounting to depression,
- Therefore, when identifying depression, it is important to consider both:
  - The duration of the symptoms.
  - The effect on daily functioning

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

SCHIZOPHRENIA, BIPOLAR DISORDER AND OTHER PSYCHOSES

- Schizophrenia is a severe mental disorder, affecting about 23 million people worldwide
- Psychoses, including schizophrenia, are characterized by distortions in thinking, perception, emotions, language, sense of self and behavior.
- The disorder can make it difficult for people affected to work or study normally.
- Schizophrenia typically begins in late adolescence or early adulthood
- Some patients may present clear symptoms, but on other occasions, they may seem fine until they start explaining what they are truly thinking.
- Symptoms and signs of schizophrenia will vary, depending on the individual. The symptoms are classified into four categories (APA):

    1. Psychotic symptoms. For example, delusions and hallucinations.
    2. Negative symptoms - these refer to elements that are taken away from the individual. For example, absence of facial expressions or lack of motivation.
    3. Cognitive symptoms - these affect the person's thought processes. They may be positive or negative symptoms, for example, poor concentration is a negative symptom.
    4. Emotional symptoms - these are usually negative symptoms, such as blunted emotions.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

BIPOLAR AFFECTIVE DISORDER

- It affects about 60 million people worldwide.
- Bipolar disorders are brain disorders that cause changes in a person's mood, energy and ability to function.
- It typically consists of both manic and depressive episodes separated by periods of normal mood.
- **Manic episodes may** involve these symptoms:
  - Increased activity levels, elevation of mood potentially very happy and very agitated.
  - Elevated or irritable mood.
  - They may talk very rapidly, have lots of different ideas and increased levels of self-worth and self importance.
  - A decreased need for sleep.
  - They may have hallucinations and delusions, i.e. hear voices and/or believe that they are powerful, that their ideas can change the world.
  - Engage in risk taking Behaviours (gambling, spending money, promiscuity etc.).

  People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

BIPOLAR AFFECTIVE DISORDER

- Bipolar disorder is a category that includes three different conditions:
    - Bipolar I: can cause dramatic mood swings. During a manic episode, people with bipolar I disorder may feel high and on top of the world, or uncomfortably irritable and “revved up”. During a depressive episode they may feel sad and hopeless. There are often periods of normal moods in between these episodes
    - Bipolar II: involves a person having at least one major depressive episode and at least one hypomanic episode. People return to usual function between episodes. People with bipolar II often first seek treatment because of depressive symptoms, which can be severe.
    - Cyclothymic disorder: is a milder form of bipolar disorder involving many mood swings, with hypomania and depressive symptoms that occur often and fairly constantly. People with cyclothymia experience emotional ups and downs, but with less severe symptoms than bipolar I or II.
- Bipolar disorder it is sometimes considered as a type of psycosis

BIPOLAR AFFECTIVE DISORDER : CLINICAL COURSE

- First onset typically between age 15 and 25 years
- The pattern of mood swings can vary widely between people:
  - Some will have a couple of bipolar episodes in their life time and stay stable in between.
  - Others will have many episodes.
  - Some will only experience manic episodes.
  - Some will experience more depressed episodes than manic episodes.
- There are 3 possible clinical courses
  - The person recovers completely or partially with some symptoms
  - The person recovers but has a future episode (relapse).
  - Symptoms continue for a longer period

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

PSYCHOSES: IMPACT ON LIFE

IMPACT ON THE INDIVIDUAL

- Break up of relationships
- Negative and at times scary experience of symptoms.
- Loss of employment, studies, opportunities.
- Financial consequences.
- Stigma and rejection by community.

IMPACT ON THE FAMILY

- Medical costs.
- Time and energy looking after the person (carer burden).
- Emotional distress.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

PSYCHOSES: IMPACT

IMPACT ON SOCIETY

Loss of workforce.

- Costly medical interventions and (unnecessarily) lengthy hospitalizations.

HUMAN RIGHTS VIOLATION

- People with psychoses maybe chained and confined.
- They may be beaten as punishment or treatment.
- They may receive treatments that are ineffective and dangerous due to misunderstanding the causes of psychoses.

SUBSTANCE ABUSE DISORDERS

BOX 1: PSYCHOACTIVE SUBSTANCES: ACUTE BEHAVIOURAL EFFECTS, WITHDRAWAL FEATURES, AND EFFECTS OF PROLONGED USE

	ACUTE BEHAVIOURAL EFFECTS	WITHDRAWAL FEATURES	EFFECTS OF PROLONGED USE
Alcohol	Smell of alcohol on breath, slurred speech, disinhibited behavior, agitation, vomiting, unsteady gait	Tremors, shaking, nausea/vomiting, increased heart rate and blood pressure, seizures, agitation, confusion, hallucinations ***Can be life-threatening***	Loss of brain volume, reduction in cognitive capacity, impaired judgement, loss of balance, liver fibrosis, gastritis, anaemia, increased risk of some cancers and a range of other medical problems
Benzodiazepines	Slurred speech, disinhibited behavior, unsteady gait	Anxiety, insomnia, tremors, shaking, nausea/vomiting, increased heart rate and blood pressure, seizures, agitation, confusion, hallucinations ***Can be life-threatening***	Memory impariment, increased risk of falls in the elderly, risk of fatal sedative overdose
Opioids	Pinpoint pupils, drowsiness and falling asleep, decreased awareness, slow speech	Dilated pupils, anxiety, nausea/vomiting/diarrhea, abdominal cramps, muscle aches and pains, headaches, runny eyes and nose, yawning, hair standing up on arms, increased heart rate and blood pressure	Constipation, risk of fatal sedative overdose, hypogonadism, adaptations in reward, learning and stress responses
Tobacco	Arousal, increased attention, concentration and memory; decreased anxiety and appetite; stimulant-like effects	Irritibility, hostility, anxiety, dysphoria, depresed mood, increased heart rate, increased appetite	Lung disease (in tobacco smokers), cardiovascular disease, risk of cancers and other health effects
Cocaine, Methamphetamines & Amphetamine-type stimulants	Dilated pupils, increased blood pressure and heart rate, excited, euphoric, hyperactivity, rapid speech, racing thoughts, disordered thinking, paranoia, aggressive, erratic, violent	Fatigue, increased appetite, depressed, irritable mood ***Watch out for suicidal thoughts***	Hypertension, increased risk of cerebrovascular accidents (CVAs), arrythmias, heart disease, anxiety, depression
Khat	Alertness, euphoria, and mild excitation	Lethargy, depressed mode, irritability	Khat users often spend a significant portion of the day chewing khat; consti-pation, risk of mental health problems such as psychosis
Cannabis	Normal pupils, red conjunctivae, delayed responsiveness, euphoria, relaxation	Depressed or labile mood, anxiety, irritability, sleep disturbance (there may not be any clearly observable features)	Increased risk of mental health problems including anxiety, paranoia and psychosis, lack of motivation, difficulty in concentration, increased risk of vasospasm leading to myocardial infarction and stroke
Tramadol	Opioid effects (sedation, euphoria, etc.) followed by stimulant effects (excitation and in high doses seizures	Predominantly opioid withdrawal effects but also some serotonin norepinephrine reuptake inhibitor (SNRI) withdrawal symptoms (depressed mood, lethargy)	Opioid dependence, risk of seizures, disturbed sleep
Volatile solvents	Dizziness, disorientation, euphoria, light-headedness, increased mood, hallucinations, delusions, incoord-ination, visual disturbances, anxiolysis, sedation	Increased susceptibility to seizures	Decreased cognitive function and dementia, peripheral neuropathy, other neurological sequelae, increased risk of arrythmias causing sudden death
Hallucinogens	Increased heart rate, blood pressure, body temperature, decreased appetite, nausea, vomiting, motor incoordination, papillary dilatation, hallucinations	No evidence	Acute or chronic psychotic episodes, flashbacks or re-experiencing of drug effects long after termination of use
MDMA	Increased self-confidence, empathy, understanding, sensation of intimacy, communication, euphoria, energy	Nausea, muscle stiffness, headache, loss of appetite, blurred vision, dry mouth, insomnia, depression, anxiety, fatigue, difficulty concentrating	Neurotoxic, leads to behavioral and physiological consequences, depression

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

SUBSTANCE ABUSE DISORDERS

- Addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence.
- People with addiction (severe substance use disorder) have an intense focus on using a certain substance(s), such as alcohol or drugs, to the point that it takes over their life
- People with a substance use disorder have distorted thinking, behavior and body functions.
- Changes in the brain's wiring are what cause people to have intense cravings for the drug and make it hard to stop using the drug.
- Brain imaging studies show changes in the areas of the brain that relate to judgment, decision making, learning, memory and behavior control.
- These substances can cause harmful changes in how the brain functions. These changes can last long after the immediate effects of the drug
- Over time people with addiction build up a tolerance, meaning they need larger amounts to feel the effects
- Substance-related disorders are usually broken down into two groups (Domingo, Zhang, 2019):
    - Substance-induced mental disorders: they refer to those mental changes caused by the direct effects of a substance or withdrawal, namely, depression, psychosis, or anxiety.
    - Substance use disorders: they refer to the difficulty to control the use or intake of certain substances.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

DEMENTIA

- Dementia is not a single disease in itself, but a general term to describe describe a large group of conditions affecting the brain which cause a progressive decline in a person's ability to function: symptoms of impairment in memory, communication, and thinking.
- It is **not** a normal part of ageing.
- Worldwide, approximately 50 million people have dementia
- Dementia is usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing
- It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.
- Dementia is caused by a variety of diseases and injuries that affect the brain, such as Alzheimer's disease or stroke.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

DEMENTIA

- These are some types of dementia (APA):

  - **Alzheimer's disease** is characterized by "plaques" between the dying cells in the brain and "tangles" within the cells (both are due to protein abnormalities). The brain tissue in a person with Alzheimer's has progressively fewer nerve cells and connections, and the total brain size shrinks.
  - **Dementia with Lewy bodies** is a neurodegenerative condition linked to abnormal structures in the brain. The brain changes involve a protein called alpha-synuclein.
  - **Mixed dementia** refers to a diagnosis of two or three types occurring together. For instance, a person may show both Alzheimer's disease and vascular dementia at the same time.
  - **Parkinson's disease** is also marked by the presence of Lewy bodies. Although Parkinson's is often considered a disorder of movement, it can also lead to dementia symptoms.
  - **Huntington's** disease is characterized by specific types of uncontrolled movements but also includes dementia.

DEMENTIA: Stages

1. Early stage

Becoming forgetful, especially of things that have just happened.

Some difficulty with communication (e.g. difficulty in finding words).

Becoming lost and confused in familiar places - may lose items by putting them in unusual places and be unable to find them.

Losing track of the time, including time of day, month, year.

Difficulty in making decisions and handling personal finances.

Having difficulty carrying out familiar tasks at home or work (trouble driving or forgetting how use appliances in the kitchen).

Mood and behaviour:

- Less active and motivated, loses interest in activities and hobbies.
- May show mood changes, including depression or anxiety.
- May react unusually angrily or aggressively on occasion.

