Assignment

1. **Behavioral Assessment**
2. **Psychiatric Assessment**
3. **Common Mental Disorders (Depression, Anxiety)**
    a. **Mood Disorders**
    b. **Anxiety Disorders**
    c. **Depression**
4. **Severe Mental Disorders**
    a. **Psychotic episode**
    b. **Schizophrenia**
    c. **Bipolar disorder**
5. **Posttraumatic Stress disorder**
6. **Substance Abuse and Mental Disorders**
7. **Psychotherapy**
    a. **Psychological Interventions**
8. **Pharmacological Interventions**
    a. **Psychotropic Medications**
9. **Mental Health of Older People**
10. **Psychosocial Rehabilitation**
11. **Legal Issues for Treatment of Mental Disorder for Service Providers and Evaluators**

PSYCHIATRIC SOCIAL WORK

(Students)

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Introduction

This course is designed to introduce psychiatric social work to undergraduate students. The course examines factors important for social work practice in dealing with people with mental health problems. Emphasis is placed on the relationship between values, ethics, contemporary social work and social care practice in the mental health services. In mental health services, values and ethics are at the heart of culturally competent professional practice. This means that social workers will be able to value their own culture and be able to work in a sensitive manner with people who suffer mental problems.

As you go through your course work, you are likely to be living a multitude of roles and having to meet numerous requirements and expectations as stipulated in the university regulations. These could include working to supplement your class lectures; reading assignments; attending classes; balancing personal life with college (SSW) demands; submitting assignments, taking exams and much more.

As you will know later the contents of the course, they reflect more of the western concepts and practice than of Ethiopia. In this regard, many of the western concepts are interpreted and modified to fit into the Ethiopian contexts. To help you to understand your own level of knowledge, understanding and skills, and to help you to identify any deficit in these areas, the course is designed to have the following **objectives:**

1 Prepare for and work with individuals, families, groups and communities to assess their needs and circumstances for health care services

2 Plan, carry out, review and evaluate social work practice in mental health services.

Course Content

1. The objectives of the course

1.1. Concerns about Mental Healt

Lecture I

Mental health is a significant area of community health service. Mental health problems are among the most important contributors to the burden of disease and disability worldwide. There is growing evidence of the global impact of mental illness. **Five of the 10 leading** causes of disability worldwide are mental health problems. They are as relevant in low-income countries as they are in rich ones, cutting across age, gender and social strata. Furthermore, all predictions indicate that the future will see a dramatic increase in mental health problems.

- The impact of mental health problems in the family or the workplace has serious consequences not only for the individual but also for the productivity of the family or the enterprise. Family quality of life, employee performance, rates of illness, absenteeism, accidents and staff turnover is all affected by the individual employees' mental health status.
- In the United Kingdom, for example, 80 million days are lost every year due to mental illnesses, costing employers £1-2 billion each year.
- In the United States, estimates for national spending on depression alone are US$ 30-40 billion, with an estimated 200 million days lost from work each year.

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means that community health workers will be able to value their own culture and be able to work in a sensitive manner with people who suffer mental problems.

Concerns about Mental Health

Why should we be concerned about mental illness?

There are many reasons why we need to be concerned about mental illnesses.

- *Because they affect us all*. It is estimated that one in five of all adults will experience a mental health problem in their lifetime. This shows how common mental health problems are. Anyone can suffer a mental health problem at some time in their life unless precaution is taken. Hence, *mental illness is common.* According to World Health Organization 2005), mental ill health affects every fourth citizen and can lead to suicide, a cause of too many deaths. WHO view that by 2020 depression will be the highest ranking cause of disease in the developed world (WHO, 2001).
- *Because they are a major public health burden.* Mental ill health causes significant losses and burdens to the economic, social, educational as well as criminal and justice systems. Studies from nearly every corner of the world show that as much as 40% of all adults attending general health care services are suffering from some kind of mental illness. Many of the people attending general or community health services seek help for vague physical health problems, which may be called 'psychosomatic' or something similar. Many of them are actually suffering from a mental health problem. Other statistics include the statement that: Currently, in the EU, some 58000 citizens die from suicide every year, more than from the annual deaths from road accidents, homicide or HIV/AIDS.
- *Because they are very disabling*. Even though the popular belief is that mental illnesses are less serious than physical illness, they do in fact produce severe disability. They can also cause death, as a result of suicide and accidents. Some people suffer from a mental illness and a physical illness; in such persons the mental illness can make the outcome of the physical illness worse. The World Health Report from the World Health Organization in 2001 found that four out of the ten most disabling conditions in the world were mental illnesses. Depression was the most disabling disorder, ahead of anemia, malaria and all other health problems.

- *Because mental health services are very inadequate.* There is a severe shortage of psychiatrists, psychologists and other mental health professionals in Ethiopia and most countries in the world. These specialists spend most of their time caring for people who suffer from severe mental disorders ('psychoses'). These are quite rare, but are also involved in the treatment of the very diseases that the community associates with mental illness. Most people with the much commoner types of mental health problems, such as depression or alcohol problems, would not consult a mental health specialist. General health workers are ideally placed to treat these illnesses.
- *Because our societies are rapidly changing*. Like many societies around the world, the Ethiopian society is also facing dramatic socio-economic and political changes. The social fabric of the community is changing as a result of globalization, rapid rural-urban developments and growth, migration, widening income inequality, and rising levels of work demands and requirements, inaccessibility to educational and mental health services, high unemployment rates. These factors are all linked to poor mental health.
  - *Because mental illness leads to stigma*. Stigmatization, discrimination and non-respect for the human rights and the dignity of mentally ill and disabled people still exist, challenging core values. Most people with a mental health problem would never admit to it. Those with a mental illness are often discriminated against by the community and their family. They are often not treated sympathetically by health workers.
  - *Because mental illness can be treated with simple, relatively inexpensive methods*. It is true that many mental illnesses cannot be 'cured'. However, many physical illnesses, such as cancers, diabetes, high blood pressure and rheumatoid arthritis, are also not curable. Yet, much can be done to improve the quality of life of those who suffer these conditions and the same applies to mental illness.

1.1. Terminology

There are different terms currently used to describe the same thing. For instance:

- ***Mental disorder*** is a broad term that covers any significant departure from a state of 'normal' health and includes diseases and illness. These include severe forms like schizophrenia and manic depression. Mental disorder implies that a state of 'normality' once existed and therefore offers the chance to work with the person to restore them to that state, and is usually a temporary condition.
- ***Mental illness*** is "any illness experienced by a person which affects their emotions, thoughts or behavior, which is out of keeping with their cultural beliefs and personality, and is producing a negative effect on their lives or the lives of their families".

In this aspect, mental ill health includes mental health problems and strain, impaired functioning associated with distress, symptoms, and diagnosable mental health disorders, such as schizophrenia and depression.

- For most people, mental illness is thought of as an illness associated with severe behavioral disturbances such as violence, agitation and being sexually inappropriate. Such disturbances are usually associated with severe mental disorders. However, the vast majority of those with a mental illness behaves and looks no different from anyone else. These common mental health problems include depression, anxiety, sexual problems and addiction.

- ***Mental health*** is a difficult term to be categorical about as it is far more than the absence of illness. Mental illness includes a broad range of health problems. People can have mental health problems, which are 'problems of everyday life' which just have to be got on with. The World Health Organization (WHO) describes mental health as:

> *a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*

1.2. Mental Health Professionals

There are various types of mental health specialist:

• ***Psychiatrists*** are medical doctors who, after completing basic medical training, have specialized in the treatment of mental disorders. In many countries, the majority of psychiatrists are almost entirely based in hospitals. These may be general hospitals with a psychiatric ward or a hospital specializing in mental health problems. Psychiatrists' main skills are in the diagnosis and treatment of severe mental disorders. They mainly use medicines and a variable amount of 'talking' treatments.

• ***Psychologists*** are trained in treating mental health problems using theories based on how human beings learn about life, feel emotions and behave towards others. Psychologists use only 'talking' treatments.

• ***Psychiatric nurses*** are nurses who have specialized in psychiatry. They may work either in hospitals or in the community. Their main roles are in providing talking treatments and the treatment and rehabilitation of people with severe mental disorders.

• ***Psychiatric social workers*** tend to work either in hospitals or in the community and deal with social problems and life difficulties faced by people with a mental illness. Both social workers and nurses can provide taking treatments.