DEMENTIA: Stages

2. Middle stage

Becoming very forgetful, especially of recent events and people names.

Having difficulty comprehending time, date, place and events.

Increasing difficulty with communication.

Need help with personal care (i.e. toileting, dressing).

Unable to prepare food, cook, clean or shop.

Unable to live alone safely without considerable support.

Behaviour changes (e.g. wandering, repeated questioning, calling out, clinging, disturbed sleeping, hallucinations)

Inappropriate behaviour (e.g. disinhibition, aggression)

DEMENTIA: Stages

3. Late stage

Unaware of time and place.

May not understand what is happening around them.

Unable to recognize relatives and friends.

Unable to eat without assistance.

Increasing need for assisted self-care.

May have bladder and bowel incontinence.

May be unable to walk or be confined to a wheelchair or bed.

Behaviour changes may escalate and include aggression towards carer (kicking, hitting, screaming or moaning).

Unable to find their way around in the home.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

ANXIETY DISORDERS

- Anxiety is a very normal response to stressful life events like moving, changing jobs or having financial troubles.
- But Anxiety disorders differ from normal feelings of nervousness or anxiousness, and involve excessive fear or anxiety. When symptoms of anxiety become larger than the events that triggered them and begin to interfere with your life, they could be signs of an anxiety disorder
- Anxiety refers to anticipation of a future concern and is more associated with muscle tension and avoidance behavior
- Anxiety disorders are the most common of mental disorders and affect nearly 30 percent of adults at some point in their lives.
- Anxiety disorders are treatable and a number of effective treatments are available. Treatment helps most people lead normal productive lives.
- People under the age of 65 are at the highest risk of generalized anxiety disorder, especially those who are single, have a lower socioeconomic status and have many life stressors.
- Anxiety disorders can cause people into try to avoid situations that trigger or worsen their symptoms. Job performance, school work and personal relationships can be affected.
- In general, for a person to be diagnosed with an anxiety disorder, the fear or anxiety must:
    - Be out of proportion to the situation or age inappropriate
    - Hinder the ability to function normally

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

ANXIETY DISORDERS

- Symptoms:
  - **Excessive worrying**: disproportionate to the events that trigger it and typically occurs in response to normal, everyday situations.
  - **Feeling agitated**: When someone is feeling anxious, part of their sympathetic nervous system goes into overdrive. This kicks off a cascade of effects throughout the body, such as a racing pulse, sweaty palms, shaky hands and dry mouth.
  - **Restlessness:** they often describe it as feeling “on edge” or having an “uncomfortable urge to move
  - **Fatigue**
  - **Difficulty concentrating**
  - **Irritability.**
  - **Tense Muscles**: Having tense muscles on most days of the week
  - **Trouble Falling or Staying Asleep.**
  - **Panic Attacks:** Intense, overwhelming sensation of fear that can be debilitating
  - **Avoiding Social Situations:** Feeling anxious or fearful about upcoming social situations
  - **Irrational Fears:** Extreme fears about specific things, such as spiders, enclosed spaces or heights, could be a sign of a phobia (an extreme anxiety).

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

DEVELOPMENTAL DISORDERS

- Developmental disorder is an umbrella term covering intellectual disability and autism spectrum disorders.
- Developmental disorders are defined by limitations in core functional domains (e.g., motor, communication, social, academic) resulting from aberrant development of the nervous system. These limitations can manifest during infancy or childhood as delays in reaching developmental milestones, and as qualitative abnormalities or lack of function in one or multiple domains
- Developmental disorders usually have a childhood onset but tend to persist into adulthood, causing impairment or delay in functions related to the central nervous system maturation.
- They generally follow a steady course rather than the periods of remissions and relapses that characterize many other mental disorders.
- Currently 10–20% of children and adolescents worldwide live with mental and developmental disorders.

2. MENTAL HEALTH DISORDERS & SYMPTOMS: DESCRIPTION

DEVELOPMENTAL DISORDERS

Neurodevelopmental disorders include, among others (Sulkes, 2018):

- ATTENTION-DEFICIT/HYPERACTIVITY: poor or short attention span and/or excessive activity and impulsiveness inappropriate for the child's age that interferes with functioning or development. Symptoms may include difficulty in concentrating, in completing tasks (poor executive skills), restlessness, mood swings, impatience, and difficulty in maintaining relationships.

- AUTISM SPECTRUM DISORDERS (ASDs) are conditions in which people have difficulty developing normal social relationships, use language abnormally or not at all, and behave in compulsive and ritualistic ways. Autism spectrum disorder (ASD) comprises a group of neurodevelopmental disabilities. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) includes autism, Asperger's disorder, and "pervasive personality disorder not otherwise specified" under the umbrella heading of ASD. (APA, 2013)

  Symptoms of autism spectrum disorders include impaired social behavior, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively (Reis). Children with autism spectrum often repeat certain behaviors, for instance:
  - Avoid eye contact
  - Not be able to express what they're thinking through language
  - Have a high-pitched or flat voice
  - Find it hard to keep up a conversation
  - Have trouble controlling emotions
  - Perform repetitive behaviors like hand-flapping, rocking, jumping, or twirling
  - Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability.

DEVELOPMENTAL DISORDERS

- With early identification and treatment, the prognosis for a child/ adolescent with mental and behavioral disorders can improve drastically and change the course of a person's entire life.

- What happens to the child in the early years is critical for the childs develoment trajectory and life course.

  Healthy early development strongly influences well-being, mental health, transversal competences and civic participation through out life. Healthy development includes:
  - Physical motor skills
  - Social/emotional skills
  - Language/cognitive skills

- Children/adolescents with developmental disorders face major challenges with stigma, isolation and discrimination. Some forms of discrimination may be:
  - Bullying by siblings or peers at school
  - Harshly treated by frustrated parents
  - Excluded from school activities by peers and/or teachers
  - Others….

DEVELOPMENTAL DISORDERS

IMPACT:

- Poor school performance
- Reduced community participation
- Impaired capacity to live independently
- Limited employment opportunities
- High carer burden (socially, emotionally, financially)
- Mothers or families may also be stigmatized or become isolated

2. MENTAL HEALTH DISORDERS & SYMPTOMS

Symptoms and diagnoses

The diagnoses help to establish a series of intervention guidelines: from the cognitive, emotional and behavioral symptoms

Diagnoses in most cases are not pure:
Symptomatology of other diseases associated with the main diagnosis (intellectual disability, toxic consumption, anxiety, depression ...) may appear.

Symptoms used to be divided into two categories:

Possitive: thoughts, behaviors, or sensory perceptions present in a person with a mental disorder, but not present in people in the normal population.

Negative: thoughts, feelings, or behaviors normally present in healthy persons that are absent or diminished in a person with a mental disorder.

2. MENTAL HEALTH DISORDERS & SYMPTOMS

Types of Symptoms

POSSITIVE SYMPTOMS

- Thoughts, behaviors, or sensory perceptions present in a person with a mental disorder, but not present in people in the normal population..
- They are more common in the acute phase
- They respond better to medication
- Easy to diagnose

Examples:

- Hallucinations
- Delusions
- Bizarre behaviour
- Formal thought disorder
- Disorganized speech

NEGATIVE SYMPTOMS

- Thoughts, feelings, or behaviors normally present in healthy persons that are absent or diminished in a person with a mental disorder
- Most common in the stabilization phase.
- More resistant to medication
- Difficult to diagnose

Examples:

- Apathy
- Poverty of speech
- Inability to experience pleasure (anhedonia)
- Limited emotional expression
- Defects in attention control

http://www.minddisorders.com/Ob-Ps/Positive-symptoms.html

2. MENTAL HEALTH DISORDERS & SYMPTOMS

POSSITIVE Symptoms (1)

HALLUCINATIONS

False perception occurring without any identifiable external stimulus and indicates an abnormality in perception. The false perceptions can occur in any of the five sensory modalities. Therefore, a hallucination essentially is seeing, hearing, tasting, feeling, or smelling something that is not there.

Symptom of either a medical (e.g., epilepsy), neurological, or mental disorder.
Hallucinations may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Bipolar disorder
- Major depression with psychotic features
- Delirium
- Dementia

http://www.minddisorders.com/Flu-Inv/Hallucinations.html

2. MENTAL HEALTH DISORDERS & SYMPTOMS

POSSITIVE Symptoms (2)

DELUSIONS

Believes that are clearly false and that indicate an abnormality in the affected person's content of thought. The false belief is not accounted for by the person's cultural or religious background or his or her level of intelligence. A person with a delusion will hold firmly to the belief regardless of evidence to the contrary. Delusions can be difficult to distinguish from overvalued ideas, which are unreasonable ideas that a person holds. A person with a delusion is absolutely convinced that the delusion is real, without any doubt.

Symptom of either a medical, neurological, or mental disorder.
Delusions may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Bipolar disorder
- Major depression with psychotic features
- Delirium
- Dementia

http://www.minddisorders.com/Flu-Inv/Delusions.html

2. MENTAL HEALTH DISORDERS & SYMPTOMS

POSSITIVE Symptoms (3)

FORMAL THOUGHTS DISORDER & DISORGANIZED SPEECH

The thoughts that the person has are translated into their language and show a disorganized speech, the person moves from one topic to another without connection or any relationship, emits strange words, suffers a blockage of language, looses association between ideas, derails sentences, says incoherent ideas, illogical statements, gives excessive detail, and rhyming of words

It may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Bipolar disorder
- Delirium
- Dementia

2. MENTAL HEALTH DISORDERS & SYMPTOMS

POSSITIVE Symptoms (4)

BIZARRE BEHAVIOUR
Disorganized behavior, or behavior lacking in logic and common sense. I.E.: agitation, disorganized behavior, unmotivated laughter .
It may be present in any of the following mental disorders: • Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder) • Bipolar disorder • Depression • Dissociative identity disorder (DID) • Post-traumatic stress disorder • Obsessive-compulsive disorder

NEGATIVE Symptoms (1)

APATHY

Disinterest for life and lose motivation to do things that you liked before. It can translate into exhaustion, slowness, lack of hygiene

It may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Depression

SOCIAL WITHDRAWAL

Diminution of social relationships, isolation, individual's reticence to engage in social interaction

It may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Depression
- Autism

2. MENTAL HEALTH DISORDERS & SYMPTOMS

NEGATIVE Symptoms (2)

EMOTIONAL FLATTENING

The person does not express any emotion with gestures or words (he/she does not laugh at funny situations, he/she does not smile when other people smile at him/her, he/she does not cry or express pain in the face of misfortune). Inexpressiveness in the face and lifeless gaze. He/she speaks monotonously and without modulation

It may be present in any of the following mental disorders:

- Autism
- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Depression

ANHEDONIA

The inability to experience pleasure, the loss of interest or satisfaction in almost all activities. It is considered a lack of reactivity to pleasant stimuli.

It may be present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia)
- Depression
- Autism

2. MENTAL HEALTH DISORDERS & SYMPTOMS

NEGATIVE Symptoms (3)

COGNITIVE DEFICIT

The person finds difficulties in understanding information, explaining things, paying attention, remembering , reasoning, etc.