1.3. Personal Qualities of Mental Health Professional

To become competent requires empathy, understanding and acceptance of differences in addition to theoretical knowledge, skills and values individuals acquire their social and academic progress in their lives. Additionally, anyone who enters this profession should have a disposition to be emotionally and psychologically matured. To that aspect, they must be able first to promote their own mental health in order to be able later to help others to be healthy and productive in their lives. This suggests that those who are in the field should acquire bot the skills and knowledge necessary to w ork with a range of clients in various settings. As a consequence, they need to:

- prepare for and work with individuals, families, groups and communities to assess their needs and circumstances for health care services, and
- plan, carry out, review and evaluate social work practice in mental health services.

1.4. The Foundations of Good Knowledge

Lecture Two

The Concept of Health and Mental Health Social Work

Defining Mental Health and Mental Illness

Health in its broadest sense includes physical and mental health.

- Broad conception of health, but in reality the focus is mainly on physical health. Why?
  - many social workers do not understand much about mental health and thus become less comfortable dealing with mental health problems.
  - various types of mental illnesses require different expertise (mental illnesses occurs in children, in the elderly and in mothers).

Hence the need for improvements in these areas is high to promote healthy society. This need could be met only when a broad range of institutions, health professionals, social care professionals, research communities and service users within society is stimulated and engaged in developing strategies about how best to improve public mental health and work accordingly.

- Clearly, the need for various strategies and practice models is *sin quo non* to focus upon prevention of mental ill health, the improvement of the quality of life for people with mental health and the development of a mental health information and research system for the country. Moreover, the mental condition of people is determined by a multiplicity of factors including biological, individual, family and social, economic and environmental.
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As a result, mental health is no longer a subject for the specialists; in fact, it is a basic aspect of care for any health worker in any community. It is essential that, just as with physical illnesses, the health worker is well informed about mental illnesses.

What constitutes mental health? What constitutes mental health is difficult to define. Most attempts at definition appear to group around three elements:

1. *The idea of the mature self* – the sort of people we are. Mentally healthy people will be satisfied with and enjoying their lives. They will have a positive self-image but be realistically aware and accepting of their limitations.
    - Their self-identity will be linked to an underlying philosophy or value system which forms the basis of their integrity and their internalized standards for behavior.
    - They will have a capacity to learn and develop factors worthwhile in themselves and necessary if they are to maintain their mental health as their life circumstances change.
        - A person with a healthy mind should be able to think clearly, should be able to solve the various problems faced in life, should enjoy good relations with friends, colleagues at work and family, and should feel spiritually at ease and bring happiness to others in the community. It is these aspects of health that can be considered as mental health.
        - Even though we talk about the mind and body as if they were separate, in reality they are like two sides of the same coin. They share a great deal with each other, but present a different face to the world around us. If one of the two is affected in any way, then the other will almost certainly also be affected. Just because we think about the mind and body separately, it does not mean that they are independent of each other. Just as the physical body can fall ill, so too can the mind. This can be called mental illness.

2. *Self-management in social relations* – Some literature suggests that our most important capacity is the ability to make and sustain intimate relationships. The number and nature of such relationships may not be specified, but the inference

is that close relations with one's parents, one's children and at least one friend are very significant.

- The epitome of a healthy capacity to relate would appear to be a successful marriage or cohabitation: an ongoing relationship with a member of the opposite sex which includes physical intimacy.
- With this ability to make and sustain intimate relationships is the notion of the ability to retain one's autonomy: the 'one flesh, separate persons' concept. Despite the intimacy, the partner is not essential for survival. This idea of autonomy links to another, of being in control of oneself and one's circumstances.
- A mentally healthy person is not at the mercy of their inner needs, desires or feelings but can control, express and direct them in a socially constructive way.
- Nor are they at the mercy of other people: they can resist emotional demands, pressures and manipulations without either meekly submitting or angrily rejecting.
- They can tolerate frustration and postpone gratification as necessary. They can read and respond to social situations with realism and appropriateness; exercise choice and make decisions with objectivity and a greater chance of a successful outcome. Even when engaged in 'non-intimate' relations of the day-to-day kind, they will interact with interest, sensitivity and receptivity to others' messages, conscious of what they are communicating, aware of its effects and modifying matters where this is called for.

2. *The discharge of social roles*, whether these relate to home-based life within family, kinship and neighborhood groups, to work related functions, or to recreation/interest activities.
    - To discharge any social role involves a realistic understanding of what general social expectations accrue around that particular role as well as the more particularized ideas of one's immediate social groups. Effective role performance will depend on one's capacity to meet the obligations of that role, together with the ability to adjust that performance, since many roles, such as parent, are developing, not static.
    - Other role performances may have unexpected challenges thrown up within them, from new technology at work to a friend becoming seriously ill, which demand adjustment. Adjustment is to be distinguished from conformity.
    - Mentally healthy people will be able to choose whether they conform. They have the capacity to evaluate and weigh the social and personal consequences of conforming or not.

- Most societies and groups will tolerate, in varying degrees, some flexibility in the way roles are executed; but there can be times when individuals are faced with painful, even dangerous choices.

- The discharge of social roles will call for qualities such as a sense of responsibility and a reasonable self-reliance, but will also require the associated technical and social skills.
    - Modern living is making increased demands in technical terms (domestic appliances, computers, cars, form-filling and so on) and in the social sphere (negotiating with bank managers, resisting sales pressures, holidaying abroad, meeting neighbors from different ethnic backgrounds and so on).

- These represent routine demands: the literature goes on to suggest that the really mentally healthy will also be able to cope with emergencies. They will need problem solving skills, the ability to handle crises and manage stress, to recognize where to find help when it is needed and a willingness to use it.
- Mentally healthy people will make a success of their lives and this will reinforce their competence, self-image and satisfaction. They will have achieved success by approved social processes since means as well as ends are significant. Acquiring wealth is one thing if you earn it, quite another if you steal it.

Models of mental illness **Determine Which Academic Disciplines Study and Learn about People with** mental illness

- In the past, mental illness was thought to be solely a medical and biological phenomenon, and therefore only medical schools taught about mental illness. Because mental illness was not viewed as a social concern or responsibility, few mental health issues were taught in the social sciences, such as psychology, sociology, or social work. Therefore, professionals graduated unaware, or falsely assuming, that they would not provide services for people with mental illness.

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Models of mental illness **Shape the Self-Identity of People With** mental illness

- Models provide labels, diagnoses, and theories of causation and responsibility, all based upon (seemingly) authoritative and prestigious sources. These beliefs are widely held, strongly believed, and constantly

socially reinforced. Because these beliefs are pervasive and widespread, many professionals in the field have adopted these beliefs as self-identifiers.

- Simply because they have heard these stereotypes so often and also because people with mental illness frequently lack role models after recovery, society accepts the stereotypes as truth about people with mental illness. Society, therefore, has effectively taught many people to feel individuals with mental illness inferior and dangerous.

Models of mental illness Can Cause Prejudice and Discrimination

- Models of mental illness are not harmless abstractions or theories (they are abstractions and theories, but they are not harmless).
  - Rather, models of mental illness guide public attitudes, shape legislation, determine the services provided, and influence the training of professionals, all of which can create prejudice and discrimination.
  - In addition, models of mental illness have a significant impact on how (or if) people with mental illness are portrayed in the mass media.
  - With a normative emphasis, mental illness is thought to be insane or deviance from a valued norm or standard. If a model of mental illness has a normative element, prejudice, discrimination, marginalization, and reduced opportunity will result.

It is known that mental illness is a complex area of study both in its definition and in its classification. It is still a challenge discussing whether it is possible to define mental illness as 'abnormal behavior'. The difficulties in defining what 'normal' and 'abnormal' behavior is mean that it is incorrect to categorically state that 'mental illness is nothing other than abnormal behavior'.

"Normality vs Abnormality"

Powerful people judge "normality" and then strive to achieve conformity through various interventions.

- the normalizing judgement 'hierarchizes in terms of value the abilities, the level, the "nature" of individuals'.
    - Thus, a normalizing judgement is a value judgement.
    - Classifications utilize stigmatizing or non-stigmatizing language.
- The normalizing judgement is an instrument of power wherein the actions, participation, indeed value of each individual are assessed, measured and compared.

JUDGING "NORMALITY": THE EXERCISE OF POWER

One of the most powerful tools wielded by the dominant group in a society is the power to define people. '

- Powerful people, most often those with high status, defined the mentally ill person experience and developed the mechanisms with which to respond. For example, much of the legal disenfranchisement and marginalization of people with psychiatry disabilities have been legalized and enforced by adherence to and belief in the biomedical model of mental illness, although the general public often assumes that clinical definitions are neutral. Nonetheless, all the models of mental illness are neither reality nor objective.