This is the main symptom of dementia but may be also present in any of the following mental disorders:

- Psychotic disorders (including schizophrenia, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder)
- Depression

OTHER SYMPTOMS

Depression, loss of appetite, difficulties to get asleep or insomnia, etc.

“

UNIT 3: Recovery

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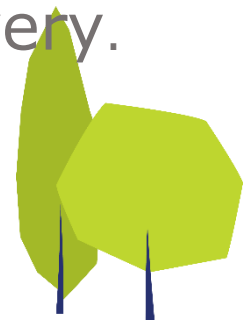
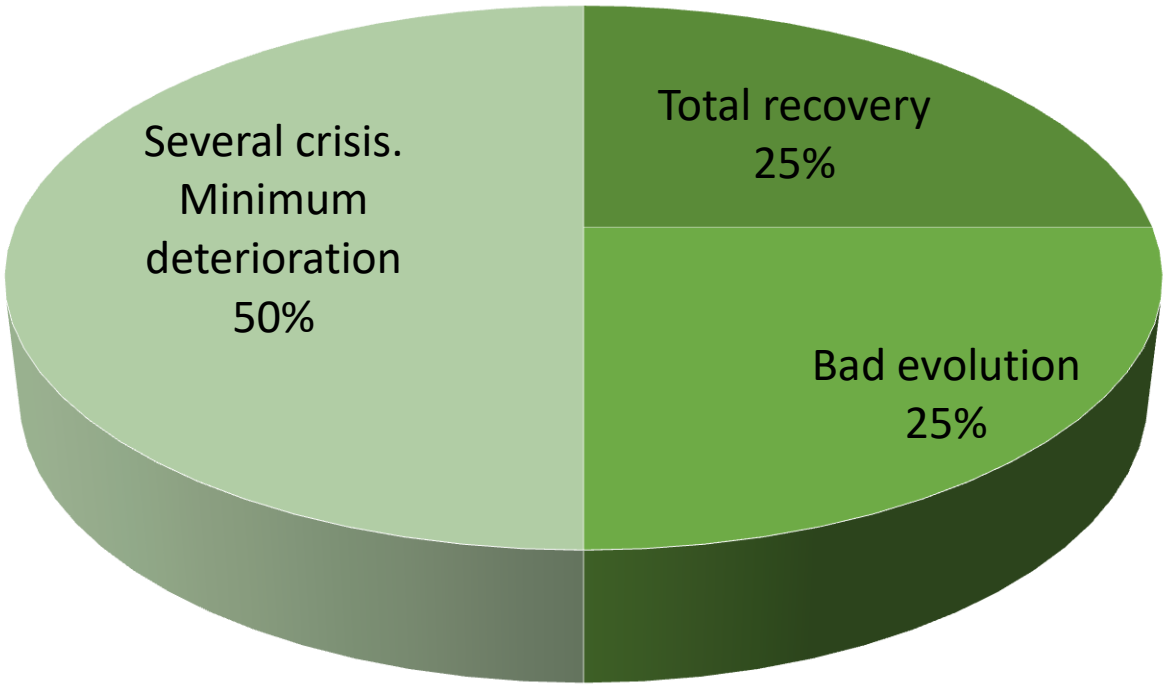
UNIT 3: Recovery

Learning objectives

- Learning that recovery depends on a combination of factors.
- Getting a general idea of the biopsychosocial model.
- Knowing the main principles that should be taken into consideration to contribute to recovery.
- Understanding the role of the sport professional in the recovery.

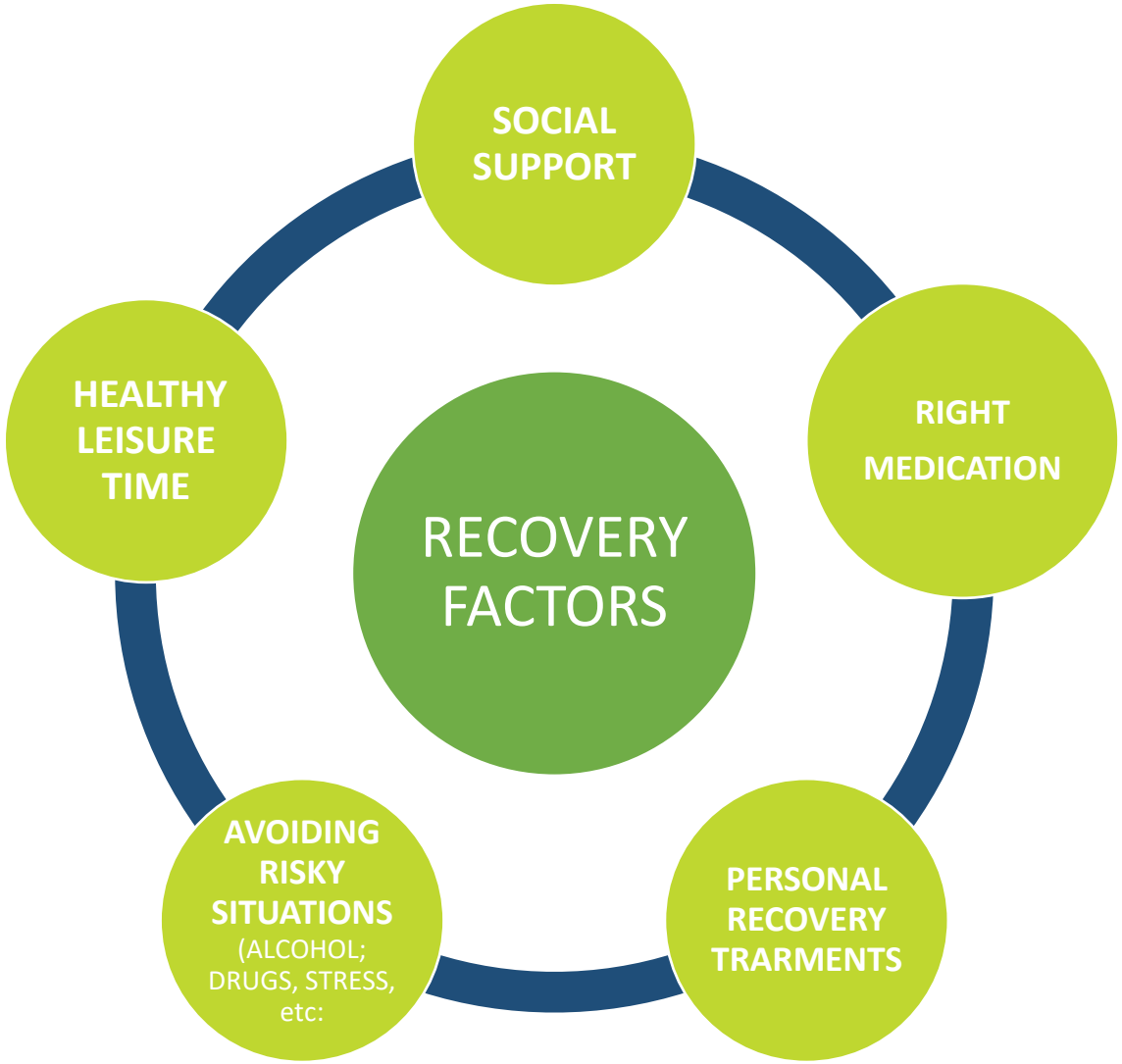


3. RECOVERY: PERCENTAGES



Evolution is unpredictable: it depends largely on the conditions sociofamiliares, medication taking, coping capacity ...

3. RECOVERY: FACTORS



3. RECOVERY: BIOPSYCOSOCIAL MODEL

BIOPSYCOSOCIAL MODEL (BPS)

The Biopsychosocial model was first conceptualised by George Engel in 1977, suggesting that to understand a person's medical condition it is not simply the biological factors to consider, but also the psychological and social factors.

BPS is a holistic approach that systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.
It emphasizes the importance of understanding human health and illness in their fullest contexts.

It contradicts the prevailed biomedical model that had dominated the industrialized societies since mid-20th century

3. RECOVERY: BIOPSYCOSOCIAL MODEL *versus* TRADITIONAL MODEL

TRADITIONAL BIOMEDICAL MODEL

Focused on pathophysiology and other biological approaches to disease.

Tries to explain psychological phenomenon with pure biological explanations (i.e. neurotransmitter dysregulation to fully explain a mental disorder)

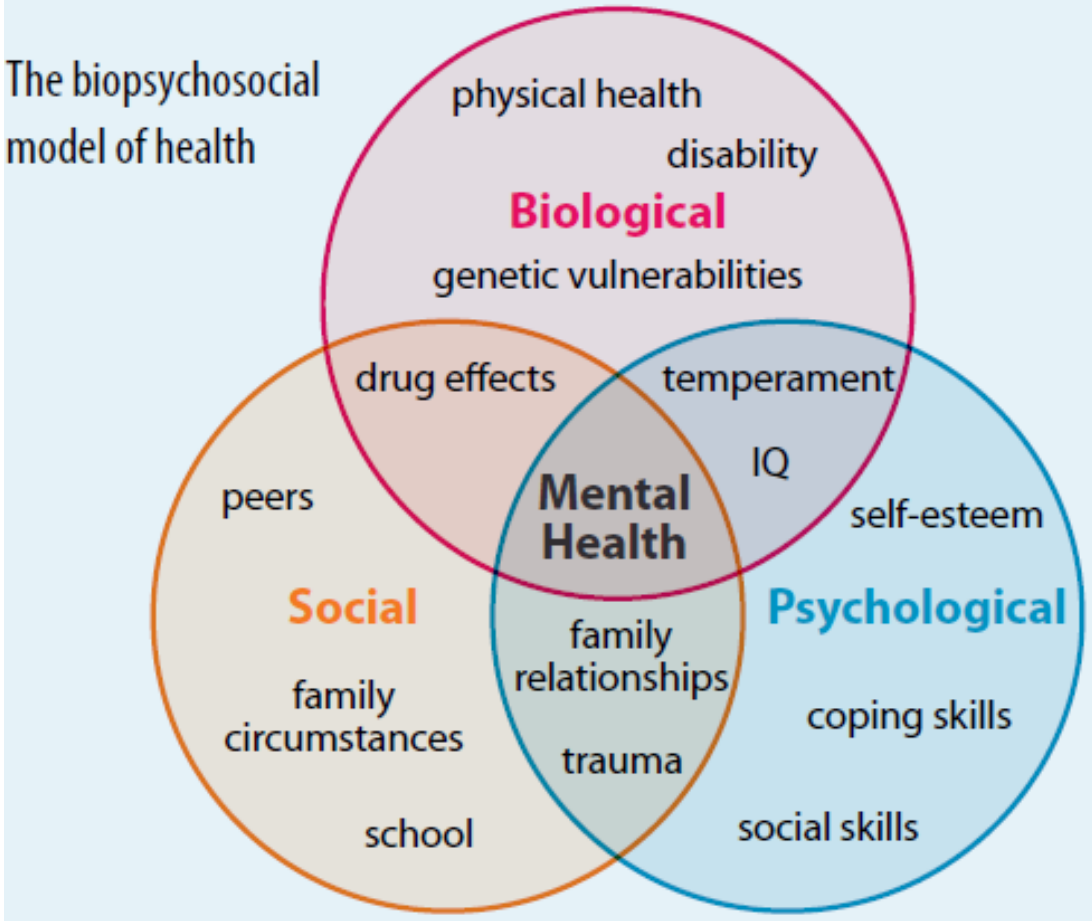
It only treats the physiological manifestations of the disease.