- Those with the most power are able to wield that power by imposing inferiorizing and invalidating labels on those with less power'.
    - Despite being scientifically erroneous, 'once invalidating labels are imposed, dominant authorities can justify injustice'.
- Within rehabilitation, those who wield power – doctors, nurses, therapists – are socially privileged to judge the ways in which people deviate from valued cultural norms.
    - Indeed, the process of defining "normality" and "abnormality" is inevitably a process by which the powerful define the powerless.

E.g., disabled people do 'not get to decide what is "normal" nor even who is to decide what is "normal"', rather, medical "experts" are empowered to judge the people they define as abnormal, deviant or impaired.

- The ICF accords "experts" the authority to identify "normality", draw a distinction between the "normal" and the "abnormal" and assess the desirability of certain forms of performance.
- Non-impaired "normality" is the yardstick against which disabled people are measured.
- Advocates of systems that classify (other) people contend that they possess the expertise to judge the normal and the abnormal, the valued and the deviant, and that they have the right to do so. Clearly, they also hold the power to do so.

- Implicit within this exercise of power is the assessment of the 'expectations for usual functioning in physical, psychological and social terms' and the 'reasons' for any failures to achieve levels of performance deemed to be normal
- .Although it is recognized that an individual's assessment of his or her situation is unavoidably 'subjective', it is less commonly acknowledged that assessments undertaken by "experts" are also subjective: '"objectivity" is not bestowed upon a measure merely because another person makes it'.
- Noting that the process of designating norms is inevitably value-laden and subjective, many argue that: 'Claims to scientific objectivity through engaging expert practitioners to establish "anchor points" (i.e. of "normality") [are] somewhat spurious'.
  - Every assessment reflects the values of those undertaking the assessment. This is not a politically neutral enterprise, rather,

'power is veiled by a rhetoric of neutrality that creates the illusion of meritocracy'.

- Some contend that psychologists have contributed to the oppression of minority populations through their use of various classificatory tools.
    - 'Disabled people, women, ethnic minority groups, lesbian women, gay men and low-income groups have all found themselves brutalized by psychological discourse . . . This has been achieved through, among other tactics, the construction and use of tools such as Intelligence Quotient (IQ) tests and the mental health Diagnostic Statistical Manual (DSM).
        - Both are riddled with disabilist, racist, sexist, homophobic and middle-class ideologies'.

- Although classificatory tools might appear to be objective, neutral and scientific, critics contend that this is an illusion that masks the specific values and ideologies that support the status quo.
    - For example, breaking the taboos of culturally accepted behavior constitutes a deviation from the norm, but the manner in which this is classified is subject to class bias: 'if you are poor, then you are a misfit. If you are rich, then you are an eccentric'.
    - In nineteenth century America a category of dementia known as 'drapetomania' was identified among those slaves who demonstrated an uncontrollable urge to escape from slavery.
    - This provides further evidence of the social power underlying the designation of social norms; and the collusion between the classificatory practices of the medical professions and the sociopolitical status quo.

- Disability theorists contest the power of "experts" to reserve for themselves the privilege of classifying other people and challenge the suggestion that every problem experienced by those deemed 'different' should be blamed on their differences.
- They also reject the premise that impairment is the sole determining force in disabled people's lives or that an impairment is more salient than other dimensions of identity such as social role or economic status: a "master" status . Importantly, they contest those rehabilitation practices that strive to norm the non-standard.

STRIVING FOR NORMALITY

- Rehabilitation enforces 'a version of normalcy that pressures disabled persons to fit in by appearing and functioning as much like non-disabled persons as possible'.
- The ideology of normality has tended to be accepted uncritically by rehabilitation professionals).
- Indeed, the rehabilitation professions have created their own norms; for example, "normal" posture, "normal" gait, "normal" handwriting.
- Each rehabilitation profession 'must foster society's ongoing acceptance of its norms [e.g. "normal" gait, "normal" speech] in order to perpetuate its viability and gain access to new economic niches'. Thus the ideology of normality serves to reinforce professional power.

Once norms have been established, these easily become the goals towards which everyone 'ought' to aspire and strive. Indeed, the actions of therapists are said to be 'implicitly designed to make individuals more "normal"'.

- From their experiences as rehabilitation clients, disabled people have criticized the emphasis that is placed on efforts to appear "normal",

claiming that pursuit of this particular ideology is often undertaken at the expense of function, comfort or expediency.

- They argue that the goal of "normality" reflects dominant standards and values of ableist societies and might not be in the best interest of disabled people. (Ableism refers to social practices that assume and privilege [physical] ability.)
- It is noted that repeated and often painful medical and surgical procedures are frequently undertaken solely with the goal of making an individual appear more "normal".
- Tara, for example, complained that she and other disabled children: 'were told that we must be as "normal" as possible'.
- Indeed, disability scholars contend that the pressure placed on disabled children to strive for "normality" and conformity could constitute serious abuse.
- Although disabled people are encouraged in Western cultures to strive for 'functional improvement' through rigorous physiotherapy, critics suggest this might be to achieve physiotherapy's normalizing goals rather than its supposed therapeutic ones: an effort to induce conformity rather than enhance function.
- The rehabilitation enterprise can be seen as reinforcing social control and maintaining social norms: 'therapy aims to eliminate clients' characteristics and traits that threaten the legitimacy of mainstream values, ideals, practices and rules'.
- Thus, rehabilitation is a political practice. It should not be surprising that disability theorists contend that "normality" is 'the illusion at the heart of the oppression of disabled people'.

REHABILITATION, IDEOLOGY AND POWER

- An ideology is a system of ideas, beliefs and assumptions that operates below one's level of conscious awareness; thus an ideology constitutes 'the ideas and prejudices that are contained in what appear to be the basic assumptions of normal life'.
- It has been contended that 'the ideas we blithely accept may often be, in fact, political ideas only masquerading as facts about the world', and indeed, ideologies play an important role in reinforcing and exercising power.
- Many of the critics have alluded to the ideological underpinnings of the WHO's enterprises and the ways in which systems of classification are employed to reinforce specific relations of power.
    - Rehabilitation therapists are not accustomed to thinking about their location within axes of power, having been socialized to view themselves as 'powerless' (relative to the dominant medical profession).
    - Neither are they accustomed to thinking about their values and assumptions in terms of 'ideologies', having been absorbed into a professional culture where these ideas and beliefs are made to appear not only 'natural' and self-evident but benevolent and beneficial.
    - Social theorists explain that this precisely characterizes a dominant ideology: an ideology that is taken for granted, that appears to be a 'natural' way of thinking and that operates by legitimizing social inequalities and power relations.
    - Dominant ideologies establish what is "normal" (and therefore what is "abnormal") and define cultural values.
    - However, because 'ideas do not descend fully formed from the heavens, but are always social products', all ideas and beliefs require critical scrutiny.

- The ideology of normality is regarded by some critics as the foundation of rehabilitation.
    - The primary aim of rehabilitation, it is argued, is to restore a disabled person to "normality" (whatever normality is understood to mean within a given social and cultural environment); and failing this, to restore the person to a state that is as close to "normality" as possible.
    - In pursuit of this objective, 'surgical intervention and physical rehabilitation, whatever its cost in terms of the pain and suffering of disabled individuals, is always justified and justifiable'.
    - Because "norms" reflect specific ideals of function and behavior, there is a relationship between the demands of social conformity and those of rehabilitation.

It is clear that the rehabilitation professions must challenge the ideology of normality and acknowledge that this is a social construction and not a factual reality.

- rehabilitation supports the status quo and reproduces many of the values of ableism in that professionals shape the meaning of impairments around purely medical concerns with the objective of achieving social conformity and deflecting attention away from questions of power and status.
- The critiques suggest that the ideology of normality, the practice of classifying people, the hierarchical power relations between those who classify and those who are classified, and the justification for resource allocation based on constructions of superiority and inferiority cannot be unexamined.

- It has been argued that classifying people on the basis of perceived deviancy is a social practice that involves the unequal exercise of power and that this has major economic, social, and psychological consequences for some people's lives.
- Rehabilitation professionals cannot, unthinkingly, collude in the institutionalized discrimination of disabled people.
- As rehabilitation therapists, we are part of the social structure that identifies ab-normality and perpetuates inequality; we are not neutral players.
- 'to understand how the power of definition is exercised and experienced, we have to ask who does the defining in practice, for what purposes and with what consequences for those who are deemed to fit the definitions'.
    - Positive intentions do not guarantee positive outcomes. Instead of classifying deviations from assumed norms in every dimension of human activity and participation it might be more fruitful to ascertain how people who have illnesses, injuries and impairments manage their everyday lives in a world designed to meet the needs of "normals".
    - It has been argued that rehabilitation is grounded in an ideology of normality and attempts to "norm" non-standard performance and behaviour. (Indeed, to be "normal" is to conform to what is usual or standard).
    - Far from being a benevolent and scientific enterprise, the pursuit of "normality" was seen to be the pursuit of a human invention, culturally specific and value laden: an ideology with oppressive consequences for those who do not conform to its standards.
    - It has been proposed that all theory should be judged on the grounds of its political usefulness:

- that theories should be evaluated not in terms of their utility, but of their consequences. The consequences of being classified as deviant to an assumed norm should be explored.

CLASSIFICATORY PRACTICES

Critics contend that societal practices that divide certain categories of people from others – e.g. by ability, religion or ethnicity – contribute to marginalization by establishing value: superiority and inferiority.

- They argue that marginalization results from classificatory systems whereby certain sorts of people are not only compared and categorized, but hierarchized, separated, excluded and institutionalized.
- Classificatory practices are those techniques that enable the separation of the normal from the deviant.
- Classification is seen as integral to the practice of marginalizing those believed to deviate from the "norm".
- Systems of classification that are based on bodily traits – ability, color, gender – are perceived to promote and support the exclusion of certain people from 'the continuum of acceptable human variations'.
- Indeed, it has been argued that 'the real function of classification systems' is to 'oppress the people they define . . . First, they imply we are inferior. Second, they allow the dominant culture to institutionalize those of us they consider outcasts and misfits'.
- Critics contend that such taxonomies have always been oppressive tools of power, used to justify abhorrent social practices such as apartheid, slavery and the institutionalization of disabled people
    - In apartheid South Africa, for example, the ways in which people were classified determined the 'rights' to which they were entitled. Rather than insisting on the rights of all disabled people, South

African therapists '(silently) accepted, and thus maintained, the status quo'.

- It was only at the Truth and Reconciliation hearings that the privileged, White health and social care professionals were forced to review their own complicity in the marginalization of the Black majority.
- Healthcare professionals are not neutral players but active participants in enforcing specific political practices, for example through classificatory practices that are used to enable and justify the separation of the "normal" from the deviant.

DECONSTRUCTING DUALISM

The practice of dividing the world into binary opposites – normal and abnormal, 'us' and 'them' – has characterized Western thought since at least the time of Plato. Plato proposed, for example, the dualistic concepts of heaven and earth, body and soul, permanence and change.

- The dualistic concepts of mind and body that were further developed by Descartes became central to the ideology underpinning Western medicine.
- Dualistic thinking is specific to Western philosophy and does not represent a universal "truth".
- Eastern philosophies such as Buddhism and Taoism have long and intellectually rigorous histories centred not on compartmentalism but on the interconnectedness and 'oneness' of all life.
- The Tai Chi T'u – the familiar black and white double 'fish' symbol – that represents yin and yang, for example, contains an 'eye' or seed of its other, indicating the interplay and fluidity of apparent opposites. Recent work by Western 'queer' theorists seeks to deconstruct dualistic 'thinking

as usual', contesting the tendency to divide people into either/or categories such as straight/gay, white/black, man/woman, able/disabled.

- 'binary oppositions between straight and gay, disabled and non-disabled are inaccurate and oppressive ideologies, which obscure the continuities of disability and sexuality'.
- Queer theory explores the ideological construction and presumed naturalness of "the norm", the processes by which certain people become labelled as deviant and demonstrates the instability of binary oppositions, such as homosexual/heterosexual or male/female.
- These issues are also central to the intellectual interrogation of disability. Formerly a term of homophobic abuse, 'queer' has been redeployed as an umbrella term for a spectrum of culturally marginal sexual self-identifications. Queer theory is an interdisciplinary school of thought that interrogates the kaleidoscope of human sex, gender and desire and critiques and destabilizes heteronormativity.
- Transvestites, bisexuals and other sex rebels illustrate the diverse spectrum of identity and desire that precludes dualistic divisions of the global population into simple categories of straight/gay. Further, transsexuals, transgendered people, intersexuals (formerly termed 'hermaphrodites') and other gender benders demonstrate that the categories 'male' and 'female' lack rigid boundaries, thereby challenging the belief that the world can be neatly divided into two sexes.

- Two of the models of mental illness consider the absence of mental illness to be the desired state and, conversely, view the presence of a mental illness as undesirable deviance.
    - Indeed, the search for the origins of prejudicial attitudes leads back to societal or cultural practice. Further, much of the prejudice and discrimination may not appear (to those without mental illness) to be prejudicial or unwarranted, simply because these models of

mental illness have had long histories, and two of these models have the support, authority, and prestige of the established disciplines of science (biology and economics).

RESULTS OF MODELS

- After revising the basic components and functions of models of mental illness, two issues should become apparent:
  - First, models of mental illness, although abstractions, result in the daily, lived experience of people of mental illness. The services people with mental illness receive, their social integration—indeed, all aspects of the lives of people with mental illness—are influenced by the model(s) of rehabilitation one accepts.
  - Second, both the experience of having a mental illness and the experience of responding to people with mental illness are not wholly biological in nature, but are also social and cultural constructions. Examining the ways in which we describe and understand the world around us, including the people in it, is important. Occasionally, our understandings can be flawed or incomplete. Nonetheless, it is essential to be clear about the model of rehabilitation in use, including its shortcomings; therefore, we now briefly review the three main models of rehabilitation (biomedical, economic, and sociopolitical).

- Mental health professionals have posited other models of rehabilitation, but the three presented here are considered to be the most common. Also, these models are occasionally labeled differently; for example, the biomedical model is also termed the ***disease model***, the economic model is sometimes referred to as the ***functional model***, and occasionally the sociopolitical model is termed the **minority group** paradigm.
- There are two important components of this model.
  - First, pathology must be present, and
  - second, the pathology is located within the individual.
- Mental illness is not viewed as a valued difference, but as deviance from a desired normality or standard of evaluation.
- Further, mental illness is treated as objective conditions that exist in and of themselves. Certainly, the degree of societal stigma toward an

individual's type of mental illness is never considered when clinicians determine the mental illness's level of severity. According to the biomedical model, people with mental illness, as victims of misfortune, should be grateful for any sympathy, pity, and charity that might be offered.

- Taken further, their "personal tragedy or flaw" (the psychiatric disability) relieves society of the responsibility of according full civil rights to people with mental illness.
  - The biomedical model is not considered to be interactional, because the problem of mental illness exists entirely within the individual. Therefore, society tells people with mental illness, "This is how the world is. Take it or leave it." It is the person with a mental illness and societal caring system which must be modified.
  - In order to establish the presence of a mental illness (or pathology), diagnostic testing and assessment are necessary.

Challenging Behavior

What is challenging behavior?
How common is challenging behavior?
Explanations of a difficult or challenging behavior
Functional analysis of challenging behavior
Components of a functional analysis and assessment process
Different kinds of therapeutic interventions
Monitoring of interventions
Consent

Key messages

- Challenging behavior is not an illness, but is a form of socially inappropriate or unacceptable behavior that can develop for a number of different reasons. For example, it can be something a person learns to do in order to let other people know what they want, or what they are feeling. It can also develop as a result of a mental or physical illness, or as a result of abuse.
- It is usually thought that challenging behavior has a 'function' or purpose. In other words, the challenging behavior might be used by the person as a way to communicate something to others around them.
- 'Functional analysis' is a means of developing an understanding of the function of a challenging behavior for an individual. It consists of

gathering information, in a structured way, to work out what makes the behavior useful for the person.

- Therapeutic interventions are based on adequate understanding of the behavior, are individually tailored and aim to replace the challenging behavior with a more appropriate one. Removing the behavior will not remove the purpose that it served for the individual.
- The aim is to replace dysfunctional behaviors with more functional ones, in order to ensure that the person is not restricted in their access to the community and an improved quality of life.
- Professionals must also obtain the person's informed consent or involve a responsible carer or advocate.

What is challenging behavior?

Challenging behavior is behavior that people think is abnormal or unusual within the person's culture. Examples could include:

- Someone being aggressive to themselves or to others
- Someone damaging property
- Someone screaming and other socially inappropriate behaviors
- Someone refusing to take part in activities and other more 'resistant' types of behaviors

This type of behavior is seen as a problem because of what it can do to the person involved and others around them. These behaviors can physically hurt people. They can also stop people from doing what they want. It might make their life more difficult because they find it hard to get along with other people in their community.