The disease is seem as a biological dysfunction without considering other factors.

It is more important to cure the symptoms than to promote health.

RECOVERY : The patient establishes an obedience relationship with the doctor. Responsible professional

3. RECOVERY: BIOPSYCOSOCIAL MODEL



- Biological: anatomical, structural and molecular substrate of the disease. Chemical, physical factors ...
- Psycological: thougths, emotions, experiences, expectations, affections...
- Social : familial, cultural, economic context.

RECOVERY: The person is considered responsible for him/herself (not the professional)

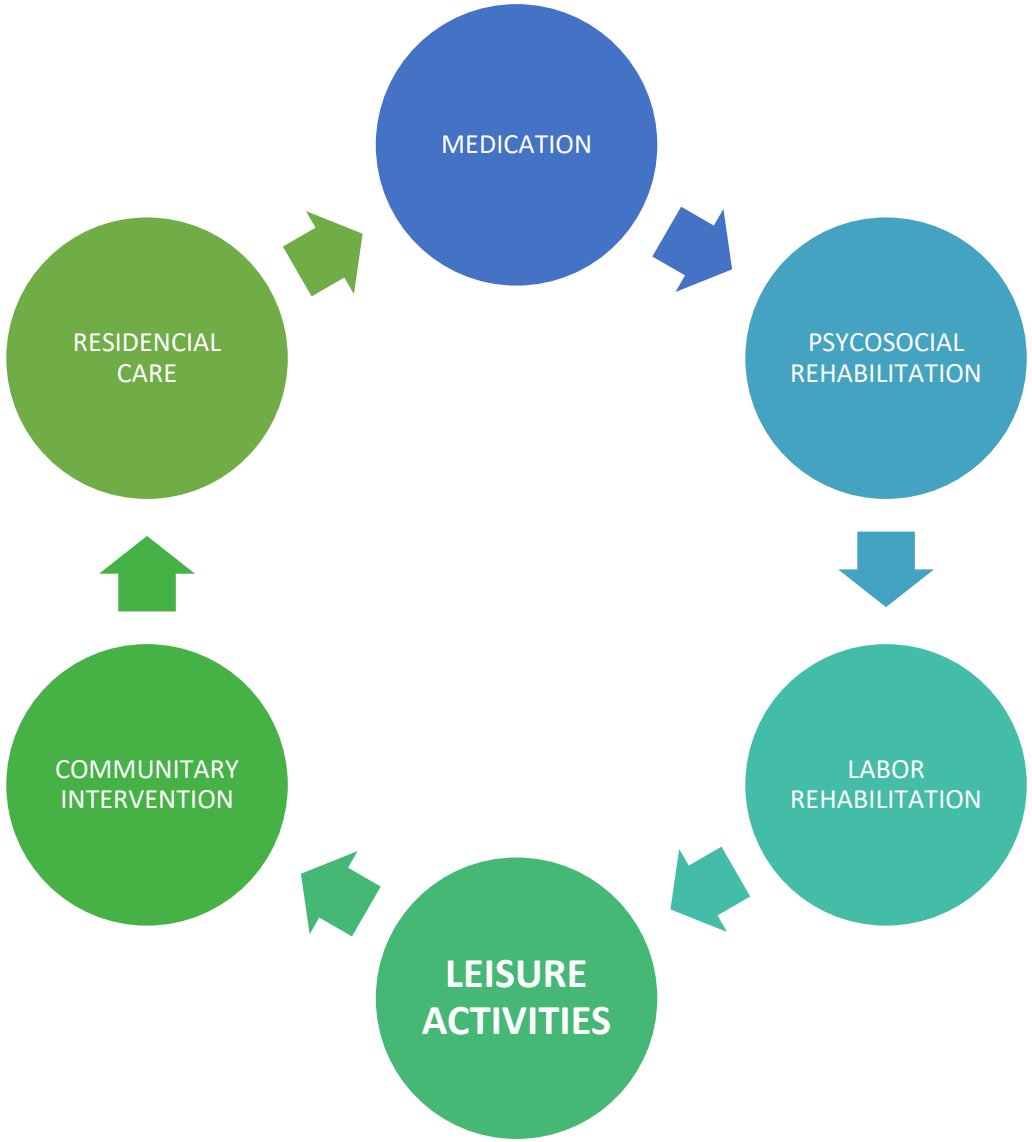
3. RECOVERY: BIOPSYCOSOCIAL MODEL PRINCIPLES

- **Building the own project life**: defined by the person who decides his/her own goals and designs the path to reach them, regardless of the evolution of their symptoms.
- **Recovery interconnected** with health, strength and general well-being.
- **Based on hope:** persons can recover and they also feel an increasing hope as he assumes greater control over his life.
- **Personal identity**: Promoting a discovery or rediscovery of a sense of personal identity.
- **Coaching**: Professionals play a simila role of a coach, a facilitators or a travel companion in the process.
- **Respect and inclusion**: It is related to social inclusion and with the development of satisfactory social relationships within the community.
- **Personal stories:** Language and personal stories are very important as they reinforce a sense of hope and possibilities.
- **Personal skills of professionals :** empathy, hope, care, realism , creativity and resilience are skills required in mental health professionals.

3. RECOVERY COMPONENTS

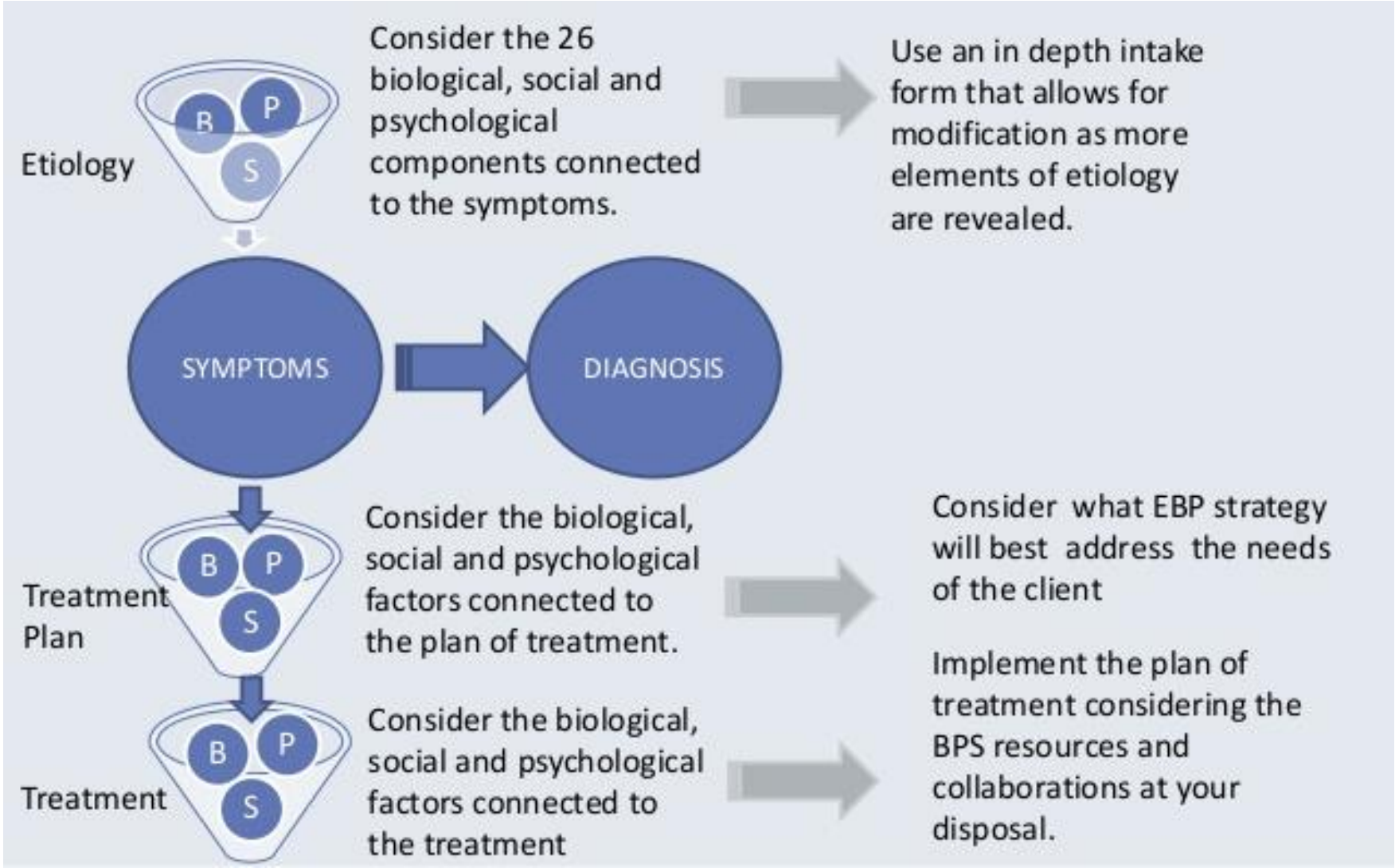
- **Self-direction by the individual:** She/he defines her/his own goals and design a path to reach them..
- **Comprehensive**: covers every factor of the life of the person (housing, employment, education, treatment, services, spirituality, creativity, social networks, community participation, family support ...).
- **Person centered** intervention, individualized treatments.
- **Empowerment**: they can choose from a range of options and participate in decisions that will affect their lives.
- **Hope**: people can and effectively overcome the barriers and obstacles they face.
- **Personal responsibility** for the own care.
- **Based on strengths**: to start new life roles, new support relationships based on trust..
- **Peer support**: encourage and involve others to others, give up a sense of belonging, supportive relationships ....
- **Respect**: in the community, protection of their rights, elimination and protection of stigma..

3. RECOVERY: TREATMENT



3. RECOVERY: BIOPSYCOSOCIAL MODEL

Treatment based of he BPS model



3. RECOVERY COMPONENTS

REASONS FOR INCLUDING SPORT AND P.A. INTO RECOVERY PROCESSES

1. The burden the mental health disorders is great
2. Mental and physical health problems are interwoven
3. It is proven that sport and physical activity improve mood
4. Sport and physical activity improve general health and promotes balanced life
5. In some cases medication treatments can be reduced
6. Sport and physical activity promote social interaction and friendship
7. They contribute to social inclusion and to fight against stigma
8. It is affordable and cost-effective
9. Leisure is a key factor of the BPS recovery model and they healthy leisure activities.