This makes it a challenge for services (such as health or social services) to support this person. For people with challenging behavior who live with their families or other carers, then the challenge is also in providing support for them. To respond to this challenge the focus of the problem needs to be shifted away from the person involved. Services also need to be developed to meet their individual needs appropriately. Challenging behavior is often learnt. Sometimes it results from an underlying physical or mental health problem.

How common is challenging behavior?

- Studies in the UK have suggested that approximately 6 percent of people who have intellectual disabilities probably have challenging behavior.
- Some evidence suggests that challenging behaviors can start in childhood and persist into adulthood.
- Challenging behaviors appear to be more common amongst men. Some challenging behaviors seem to be related to additional physical or

sensory disability, such as difficulties in getting around or problems with hearing or seeing. Some types of challenging behavior such as self-injury also appear to be related to communication difficulties.

Explanations of a difficult or challenging behavior

- Most people believe that a lot of challenging behavior is something a person has learnt to do because of the way people around them have reacted to their actions.
  - For example someone might deliberately hurt himself or herself because they have learnt that when they do this, their carers stop asking them to take part in an activity that they do not want to do. Alternatively, someone might learn that if they scream or shout, their carer usually gives them a drink. This is in order to stop them screaming.
  - It is therefore thought that challenging behavior has a 'function'; or in other words it has a purpose or meaning for the person involved.
  - **Disruptive behaviors like aggression and self-injury could have many different functions, such as:**
    - **Showing a need for help or attention**
    - **Escaping from stressful situations or activities**
    - **Getting an object that they want**
    - **Protesting against unwanted events/activities**
    - **Getting stimulation**

- Something called a ***functional assessment*** is used to work out what the function of a challenging behavior is. From doing this a substitute or alternative behavior can then be taught to help the person get his or her message across in a more appropriate way.

- The person probably did not start to behave like this in order to get a reward, but instead the behavior happened and was for some reason reinforced. In other words another person reacted to the behavior in such a way that it helped to reinforce it, to make the person want to do it again in order to get the same reaction. This reaction is called a '**reinforcer**': a consequence that strengthens behavior. (See Figures 1 and 2.)

Criticism and reservations

The literature also contains criticisms and reservations about these definitions of mental health which fall into six groups:

1. There are inherent contradictions in the qualities themselves. For example, it is possible for individuals to be happy with themselves and their lives while being the cause of concern to others by, say, hedonistically sloughing off their social responsibilities. []

2. The value of drawing up lists and attributes of mental health has been seriously questioned. To possess all the attributes would be very rare and make their owners, to quote Skynner again (1990) the mental health equivalents of Olympic athletes. Most of us muddle along; not too bad in many respects but not too good in some. Lists represent a preoccupation with idealism which has little to do with the pragmatics of ordinary life.

3. Others have argued that general characteristics do not really exist and that behavior is specific to situations. There will be times when we respond in a 'mentally healthy' way and others when we do not. Parents will ordinarily respond positively to their children; but at other times they will ignore them, snap at them, or even strike out at them because at that point parents are tired, worried, absorbed elsewhere or feeling stretched to the limit.

4. Definitions are also accused of being static and focused on adults of working age. Children and elderly people rarely figure. Even within the considered range, the implicit assumption is that people are physically healthy and of average intelligence.

- What constitutes mental health for the 'others' is largely ignored. The implication, perhaps, is that you cannot expect them to be mentally healthy, which is denigrating to say the least. Definitions also change over time. A mid-Victorian list of attributes would be very different from a modern one, especially in respect of women. Whether there are, or should be, differences in attributes based on sex is a point seldom raised. Some research suggests there could be innate differences between the sexes, which suggests there should be different criteria for mental healthiness. Others would argue that different expectations of men and women are rooted in socially determined gender roles and reflect another facet of discrimination.

5. Definitions suggest that mentally healthy people can cope with anything life throws at them. I doubt this, and much prefer Bartlett's (1970) approach, which looks at the balance between coping resources and the demands being made upon them. People can break down if either their resources leave them unable to cope with 'normal' demands, or the demands are so excessive that even the

most resourceful would collapse under the pressure. 'Not coping' is not a priori a reflection of an intrinsic lack of mental health. The social and physical environment in which we live has a profound significance.

- Many studies have demonstrated that poverty, illness, poor housing, poor education, unemployment and social isolation can 'seriously damage your [mental] health' (Pilgrim and Rogers, 1999). To distinguish between these two broad categories of explanation of breakdown – inadequate resources or excessive demands – or to establish the degree of balance between them in a specific situation – is crucial in practice. Goals and means used in social work intervention will be very different for each.

6. The final criticism is perhaps the most profound. Endemic to any definition is a value system, expressed as a set of ideals or a notion of preferences. Derived from these are concepts of what constitutes normal behavior and what is appropriate to the various social roles. As individuals with variations we are nevertheless largely the products of a socialization process geared to producing a current and future society with a sufficient cohesion to survive.

- Mental health definitions, then, are typically specific to a particular culture and may have little relevance for any other. The definitions summarized above, for example, are overwhelmingly drawn from Western democratic societies – inevitably. They were the most accessible and the most meaningful to me given my own cultural background and their relevance to my work, since the bulk of my students and colleagues shared that cultural heritage. Herein lies the danger. This cultural selectivity can reinforce my attitudes, add to my conviction that I am 'right', that my views are the 'normal' ones and that 'everyone' shares them. I adopt them for practice with little questioning. This acculturation process always risked practice outcomes in a predominantly class-oriented society; it would be fatal to good practice in a multicultural one.

There is more to know and understand about the causes and treatments of mental illness - physical and mental- than just having the knowledge to practice directly with 'few clients' who come to see professionals. The caring person must first be a healthy person who should also have a healthy mind. A person with a healthy mind should be able to think clearly, should be able to solve the various problems faced in life, should enjoy good relations with friends, colleagues at work and family, and should feel spiritually at ease and bring happiness to others in the community. It is these aspects of health that can be considered as mental health in this course. It is these kinds of issues are included in the contents of this course. The course can be exciting and

meaningful if all of you can have your own inputs to make it more practical and relevant to our country. With your input, it will be a standard textbook soon.

LECTURE Three

TYPES of MENTAL ILLNESS

The types of mental illness

Relevant assessment and measurement techniques:

- Differences in childhood treatment

Diagnosis

Experts differ in the methods they choose to diagnosis childhood problems. Childhood diagnosis is done from three different perspectives: Categorical, empirical, and behavioral

Categorical Diagnosis

The most widely used categorical system for diagnosing children is the Diagnostic and Statistical Manual of Mental Disorders (DSM)[American Psychological Assocation-5th ed). The categories in this types of system are clinically derived, based on the judgment of thought to be experts in the field.

Characteristics of categorical diagnosis include a theoretical labeling of children's behavior; that is, symptoms are simply described. The labels or categories represent a comprehensive description of a disorder, including essential and correlated features such as age at onset, predisposing factors, and prevalence. Diagnostic criteria are also provided. These attempt to provide key symptoms, duration of dysfunction, and so on, and are based on clinical judgment. It is believed that corrections are made as new data becomes available. Finally, the system is multiaxial, that is, it takes into account the presenting problems, as well as related issues. The most used categories for describing problems of children and adolescents are listed below:

Mental Retardation
317. 00 Mild MR
318.00 Moderate MR
318.10 Severe MR
318.20 Profound MR
318.00 Unspecified MR
Learning Disorders
315. 00 Reading disorder
315. 1 Mathematics disorder
315. 2 Disorder of written expression

315.9 Learning Disorder
Motor Skills Disorders Communication Disorders Pervasive Developmental Disorder Attention-Deficit and Disruptive Behavior Disorder (Axis I)

Empirical Diagnosis

The development of empirically tested measures for diagnosis of child development is called empirical diagnosis. Statistical procedures such as correlational analysis and factor analysis are used to identify the specific features important for a specific diagnostic category or concept, and therefore should be included on the measurement. For example, three factors have emerged as significant predictors of child problematic behavior; conduct problems, personality problems, and inadequacy /immaturity.
In addition to identifying groupings of symptoms or syndromes that have been empirically derived, empirical diagnosis uses multivariate classification or use of number of different measures to diagnose a problem. Review of these multivariate studies show similarities.