3. RECOVERY COMPONENTS

SPORTS PROFFESIONALS CONTRIBUTION TO RECOVERY

Sport professionals can contribute to the recovery of people with MHD helping them to thrive inside and outside of the sport sessions by:

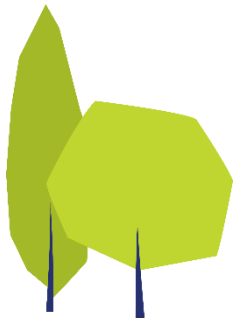
- Building people's resilience, self-esteem and confidence
- Adapting the sessions to make them more inclusive
- Enabling and supporting mental health recovery
- Tackling stigma and discrimination.

UNIT 4: Medication and side effects

UNIT 4: Medication and side effects

Learning objectives

- Knowing some general considerations about medication and side effects
- Learning about the consequences of quitting medication and how to encourage the intake
- Learning about the most common side effects
- Learning how side effects can affect physical activity



4. MEDICATION AND SIDE EFFECTS

GENERAL CONSIDERATIONS
Psychiatrist shall find the right treatment for each person.
Medication **should not be modified** without consulting the professional
Medication sometimes has to be taken for a long time, even when the person feels well
Abandonment of medication is an important cause of relapse.

SIDE EFFECTS
Medication may have side adverse effects.
Some side effects can be controlled by simple measures (reduction of doses, i.e.) or by taking some other corrective medication.
Side effects cannot be the cause for leaving the treatment .
When unexpected or extrange side effects are observed, a doctor should check them.

4. MEDICATION AND SIDE EFFECTS

CONSEQUENCES OF QUITTING MEDICATION
Higher number of relapses: 80% of those who do not take the medication relapse during the first year.
Increased severity of relapse: they enter involuntarily more frequently and present a more serious clinical
Longer duration of hospital admissions: they need more days of admission to recuperate
Worse evolution of the disease: recovery is better and more complete as soon as the pharmacological treatment is established and maintained.

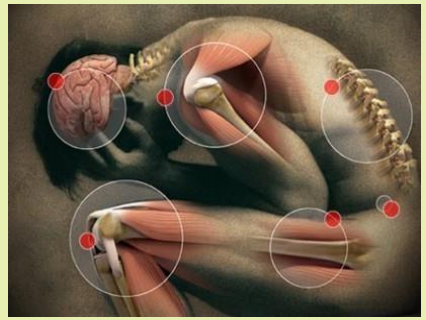
RECOMMENDATIONS TO ENCOURAGE MEDICATION INTAKE
Listen to the reasons the patient gives for not taking the medication: they usually make a lot of sense..
Try to convince him through information and understanding instead of forcing him: Long gives better result..
Achieve a quiet and less intrusive environment as possible for the patient..
Show satisfaction every time you take the medication, relating it to how well you are.
Consult with the psychiatrist as many times as necessary. Coordination between professionals.

4. MEDICATION AND SIDE EFFECTS

MOST COMMON SIDE EFFECTS

Extrapyramidal symptoms (EPS) also known as extrapyramidal side effects (EPSE) are the most common side effects:

- Dystonia (continuous spasms and muscle contractions)
- Akathisia (motor restlessness)
- Parkinsonism (characteristic symptoms such as rigidity)
- Bradykinesia (slowness of movement)
- Tremor, and tardive dyskinesia (irregular, jerky movements)
- Excessive salivation



4. MEDICATION AND SIDE EFFECTS

LESS SEVERE	MORE SEVERE
• Sun sensitive eyes. • Dry mouth • Stomach discomfort • Constipation • Dizziness • Fatigue • Dry skin • Muscle seizure • Weight gain	• Blurry vision • Drooling or trouble swallowing • Diarrhea • Body tremors or spasms • Muscle stiffness • Acne • Skin discoloration • Sexual difficulties or irregular menstruation • Sun burns • Slow or involuntary movements of body parts • Daytime sleepiness • Difficulty urinating • Nervousness and motor restlessness

4. MEDICATION AND SIDE EFFECTS

DEPRESSION MEDICATION - SIDE EFFECTS

- There are several drugs used for its treatment that are classified depending on the neurotransmitter on which they act.

The main side effects of medication for depression could be:

- Nausea
- Increased appetite, which causes increased weight
- Sexual dysfunction
- Fatigue
- Drowsiness
- Insomnia
- Dry mouth
- Blurred vision
- Constipation
- Dizziness
- Agitation,
- Anxiety
- Uneasiness
- And even genetic variations.

4. MEDICATION AND SIDE EFFECTS

ANXIETY DISORDERS MEDICATION - SIDE EFFECTS

The most commonly used medications to treat anxiety disorders are anti-anxiety medications – SNRIs (generally prescribed only for a short period of time) and antidepressants (SSRIs)

The side effects of SSRIs and SNRs are similar

- blurry vision,
- dizziness,
- drowsiness or fatigue,
- dry mouth,
- feeling agitated or restless,
- gaining weight,
- headaches,
- nausea,
- sexual problems or erectile dysfunction,
- sleep problems, an upset stomach

4. MEDICATION AND SIDE EFFECTS

BIPOLAR AFFECTIVE DISORDERS MEDICATION - SIDE EFFECTS

Medications known as “mood stabilizers”, like lithium, are the most commonly prescribed type of medication for bipolar I disorder. Anticonvulsant medications are also sometimes used and antipsychotics can also help manage bipolar disorders, especially those accompanied by periods of psychosis during severe depression or mania (APA, 2013)

The side effects of Lithium :

- Shaking
- Dry mouth
- Frequent urination
- Diarrhea
- Gaining weight
- Increased thirst
- Loss appetite,
- Kidney trouble
- Lowered thyroid activity
- Fatigue
- Emotional numbness
- Dull feeling.

The side effects of Anticonvulsant :

- Nausea
- Shaking
- Gaining weight
- Dizziness
- Drowsiness
- Blurred vision
- Dry mouth
- Decreased white blood cell or platelet count
- Skin rashes

4. MEDICATION AND SIDE EFFECTS

SCHIZOPHRENIA AND OTHER PSYCHOSES MEDICATION - SIDE EFFECTS

The neuroleptics and antipsychotics are the most common treatments. These drugs block the receptors of dopamine (substance responsible for transmitting information between cells of the nervous system), in which an excess can produce symptoms such as hallucinations and delusions. They organize the thought and consequently, they also prevent relapses acting as a “filter” which avoid the excessive transmission of information from one neuron to another in the brain.

The side effects:

- Gaining weight
- Metabolic syndrome
- Sexual dysfuction
- Extrapyramidal effects: motor restlessness, especially of legs, forcing the person to move them (akathisia), muscle stiffness, tremor (especially in hands), spasms and the tendency of having the mouth open and with excessive salivation.

4. MEDICATION AND SIDE EFFECTS

DEMENTIA MEDICATION - SIDE EFFECTS

Brain cell death cannot be reversed, so there is no known cure for degenerative dementia, nevertheless there are four drugs, called cholinesterase inhibitors that are used to reduce the symptoms, especially for Alzheimer's disease and can also help with the behavioral elements of Parkinson's disease

The majority of the people do not have side effects when they take cholinesterase inhibitors, but some do have:

- Nausea, vomiting,
- Loss of appetite
- More frequent bowel movements
- Bruising
- Muscle cramps
- Headaches
- Fatigue
- Insomnia

4. MEDICATION AND SIDE EFFECTS

DEVELOPMENTAL DISORDERS MEDICATION - SIDE EFFECTS

Medication for developmental disorders differs for each type of disorder. These are the most common ones and their side effects:

- Treatment of ADHD: Psychostimulant drugs are the most effective drug treatment. Methylphenidate and other amphetamine-like drugs are the psychostimulants most often prescribed. They have similar side effects but most children have no side effects except perhaps a decreased appetite.
  - Sleep disturbances (such as insomnia),
  - appetite suppression
  - depression, sadness, or anxiety,
  - headaches,
  - stomachaches,
  - elevated heart rate and blood pressure.

4. MEDICATION AND SIDE EFFECTS

DEVELOPMENTAL DISORDERS MEDICATION - SIDE EFFECTS II

- Autism spectrum disorders (ASDs): Drug therapy cannot change the underlying disorder, however some medication is sometimes effective to treat or reduce some ritualistic behaviors:

  - The selective serotonin reuptake inhibitors (SSRIs) are often effective in reducing ritualistic behaviors of people with an ASD. Its main side effects are:
    - blurry vision,
    - dizziness,
    - drowsiness or fatigue,
    - dry mouth,
    - feeling agitated or restless,
    - gaining weight,
    - headaches,
    - nausea,
    - sexual problems or erectile dysfunction,
    - sleep problems, an upset stomach

  - Antipsychotic drugs, may be used to reduce self-injurious behavior. Side effects:
    - Gaining weight and metabolic syndrome
    - Sexual dysfuction
    - Extrapyramidal effects

  - Mood stabilizers and psychostimulants may be helpful for people who are inattentive or impulsive or who have hyperactivity.
    - Shaking
    - Dry mouth
    - Frequent urination
    - Diarrhea
    - Gaining weight
    - Increased thirst
    - Loss appetite,
    - Kidney trouble
    - Lowered thyroid activity
    - Fatigue
    - Emotional numbness
    - Dull feeling

4. MEDICATION AND SIDE EFFECTS

SUBSTANCE ABUSE MEDICATION - SIDE EFFECTS

Medications are used to control drug cravings and relieve severe symptoms of withdrawal; nevertheless, treatment varies depending on substance and circumstances. Specific treatment depends on the drug being used, but it typically involves counseling and sometimes involves use of other drugs.

- **Cocaine abuse**: The principles of cocaine rehabilitation are similar to treatment of alcoholism or sedatives they use antianxiety medication and/or antidepressant:

  - Antianxiety medication. Side effects:
    - blurry vision,
    - dizziness,
    - drowsiness or fatigue,
    - dry mouth,
    - feeling agitated or restless,
    - gaining weight,
    - headaches,
    - nausea,
    - sexual problems or erectile dysfunction,
    - sleep problems, an upset stomach.

  - Antidepressant side effects
    - Nausea
    - Increased appetite, which causes increased weight
    - Sexual dysfunction
    - Fatigue
    - Drowsiness
    - Insomnia
    - Dry mouth
    - Blurred vision
    - Constipation
    - Dizziness
    - Agitation,
    - Anxiety
    - Uneasiness
    - And even genetic variations.