Behavioral Diagnosis

Behavioral diagnosis sees to identify or operationalize children's specific problematic behaviors and the controlling conditions that continue or promote those behaviors. Characteristics of behavioral diagnosis include emphasis on a functional analysis of behavior rather than reliance on a categorical system such as DSM. Functional analysis refers to a clear specification of problematic behavior and identification of the conditions maintaining it. These are in turn targeted for modification. For example, a child's presenting problem is behavior problems in the classroom. A functional analysis reveals that the child initiates conversations with other children and leaves his seat without permission approximately three times per half hour observation period. These incidents occur only in reading class, where the teacher has a somewhat authoritarian disciplinary style that seems to elicit the disruptive behavior from the child. The second characteristic of behavioral diagnosis is the classification of behavior into broad categories such as excesses and deficits; in the example above, the child is excessively out of his seat. Third, behavior diagnosis relies on direct measurement of the problem behavior specified. The teacher might count the number of incidents of disruptive behavior.

Write the advantages and disadvantages of each of the diagnostic criteria

In contrast to classifying children's problems according to diagnostic or other criteria, psychological theories explain how children acquire behavior, problematic or otherwise. The prominent child development theories are cognitive theories, affective theories, learning theories, social theories..

CHILDREN WITH PSYCHOLOGICAL DISORDERS: An Overview

Children who have psychological disorders are a heterogeneous group. They may have problems involving *cognitive functions* (such as impaired ability to reason or learn), *affect* (such as anxiety or depressive reactions), or *behavior* (such socially inappropriate behavior, hyperactivity, or violence toward self or others). In addition, they may have physical disabilities and medical problems.

Examples of symptoms and behaviors found in children and adolescents with psychological disorders

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Amnesia and Memory Problems
Tends to wander off
Gets lost easily
Loses things easily
Has general amnesia
Has amnesia for traumatic experiences
Has amnesia for specific situations
Has a loss of time

Attention and Concentration Problems
Is easily distracted
Has difficulty sustaining on task
Has difficulty sustaining attention
Fails to listen
Fails to follow through on instructions
Has difficulty organizing tasks and activities
Is impulsive and hyperactive
Often fidgets with hands and feet
Often leaves seat in classroom
Runs about or climbs excessively
Talks excessively
Frequently blurts out answers
Frequently has difficulty waiting turn
Interrupts or intrudes on others

Anxiety and Phobic Behavior
has generalized anxiety
has separation anxiety
has phobia
has panic attacks

Conduct Problems
is disruptive
Shows aggression
has an explosive temper
fights often
lies often
steals often
sets fires
is cruel to animals
runs away from home
is truant
sexually assaults others
has homicidal ideation
destroys property
stays out late at night
shows a lack of remorse

Motor Problems

Depression
Is sad
Has low self-esteem
Expresses hopelessness
Blames self
Is irritable
shows affective liability
has suicidal ideation
has made suicidal attempt
shows fatigue

Dissociative Symptoms
Has alter personalities
Shows age regression
Displays rapid changes in personality
Has poor body boundaries
Has spontaneous trance states
Shows involuntary movements
Displays conversion symptoms
Has fluctuating somatic complaints
Has pseudoseizures

Eating Problems
Has anorexia
Has bulimia
Compulsively overeats
Has many appetite changes
Is obese
Eats nonnutritive substances
Regurgitates and rechews food

Hallucinations
Has auditory hallucinations
Has command hallucinations
Has aggressive hallucinations
Has hallucinations that urge self-injury
Has visual hallucinations
Has tactile hallucinations
Has somatic hallucinations

Has tics (vocal or motor)
Displays nonfunctional motor movements

Obsessive and Compulsive Behaviors
has obsessions
has rituals
has compulsions

Oppositional Symptoms
loses temper often
argues with adults often
actively defies adults or refuses to comply with adult requests
deliberately annoys people
frequently blames others for mistakes
is often touchy or easily annoyed by others
is often angry and resentful
is often spiteful
is often vindictive

Posttraumatic Stress Symptoms
has traumatic nightmares
has intrusive thoughts
Has flashbacks
Is hypervigilant
has exaggerated startle reaction
avoids traumatic stimuli
shows disorganized or agitated behavior
Engages in repetitive play

School Problems
has a learning disability
has a reading disability
Has a mathematics disability
Has a spelling disability
has an oral language disability
has a written expression disability
Is truant
has been suspended from school
has been expelled from school

Separation Problems

Has imaginary companions (for adolsecents)

Language Problems

Has a delay in or lack of spoken language
Has difficulty initiating or sustaining a conversation
Shows stereotyped or repetitive use of language
Has idiosyncratic language
Displays echolalia
Has a deficit in expressive language
Has a deficit in receptive language

Elimination Disorders

Lacks bladder control
Lacks bowel control

Sexual Behavior Problems

Shows inappropriate sexual behaviors
Masturbates compulsively
Displays genitals in public
Engages in inappropriate sexual play
Perpetrates sexual abuse
is promiscuous

Speech Problems

Stutters
Makes errors in sound production

Thought Disorder Symptoms

Is confused
Is disoriented
Shows disorganized thinking
Excessive delusions
Displays paranoia
Displays grandiosity

Shows distress when separated from attachement figures
Worries excessively about losing attachment figures
Refuses to go to school
is fearful of being alone without attachment figure
Is reluctant to go to sleep without attachment figure
Has nightmares involving separation

Interpersonal Problems

Fails to develop peer relationships
Fails to share things with people
Lacks social or emotional reciprocity
Displays indiscriminate sociability

Sleep Problems

has traumatic nightmares
has night terrors
has insomnia
has hypersomnia
sleepwalks

Stereotyped Behavior

shows stereotyped or restricted behavior
has inflexible routines
Has repetitive motor mannerism
Is persistently preoccupied with parts of objects

drug abuse and mental disorder

Autism ,

Generalizations about children with psychological disorders must be made with caution because each child has unique temperament and personality characteristics, cognitive

skills, social skills, adaptive behavior skills, and support systems. *Approach each child as a unique individual and never only as a child who represents a psychological disorder*. If

How psychological disorders develop in children

1. **Genetic and biological factors**
2. **Environmental factors**

- To detect and diagnose a mental illness, you have to depend almost entirely on what people tell you. The main tool in diagnosis is an interview with the person.
    - Mental illness produces symptoms that sufferers or those close to them notice.
        - There are five major types of symptoms:
            - **Physical** – 'somatic' symptoms. These affect the body and physical functions, and include aches, tiredness and sleep disturbance. It is important to remember that mental illnesses often produce physical symptoms. Mental illness can affect a person's ability to do things at home and at work. Most mental illness can be treated.

            - **Feeling** – emotional symptoms.
                - Typical examples are feeling sad or scared.
            - **Thinking** – 'cognitive' symptoms.
                - Typical examples are thinking of suicide, thinking that someone is going to harm you, difficulty in thinking clearly and forgetfulness.
            - **Behaving** – behavioral symptoms.
                - These symptoms are related to what a person is doing. Examples include behaving in an aggressive manner and attempting suicide.
            - **Imagining** – perceptual symptoms.
                - These arise from one of the sensory organs and include hearing voices or seeing things that others cannot ('hallucinations').

In reality, these different types of symptoms are closely associated with one another. Different types of symptoms can occur in the same person. For instance,

- A person can be worried about the future: a thinking complaint …which can make her feel scared: a feeling complaint …which can make it difficult for her to sleep: a physical complaint.

- A person can hear people talking about him: a complaint of imagination …which makes him think that his life is in danger: a thinking complaint …which makes him attack others to protect himself: a 'doing' complaint.

An overview of mental illness

There are **six broad** categories of mental illness:

- common mental disorders (depression and anxiety);
- 'bad habits', such as alcohol dependence and drug misuse;
- severe mental disorders (the psychoses);
- mental retardation;
- mental health problems in the elderly;
- mental health problems in children

The causes of mental illness

The important environmental interactions for children and adolescents occur in the school, at home, and with peers.

- In many cultures, both medical and traditional explanations are used to understand the causes of ill health.
    - Traditional models are often related to spiritual or supernatural causes, such as bad spirits or witchcraft. What are the beliefs in Ethiopian culture?
    - The medical models to explain mental illness.

It is useful to keep in mind the following main factors that can lead to mental illness:

- **Stressful life events**. Life is full of experiences and events. Some of these may make a person feel worried and under stress. Most people will learn how to deal with such events and carry on with life. However, sometimes they can lead to mental illness. Life events that cause great stress include unemployment, the death of a loved one, and economic problems such as being in debt, loneliness, infertility, marital conflict, violence and trauma.
- **Difficult family background**. People who have had an unhappy childhood because of violence or emotional neglect are more likely to suffer mental illnesses such as depression and anxiety later in life.
- **Brain diseases**. Mental retardation, dementias and emotional problems can result from brain infections, AIDS, head injuries, epilepsy and strokes. No definite brain pathology has yet been identified for many mental illnesses. However, there is evidence to show that many illnesses are associated with changes in brain chemicals such as neurotransmitters.
- **Heredity or genes**. Heredity is an important factor for severe mental disorders. However, if one parent has a mental illness, the risk that the children will suffer from a mental illness is very small. This is because, like

diabetes and heart disease, these disorders are also influenced by environmental factors.