4. MEDICATION AND SIDE EFFECTS

SUBSTANCE ABUSE MEDICATION - SIDE EFFECTS

- **Opioids abuse**: The medicines used to treat opioid abuse and addictions are methadone, buprenorphine, and naltrexone:
    - Side effects of methadone can be:
        - headache,
        - weight gain,
        - stomach pain,
        - dry mouth,
        - sore tongue,
        - flushing,
        - difficulty urinating,
        - mood changes,
        - vision problems,
        - difficulty falling asleep or staying asleep.
    - Side effects of buprenorphine may be:
        - headache,
        - stomach pain,
        - constipation,
        - difficulty falling asleep or staying asleep,
        - mouth numbness or redness,
        - tongue pain,
        - blurred vision,
        - back pain.
    - Naltrexone side effects may include:
        - nausea,
        - vomiting,
        - stomach pain or cramping,
        - diarrhoea,
        - constipation,
        - loss of appetite,
        - headache,
        - dizziness,
        - anxiety,
        - nervousness,
        - irritability,
        - difficulty falling or staying asleep,
        - increased or decreased energy,
        - drowsiness, muscle or joint pain,
        - rash

4. MEDICATION AND SIDE EFFECTS

SUBSTANCE ABUSE MEDICATION - SIDE EFFECTS

- **Alcohol abuse**: A number of medications are recommended to treat alcohol misuse. These include:

  - Acamprosate: is used to help prevent a relapse in people who have successfully achieved abstinence from alcohol. Some side effects of acamprosate can be:
    - diarrhea,
    - gas,
    - upset stomach,
    - loss of appetite,
    - dry mouth,
    - dizziness,
    - itching,
    - weakness,
    - nausea,
    - anxiety,
    - difficulty falling asleep or staying asleep,
    - Sweating

  - Naltrexone: also use for opioids abuse (side effects already described)

  - Disulfiram: works by deterring from drinking by causing unpleasant physical reactions:
    - nausea,
    - chest pain,
    - vomiting,
    - Dizziness

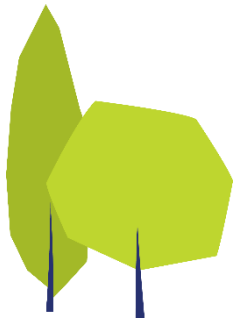
  - Nalmefene: can be used to prevent a relapse or limit the amount of alcohol someone drinks. It works by blocking opioid receptors in the body, which reduces cravings for alcohol.
    Side effects may include:
    - nausea,
    - vomiting,
    - tachycardia and hypertension.

UNIT 5: Patterns of Professional Interaction

UNIT 5: PATTERNS OF PROFESSIONAL INTERACTION

Learning objectives

- Identify the general principles of interaction with people with MHD
- Understand and practice using effective communication skills
- Identify the signs of crises and risk factors
- Learn patterns of intervention when crises occur and in specific situations
- Learn about the most common errors of professionals' reactions and the best attitude to take



5. INTERVENTION- GENERAL PRINCIPLES

Use effective communication skills

Promote respect and dignity

5. INTERVENTION- COMMUNICATION PATTERNS

NON VERBAL ASPECTS

Look directly at the face when we talk with another person.

Keep an appropriate tone or volume of voice.

Maintain the appropriate physical distance.

Accompany the message we convey with our words with gestures and a proper body posture.

Be careful about the moment and place we choose to talk about important issues (avoid public spaces with people, moments when you will not have enough time...).

5. INTERVENTION– COMMUNICATION PATTERNS

VERBAL ASPECTS (I)
First give the positive information, whatever has been done well.
Follow with the negative information with a positive approach.
Be specific: comment about the behaviour, not the person.
Avoid expressions such as “never”, “always” ...
Make questions, suggestions or requests, do not accuse or impose (make people get defensive and are useless to find solutions).
Raise concerns when they arise, not accumulate them.
Focus on the present and not bring problems from the past.
Express your satisfaction for things he/she has done and that do not dislike. A positive note has much more influence on the influence in the future conduct than criticism

5. INTERVENTION– COMMUNICATION PATTERNS

VERBAL ASPECTS (II)
Reinforce minimum attempts at dialogue initiative. Managing minor but enjoyable issues (sports, TV, recent events)
Accepting silences and lack of social initiative as part of the person's problem.
Graduate the level of demand.
Not hyper stimulate. Do not make many demands and simultaneous stimulation.
Talk in an open and honest way about the issues raised.
Be tolerant (mistakes, passive attitudes, limitations…).
Appreciate attempts to progress, encourage her/him to try again.
Talk about different issues than mental disorder, do not allow it to monopolize her/his life.

5. INTERVENTION– COMMUNICATION PATTERNS

ACTIVE LISTENING

Listening without being distracted

Listening and paying attention:

- Verbal messages (what is being said).
- Non-verbal messages (what is being said with body language, pauses, facial expressions etc.).

Allowing time:

- Don’t rush.
- Allow for silences.

5. INTERVENTION– COMMUNICATION PATTERNS

EMPATHY

Recognizes the feelings of another person and *communicates* understanding in verbal or non-verbal ways

Shows respect.

Provides emotional support to person

Builds rapport, encourages dialogue, builds relationship with the person

CRISES

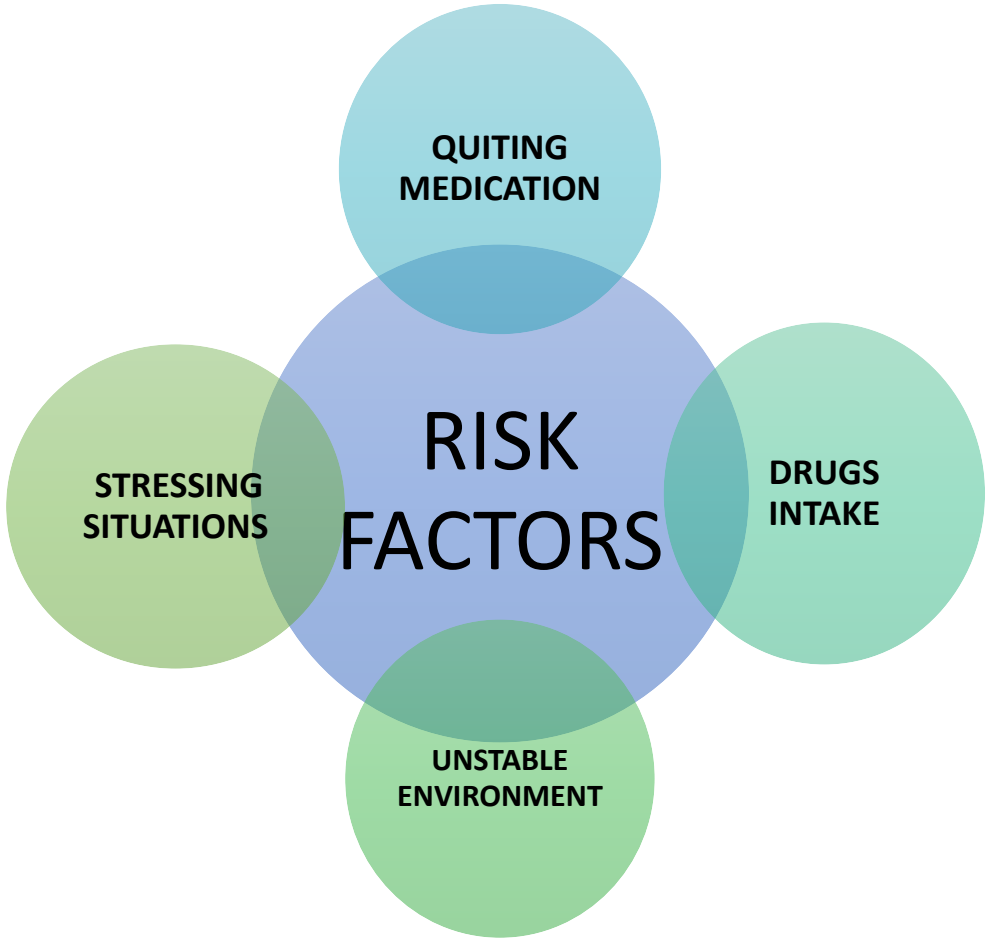
Mental disorders can evolve in the form of outbreaks: Periods of crisis - periods of normalcy or residual symptoms

Crises do not usually appear abruptly but from **INESPECTIVE SYMPTOMS (Prodromes)**: they are alarm signals that indicate that there is some problem

ALARM SIGNS

- Insomnia or inversion day/night rythm
- Social rejection, isolation, fear and distrust
- Absences in work or study center, avoiding going out.
- Incapacity to concentrate
- Alcohol and/or drugs abuse
- Eating in a messy way
- Deterioration of personal hygiene, strange dressing
- Irritability
- Hyper sensibility to stimulus (noises, light…)
- Exaggerated worrying about one concrete question
- Estrange behaviours
- Abstract, non logic conversation

3. CRISES: FACTORS



There are some risky situations associated to crises

It is **not possible** to determine with certainty the causes.

We can try to avoid the situations associated to crises.

If we detect any risky situation we should inform the family, the professional of reference (psychitrist, psicologist, nurse…), in order to prevent the crises.

5. CRISIS – WHAT TO DO? GENERAL PATTERNS

REDUCE DANGERS	Prevent physical damages of the person and of the people around
	Take measures to reduce destructive possibilities (remove objects).
PROVIDE SUPPORT AND CONTAINMENT	Make the person feels he/she is heard, accepted, understood and supported
	Try to accompany in reducing the intensity of emotions.
	Respond in a calm and controlled way..
	Use effective communication skills
	Promote respect and dignity

5. CRISIS – INTERVENTION ON SPECIFIC DIAGNOSIS

NERVOUS, AGITATED, UPSET	Keep physical distance
	Remove dangerous objects.
	Express our desire to help.
	Move and talk calmly.
	Take into account previous history episodes.
	Do not contradict her/him
	Do not react to your insults or threats

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

DEPRESSED	Adapt the relationship to his/her demand.
	Don't be too effusive at first
	Listen, do not force him/her to talk.
	Avoid focusing conversations on your mood (introduce other general topics)..
	Recognize her/his efforts and attempts to do things
	Propose activities without forcing you (motivating, easy and with short-term results)
	Do not hyperstimulate with many tasks

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

MANIAC	Be kind and open to dialogue but firm.
	Do not try to dominate, neither to argue with him/her
	Praise the right behaviors
	Indicate inappropriate behavior but not criticize excessively.
	Try to reduce the level of activity

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

DELIRIOUS

Do not speak out for or against your delusional ideas. Take them as possible (not as true).

Our interest must be directed to know your thoughts (not to censor them)

Do not try to dissuade or reason delirium

Show willingness, and accept his/her anxiety and worry. Make her/him perceive your interest in helping her/him

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

PSYCHOPATHOLOGICAL DECOMPENSATIONS	Early detection: prodromes
	Coordination with reference mental health services.
	Identify which person is the one from whom best accepts the proposals.
	Facilitate follow-ups with mental health services (consultations, taking medication ...)
	Give support in the management of economic resources, even temporarily.
	Review the programming of activities: distract the attention of the symptomatology but without overloading.
	Give emmotional support
	Increase supervision.
	Make norms and requirements more flexible.

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

AGRESSIONS

Early detection: prodromes

- Breaking limits: progressive: verbal-objects-people (low-high intensity):
- Empathize: active listening and partial agreement.
- Try to reassure him: decrease the tone of voice..

Protect users and professionals: taking them to another place if necessary.

Assess if it is necessary to manage an urgent assessment with the reference mental health professional

Use behavior modification techniques..

Be very clear that an aggression is serious, and that you have to assess the situation and the alternative solutions to implement (teach more appropriate ways of communicating, negative consequences ...).

Consequences from the part of professionals: verbal, tasks, apologize, buy what has been broken, expulsion for a period of time from the resource ...

If necessary call emergency service phone

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

SELF AGRESSIONS

If it were due to psychopathological decompensation: same measures as previous situation (agressions)

If the cause is depressed mood:

- They usually warn of suicide, sometimes saying goodbye to the closest people.
- When there have been previous attempts: it increases the probability that she/he will try again.
- The more planned the more dangerous act, but sometimes it is carried out equally. - Discussing her/his ideas with a professional can help her/him to find other solutions.

Guidelines for suicide risk:

- It should be accompanied as much as possible, or if the risk is high, do not leave him/her alone.
- Make him/her see that we can find solutions and that there may be other possible futures.
- Support him emotionally.
- Don't blame him for his suicidal ideas.
- If it is very serious: hospital admission

Professional secret: the professional is not obliged to keep it when there is a vital risk to the user or to third parties

Discuss the situation with your team

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

REFUSAL TO FOLLOW THE RULES, TAKE PART IN ACTIVITIES	It is an indicator of medium-term risk if it is not intervened.
	Recognize and assume limits: behavior modification:
	Strengthen the minimum progress of the person in the involvement with the different tasks..
	Involve the user from the beginning in his Intervention Plan (Responsibility).
	Explain to her/him why the different interventions are made..
	Start with the minimums and then gradually increase..

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

DRUGS/ ALCOHOL INTAKE	It carries a risk of crisis or relapse in the disease.
	It can be a stimulus for other users with a history of consumption to restart their behavior, or to start consumption for others.
	Performances: Limit interventions at the time it is under the effects of the substance.
	Promote the motivation of the person to reduce or abandon consumption, trying to become aware of the problem.).
	Provide internal and external control strategies (go to certain places and interact with people who facilitate consumption, money management ...).
	Do not punish him if he tells us: it is positive because it shows confidence in us
	Reinforce by commenting but not approve of consumer behavior.

5. CRISIS – INTERVENTION ON SPECIFIC SITUATIONS

REFUSAL TO MEDICATION

Risk of relapse if maintained over time.

If it is for a timely shot: respond to an emotional aspect: Remember the importance of following the pattern to be well.

Let some time pass and have another person offer the medication again.

He has to understand that the interest is for him not for the professional / family member.

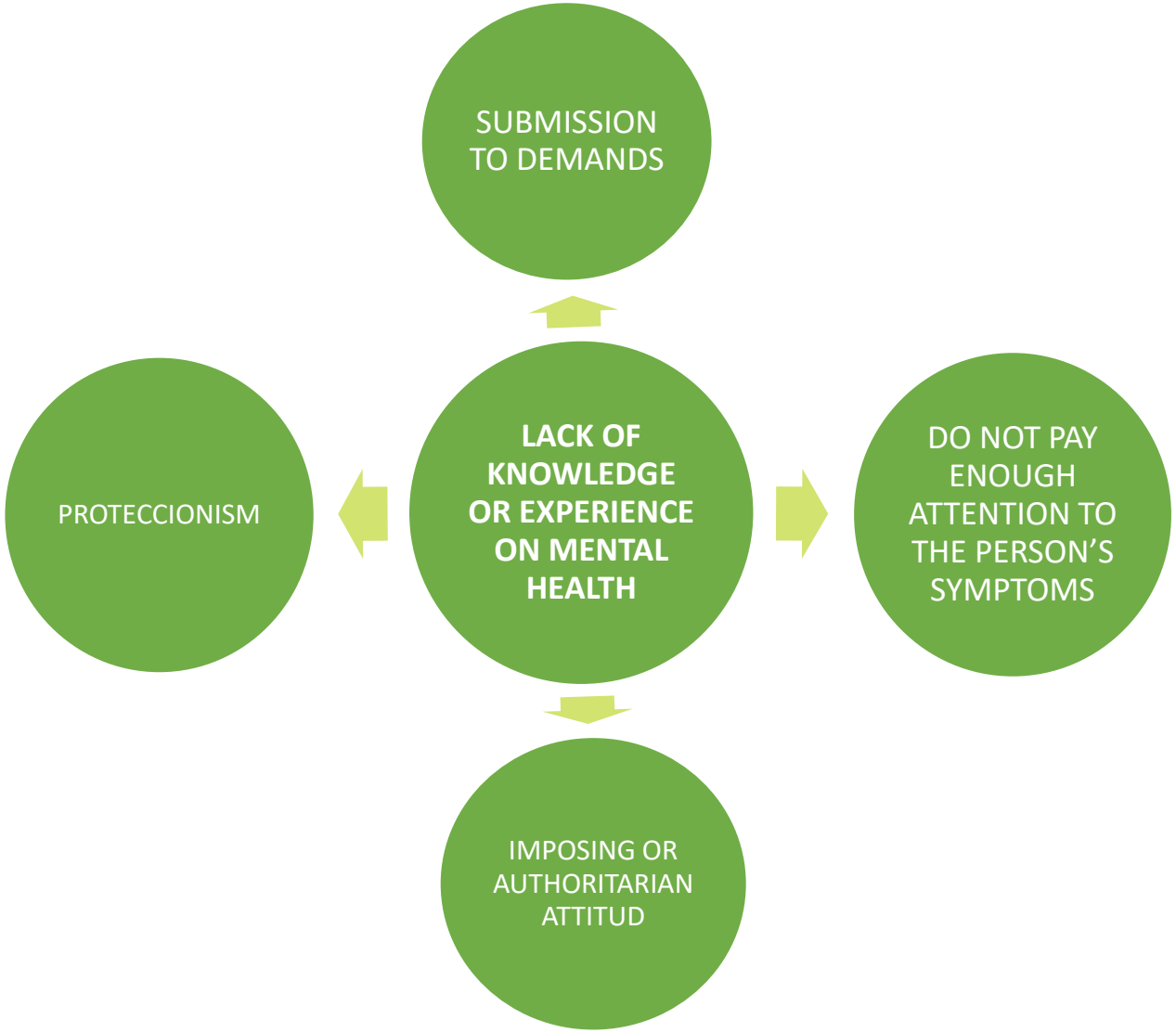
If the refusal to take the medication is continued: Inform the reference mental health professional

Raise awareness of the need to take medication.

Be consistent in the indications

Do not give her/him medication in a hidden way or without her/him consent

5. CRISES INTERVENTION:COMMON ERRORS OF PROFESSIONALS



PROFESSIONAL ATTITUDE TOWARDS CRISES AND MH IN GENERAL

- **Leave the person free, while still supporting him**: We reinforce their independence at the same time he/she feels supported.
- **Tolerate his/her routine** and his/her time to perform them: He/she needs his/her routines to feel secure and control over his/her life.
- Much of his/her attitude and behavior is due to the symptoms of his/her illness and not to conscious and intentional causes.
- **Do not blame yourself** if progress is not achieved. Try not to get frustrated. See what intervention is done and where you can intervene from another point of view. Consult with the work team.
- **Control your own impulses**: Anxiety is transmitted around, our attitude and behavior towards the user is a model. If we want them to be relaxed we must show ourselves relaxed.

“

UNIT 6: Self-care

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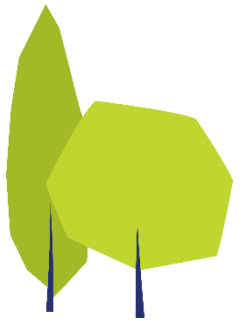
UNIT 5: SELF CARE

Learning objectives

- Understanding than working with people with MHD could be stressful and sometimes overwhelmed
- Understand the influence of biopsycosocial interventions by the own experience
- Learning and practicing different techniques of self-care.



6. SELF-CARE

- Working in with people with MHD can be highly rewarding and gratifying: by regularly making a significant positive impact in the lives of those with whom you work.
- But working in with people with MHD can also be emotionally demanding and challenging; could be a stressful job and at times everyone can feel overwhelmed and unable to cope.
- If we do not attend to our own functioning and wellness, we can be at risk of developing problems with our professional competence
- The best way to learn about the influence of psychosocial interventions is to try them on yourself as part of your own self-care.

6. SELF-CARE

Distress

- Despite its many rewards, working with people with MHD may cause us to experience feelings of distress.
- Distress is described as the subjective emotional reaction we each experience in response to the many stressors, challenges, and demands in our lives (Barnett, Johnston, & Hillard, 2006).
- Distress is a normal part of life and we each experience it, whether in response to working with difficult clients, coping with insurance paperwork requirements, caring for an ill loved one, experiencing financial concerns, and myriad other acute and chronic challenges and stressors in our lives. While distress is a normal part of life, distress left unchecked over time can lead to burnout.

6. SELF-CARE

Burnout

- Burnout, a term first coined by Freudenberger (1975), has three components:
    - Emotional exhaustion,
    - Depersonalization (loss of ones empathy, caring, and compassion), and
    - A decreased sense of accomplishment.
- Each of these components fall along a continuum and one may experience varying amounts of each at different times during one's career.
- While there is not a specific agreed upon point where one is classified as "burned out," it is vital that we each are self-aware and monitor ourselves for these signs of burnout. While of course, prevention is always best, when signs of burnout begin to develop it is hoped that we each will take a step back, reassess our current situation, and make the needed changes in our lives to help us get back on track.

6. SELF-CARE

SELF CARE

Practicing self-care will help you:

- **Identify and manage the general challenges** that all hard-working professionals face, such as the potential for stress and burnout or interpersonal difficulties.
- **Be aware of your own personal vulnerabilities**, such as the potential for retraumatization (if you have a trauma history), vicarious or secondary traumatization (if you work with individuals who report their own traumatic experiences), and compassion fatigue (which you can develop from a combination of burnout and vicarious traumatization).
- **Achieve more balance in your life**, by maintaining and enhancing the attention you pay to the different domains of your life in a way that makes sense to you.

6. SELF-CARE

SELF CARE

- Self-care is not simply about limiting or addressing professional stressors. It is also about **enhancing your overall well-being**. There are common aims to almost all self-care efforts:
  - Taking care of physical and psychological health
  - Managing and reducing stress
  - Honoring emotional and spiritual needs
  - Fostering and sustaining relationships
  - Achieving an equilibrium across one's personal, school, and work lives
- Each of us may differ in the domains we emphasize and the balance we seek among them.

6. SELF-CARE

- Self-care can involve so many different activities, it may include for example:
  - getting adequate sleep each night,
  - maintaining a healthy diet,
  - engaging in regular exercise,
  - spending time with family and friends,
  - participating in various forms of relaxation to include meditation or yoga,
  - attending to your spiritual and/or religious side,
  - playing with your pet,
  - engaging in artistic expression,
  - doing pleasure reading, and so much more.

- It also involves:

  Setting limits, saying 'no', maintaining healthy boundaries, and knowing your limits.

- Self-care also involves maintaining a **healthy balance** between various professional activities as well as between the professional and personal parts of our life.