• **Medical problems**. Physical illnesses such as kidney and liver failure can sometimes cause a severe mental disorder. Some medicines (e.g. some of those used to treat high blood pressure) can cause a depressive illness. Many medicines when used in large doses in elderly people can cause a delirium.

Culture and mental illness

There are many ways in which culture can influence mental health issues.

• What is a mental illness? Concepts about what a mental illness is differ from one culture to another.

- The group of disorders most often associated with mental illness is the severe mental disorders, such as schizophrenia and mania.
- The commonest mental health problems in general or community health care are the common mental disorders (depression and anxiety) and problems associated with alcohol and drug dependence. These disorders are rarely viewed as being mental illnesses.

- Although you should be aware of these mental illnesses, you need not add to the sufferer's problems by using labels with a potential stigma attached to them. Instead, you can use locally appropriate words to describe stress or emotional upset as a way of communicating the diagnosis.

- Find words used to describe emotional distress. The descriptions of human emotions and illness are not easy to translate into different languages. Consider the word 'depression'. This word means sadness and is used to describe both a feeling ('I feel depressed') and an illness ('the patient is suffering from depression'). In many languages, however, while there are words to describe the feeling of sadness, there are no words that describe depression as an illness. Thus, it is important to try to understand the words in the local language that best describe depression as a feeling and as an illness. Sometimes, different words may be found for these two meanings. Sometimes, a phrase or series of words will need to be used to convey the meaning of depression as an illness.

• Beliefs about witchcraft and evil spirits. People in many societies feel that their illness has been caused by witchcraft or evil spirits or is the result of some supernatural cause. There is little to gain from challenging such views (which are often shared by the community). Such an approach will only make the person feel uncomfortable. Instead, it would be better to understand these beliefs and explain the medical theory in simple language.

• Priests and psychiatrists: what do people do when in distress?

Sick people seek help from a variety of alternative, religious and traditional health care providers. Examples include: traditional Chinese medicine, spiritual healers, shamans, priests, or pastors.

This is for several reasons.

First, medical health care does not have the answers for all health problems, and this is especially true for mental illness.

Second, many persons associate their emotional upset with spiritual or social factors and thus seek help from non-medical persons. Traditional treatment may help some people get better quicker than would medical treatments.

• Counseling people with mental health problems.

In many Western societies, counseling to help people with emotional problems is based on psychological theories which have evolved from within their cultures. These theories are foreign to the cultural beliefs in many non-Western cultures. This does not mean that counseling therapies will not be useful in these cultures. You will need to search for resources and methods that have evolved in your own culture because these are likely to prove more acceptable. Only a simple form of counseling that can be applied in most cultures.

Things to remember about mental illness

•There are a number of different types of mental illness. Mental illness can produce severe disability and can lead to death.

•The commonest types of mental illness in the community or general health care settings are the common mental disorders, and disorders related to alcohol dependence; however, many patients and health workers may not consider these conditions as mental disorders.

•Schizophrenia, manic–depressive illness and acute psychoses are conditions that are most often recognized by the community and health workers as mental illnesses, because of the disturbed behavior associated with them.

•Stressful events, changes in brain function and medical factors such as brain infections are the main causes of mental illness.

•Some people may believe that spirits or supernatural factors cause mental illness. You should not challenge these beliefs but try to put forward the medical explanations for these problems.

•It is not essential that you label a person with a mental illness diagnosis. What matters is that you recognize the existence of a mental health problem, attempt to identify the type of mental illness and then offer appropriate treatment.

Lecture Three

Therapeutic Interventions

This lesson covers:
The mental health assessment process
What are therapeutic interventions?
Biological interventions
Psychological interventions
Social interventions
Helping the person to communicate
Carers' support with interventions
Resources

- Many people with mental health problems receive help from a variety of professionals including doctors, nurses, occupational therapists and clinical psychologists.
  - A thorough assessment is necessary to decide upon the most suitable management plan.
- Mental health problems have biological, psychological and social components.
  - Just as physical, psychological and social factors working together contribute to the development of a mental health problem, various physical, psychological and social interventions are available to treat a mental health problem.

There are three main ways in which to help people with mental health problems:

a. **Biological interventions**: different drugs aim to correct different chemical imbalances, which in turn have a beneficial effect on behavior. Newer drugs cause fewer unwanted effects.
b. **Psychological interventions**: different psychological therapies help the person to deal with their feelings. Referrals are accepted from GPs or mental health professionals.
c. **Social interventions**: different social interventions aim to change the person's environment or social circumstances.

- Interventions should be designed in the light of an assessment. The

intensity of the program and approach (whether group-work, individual programs, or combinations of both) will be determined by the findings of this assessment. Also, techniques that match the level of understanding and preferred approach of each person involved are used (e.g. pictures, modeling, role-playing, etc.).

- Carers can help with interventions in the home setting if agreed by the person and the clinician. A range of interventions can be used to suit the person and the carers.
- Carers often act as advocates by helping individuals to make important decisions about management plans.

A therapeutic Intervention

A therapeutic intervention, also known as simply an intervention, can be any form of treatment, such as medication, counseling, or moving to improved accommodation. Interventions aim to cure an illness or at least reduce the suffering and make it more manageable.

- What are the different types of biological, psychological and social interventions used for mental health problems?

The mental health assessment process

Mental health professionals must complete an assessment with the person in order to decide what the problem is and to decide on the best therapeutic intervention to use. Before any mental health assessment or therapeutic intervention is made it is important that a person's informed consent is sought.

- What are the 'Law, Policy and Ethical Issues' regarding consent?

- A thorough assessment may mean the difference between success and failure of any plan. For example, an interview with the person who exhibits challenging behavior might reveal that the undesirable behavior occurs at certain times of the day.

- Observing the person directly around those times might reveal what makes that behavior happen. This will then help for developing strategies to be used to make the behavior less likely to happen again.

- Physical, psychological and social factors working together can contribute to the development of a mental health problem (remember the last lecture on mental health assessments). In the same way various

physical, psychological and social interventions are available to treat these mental health problems. Whatever methods are chosen they should reflect the needs and wishes of the person who is having the therapy. The person you care for should be involved as much as possible throughout the process.

What are therapeutic interventions?

If someone has a mental health problem a therapeutic intervention may be suggested to help the person cope with illness and to make it better. For example if someone has depression a GP or psychiatrist might prescribe him or her some medication, or suggest counseling.

Most professionals believe that all illness has biological, psychological and social components. Possible examples of these components are given below for the illness tuberculosis:

- **The biological** component: infection with bacteria and the person's level of immunity.
- The **psychological** component: the way the person reacts emotionally to their illness; for instance, do they go to see the doctor as soon as they realize they are ill, do they want to take tablets, etc.
- The **social c**omponent: the person's housing situation that has resulted in conditions where tuberculosis is likely to thrive

The same is true for mental health problems. They also have biological, psychological and social components. Many people with mental health problems receive help from a variety of professionals including doctors, nurses, social workers, occupational therapists and clinical psychologists, and between them they are able to look at all of these important components.

- There are three main ways in which to help people with mental health problems:
    - **Biological therapies**: medication which acts on the physical or biological aspects of the problem
    - **Psychological therapies** which help the person to deal with their feelings
    - **Social therapies** that aim to change the person's environment or social circumstances

Therapeutic interventions can include biological interventions, psychological interventions and social interventions.

Biological interventions

Biological interventions for mental health problems consist of medication. There are many different types of medications that can be used for mental health

problems. These are sometimes referred to as psychotropic medication. Different types are described later.
First of all some information is provided about:

- The names of medication
- The different forms of medication
- Why medications are prescribed
- Why side effects can occur
- What you need to ask professionals about medication
- What you need to watch out for
- What information you should get from the doctor or nurse
- How the medication will be monitored

Names of medication

- Medications have two or more names and they can be difficult to pronounce. Two names for medications —the generic name and in parenthesis, the trade name.
  An example is fluoxetine (Prozac).

- One is the chemical name (from the compound it is made from) and the others are brand names (given to them by the companies that make them).
  For example:
  Chemical name: Chlorpromazine
  Brand name: Largactil

What form do medications come in?