6. SELF-CARE ASSESMENT

Kramen-Kahn (2002) suggests the following questions to determine ones current level of personal self-care.

- Do you….

1. appear competent and professional?
2. appear warm, caring, and accepting?
3. regularly seek case consultation with another professional while protecting confidentiality.
4. at the end of a stressful day, frequently utilize self-talk to put aside thoughts of clients?
5. maintain a balance between work, family and play?
6. nurture a strong support network of family and friends?
7. use healthy leisure activities as a way of helping yourself relax from work? If work is your whole world, watch out! You do not have a balanced life.
8. often feel renewed and energized by working with clients?
9. develop new interests in your professional work?
10. perceive clients' problems as interesting and look forward to working with clients?
11. maintain objectivity regarding clients' problems?
12. maintain good boundaries with clients, allowing them to take full responsibility for their actions while providing support for change?
13. maintain a sense of humor? You can laugh with your clients.
14. act in accordance with legal and ethical standards?

6. SELF-CARE ASSESMENT

ASSESS YOUR WARNING SIGNS

- ❑ I have disturbed sleep, eating, or concentration.
- ❑ I isolate myself from family, friends, and colleagues.
- ❑ I fail to take regularly scheduled breaks.
- ❑ I enjoy my work less than in the past.
- ❑ I find myself bored, disinterested, or easily irritated by clients.
- ❑ I have experienced recent life stressors such as illness, personal loss, relationship difficulties, financial problems, or legal trouble.
- ❑ I feel emotionally exhausted or drained after meeting with certain clients.
- ❑ I find myself thinking of being elsewhere when working with clients.
- ❑ I find my work less rewarding and gratifying than in the past.
- ❑ I am feeling depressed, anxious, or agitated frequently.
- ❑ I am enjoying life less than in the past.
- ❑ I find myself experiencing repeated headaches and other physical complaints.
- ❑ I sit staring into space for hours and can’t concentrate on my work.

6. SELF-CARE ASSESMENT

CHECKLIST FOR POSITIVE COPING BEHAVIORS

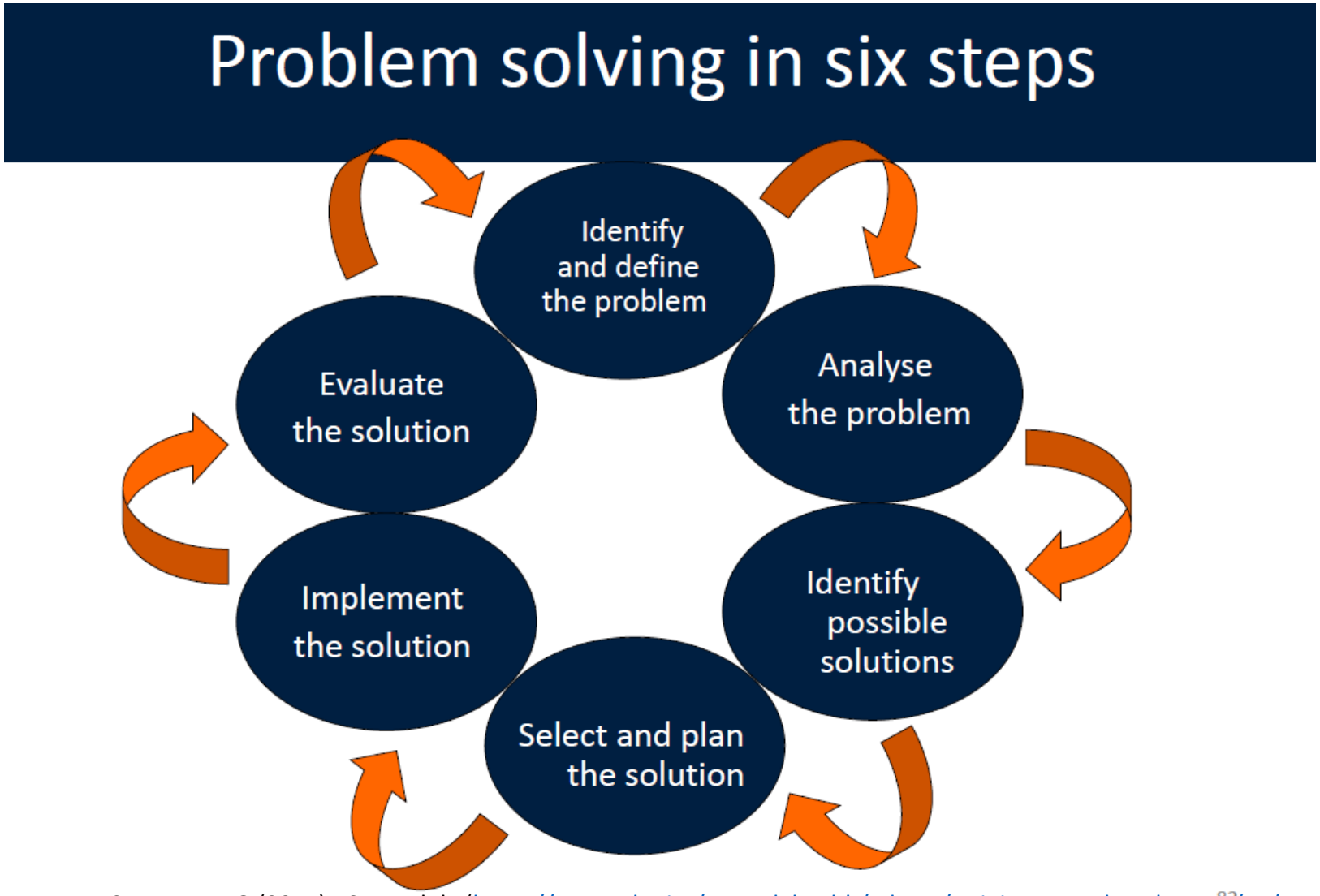
- ❑ I take regularly scheduled breaks.
- ❑ I take vacations periodically and *don't* bring work with me.
- ❑ I have friends, hobbies, and interests unrelated to work.
- ❑ I exercise regularly, have a healthy diet, and maintain and appropriate weight.
- ❑ I limit my work hours and caseload.
- ❑ I regularly participate in relaxing activities (e.g., meditation, yoga, reading, music).
- ❑ I regularly participate in activities that I enjoy and look forward to.

6. SELF-CARE

SELF CARE STRATEGIES

- ✓ Make adequate time for yourself. Schedule breaks throughout the day..
- ✓ Do things you enjoy. Engage in hobbies.
- ✓ Take care of yourself physically and spiritually.
- ✓ Take care of the relationships in your life.
- ✓ Say NO!
- ✓ Don’t isolate yourself.
- ✓ Keep in mind that self-care is a good thing and make time for self-care!
- ✓ Don’t try to be perfect, to have it all, or to do it all. Know your limits and be realistic.

6. SELF-CARE TECHNIQUES

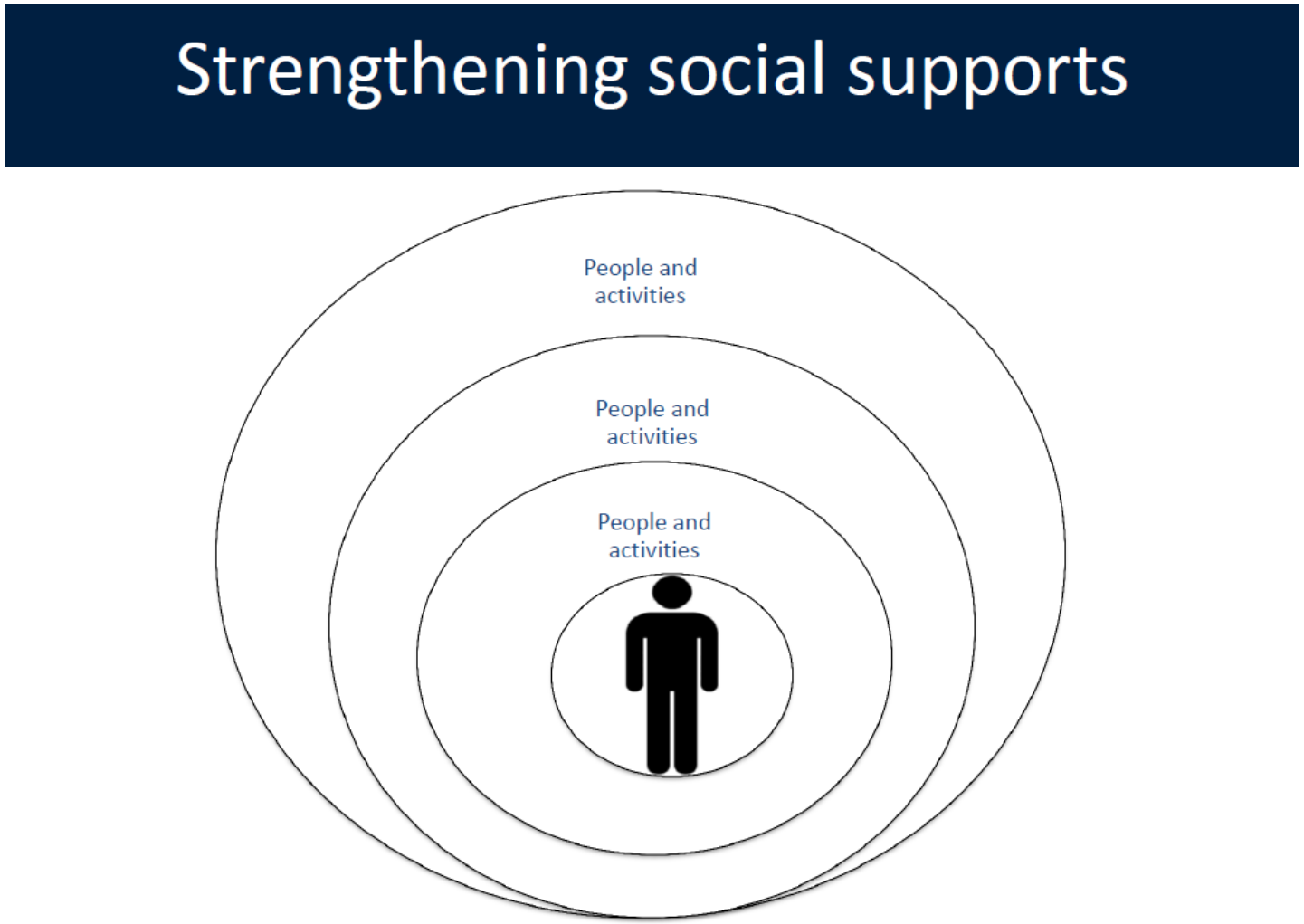


Source: WHO (2017) ECP module (https://www.who.int/mental_health/mhgap/trainingmanuals_tohp_ecp/en/

This is a technique for reducing psychosocial stressors

It cannot solve all problems instantly, especially if the psychosocial stressors are ongoing and/or complicated. It can help to alleviate and reduce some of the stress that a person is feeling

6. SELF-CARE TECHNIQUES



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Thanks for your attention!

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