Medication can come as a tablet, capsule, liquid to drink, or as an injection. Most people will be prescribed tablets and they are likely to be taken at least once a day. Sometimes doctors will prescribe the medication in what is called a depot injection. The person will be given the injection every two to six weeks. The depot slowly releases the medication into the blood stream, making sure there is a steady amount until the next injection is given. Injections are more likely to be given to people who sometimes forget to take tablets.

Why is medication prescribed?

Chemicals carry different messages from brain cell to brain cell. Sometimes if we have too little or too much of one chemical, it can lead to a mental health problem. Medication reverses these problems and restores the right amount of chemicals in the brain.

Side effects

As well as treating the mental health problem medications can also cause unwanted side effects. These side effects are caused because the medication

affects other parts of the brain or body as well as the one it is trying to target. For example, a medication that is still sometimes given for schizophrenia is chlorpromazine.

Chlorpromazine reduces the build-up of the chemical 'dopamine' that causes psychotic symptoms. But it also affects parts of the brain that help control our movements, so some people might get tremors or shakes as a side effect.

When prescribing medication the doctor will weigh up the benefits of the medication against the possible side effects. The doctor will tell you about these side effects. Sometimes a doctor might prescribe another medication that counteracts the side effects of the original medication.

- Recent advances in science, however, have introduced newer drugs, which cause fewer unwanted effects for some mental health problems. It is important that you as social workers aware of the possible side effects, as people with mental illness may not be able to recognize them and/or communicate them to other people. If you think the person you care for is suffering from side affects you should report them to the doctor or nurse as soon as possible.

What information should you get from the doctor or nurse?

When a drug is prescribed to the person you care for there is some information that you should know. Doctors and nurses will normally provide you with this information, but they might need to be reminded. You will need to know:

I. What it is prescribed for
II. Why the doctor thinks it will be helpful for the person
III. What the possible side effects are
IV. What you should do if the side effects occur
V. How the medication should be given (i.e. with water etc.)
VI. At what times it should be given

If you require further information, you could ask if there are any information leaflets available on medication. There are some leaflets that are available especially for people with intellectual disabilities on medication;

How will the medication be monitored?

Once a medication is started there should be a procedure to ensure it is monitored and regularly reviewed. Immediately after a new medication is started it would be normal for the doctor or nurse to want to see the person every four to eight weeks. Once the person is settled on the medication it should be reviewed at least every six months. You can help this process by providing information on the following:

- Is the person agreeing to take the medication and do they take it as prescribed?
- Have their views changed about taking the medication?
- Have the signs and symptoms of the mental health problem gone away or reduced?
- Have they had any side effects?
- Do you think it has improved their quality of life?

Medications are used to treat the symptoms of mental disorders such as schizophrenia, depression, bipolar disorder (sometimes called manic-depressive illness), anxiety disorders, and attention deficit hyperactivity disorder (ADHD).

- Sometimes medications are used with other treatments such as psychotherapy. Can you describe:
    - Types of medications used to treat mental disorders
    - Side effects of medications
    - Directions for taking medications
    - Warnings about medications from the U .S. Food and Drug Administration (FDA).

- Choosing the right medication, medication dose, and treatment plan should be based on a person's individual needs and medical situation, and under a doctor's care.
- Information about medications is frequently updated.
- Check the FDA website (http://www .fda.gov) for the latest information on warnings, patient medication guides, or newly approved medications.

What are psychiatric medications?

Psychiatric medications treat mental disorders. Sometimes called psychotropic or psychotherapeutic medications, they have changed the lives of people with mental disorders for the better.

- Many people with mental disorders live fulfilling lives with the help of these medications. Without them, people with mental disorders might suffer serious and disabling symptoms.

How are medications used to treat mental disorders?

- Medications treat the symptoms of mental disorders. They cannot cure the disorder, but they make people feel better so they can function.
- Medications work differently for different people. Some people get great results from medications and only need them for a short time. For example, a person with depression may feel much better after taking a medication for a few months, and may never need it again. People with disorders like schizophrenia or bipolar disorder, or people who have

long-term or severe depression or anxiety may need to take medication for a much longer time.

- Some people get side effects from medications and other people don't.
- Doses can be small or large, depending on the medication and the person.
- Factors that can affect how medications work in people include:
  - Type of mental disorder, such as depression, anxiety, bipolar disorder, and schizophrenia
  - Age, sex, and body size
  - Physical illnesses
  - Habits like smoking and drinking
  - Liver and kidney function
  - Genetics
  - Other medications and herbal/vitamin supplements
  - Diet
  - Whether medications are taken as prescribed.

Biological interventions for depression

A person suffering from depression may be prescribed medication to take. New antidepressant medication has fewer unwanted effects and is safer than older ones. Antidepressants are not addictive. They can be prescribed by a GP.

There are two main categories.

(1) SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)
Low levels of a certain chemical in the brain called serotonin cause depression. These types of drugs increase the amount of it in the brain. Examples.

Table.1 Selective Serotonin Reuptake Inhibitors (SSRIs)

Chemical name	Brand name
citalopram	Cipramil
fluoxetine	Prozac
paroxetine	Seroxat
fluvoxamine	Faverin
sertraline	Lustral

The most common side effects of these drugs are nausea and headaches, although they may also cause restlessness, irritability, anxiety and some difficulty in getting off to sleep. These side effects are generally mild and usually only occur in the first few days of taking the medication. When coming off these tablets, it is important not to stop them suddenly, but to tail off the dose gradually with the advice of a doctor.

(2) TRICYCLIC ANTIDEPRESSANTS

These types of drugs interfere with two brain chemicals: serotonin and noradrenaline. This group includes the examples given below.

Table 2 Tricyclic antidepressants

Chemical name	Brand name
amitriptyline	Lentizol, Tryptizol
clomipramine	Anafranil
dothiepin	Prothiaden
lofepramine	Gamanil
imipramine	Tofranil

These drugs are more sedative than the SSRIs, and can cause more troublesome side effects, such as a dry mouth, blurred vision, dizziness, constipation and difficulty passing water, which can rule out their use in the elderly. However, they are effective antidepressants and suit some people well.

- If taken as an overdose these drugs can cause heart irregularities. Most people with an episode of depression respond to the first drug they try. For all antidepressants it takes about 3 to 4 weeks before any change in mood is apparent. The improvement in mood is gradual, and a person may still have 'bad days' even though they are significantly better. It is important that the drug is tried for at least one month, and is taken regularly as prescribed.

- Some depressed people require higher doses of the drug than is first prescribed. The doctor will gradually increase the dose, which usually results in the expected improvement in mood. If this does not happen, or if side effects are intolerable, the doctor will probably prescribe from a different group of antidepressants. Also, the doctor might do a blood test to check whether the drug is at the correct levels in the blood stream for it to work effectively.
- If a depressed person is experiencing delusions or hallucinations, the doctor may prescribe some antipsychotic medication such as chlorpromazine (Largactil), haloperidol (Serenace), olanzapine (Zyprexa) or risperidone(Risperdal).

One of these drugs may also be used in a low dose if the person is experiencing anxiety or irritability.

- Circumstances such as profoundly low mood and failure to eat or drink are life threatening. Overwhelming suicidal thoughts may mean a person needs 24-hour nursing care and more intensive treatment. Admission to a

specialized mental health unit may be needed to provide appropriate assessment and treatment.

Biological interventions for manic depression: mood-stabilizing medicines
Manic depression is treated with mood-stabilizing medicines such as lithium.

LITHIUM (BRAND NAMES INCLUDE CAMCOLT, LISKONUM, PRIADEL)

People with manic depression get depressed and need antidepressants to lift their mood, but they may suddenly swing the other way to become manic, needing sedation. To prevent these huge swings in mood, which are so disruptive, a person is prescribed lithium.

- Although slight changes of mood may still occur, the lithium should reduce the 'highs' and 'lows'. Lithium is sometimes also prescribed to help manage people with challenging behavior.
- Lithium is taken on a long-term basis to prevent relapses. It is an effective medicine but can have serious side effects. Before starting lithium the doctor will ask for blood tests to check kidney and thyroid function. Once the blood level of the drug has been stabilized blood tests are then done at about six-monthly intervals.

Side effects include nausea, loose bowels, and tiredness, hand tremor, feeling thirsty and passing a lot of urine. These may improve after a while. Chronic side effects include tremor, weight gain, drinking a lot, passing a lot of urine, and slight forgetfulness. Some people on lithium become hypothyroid (that is, their thyroid gland is under-active) and need to be treated with thyroxine.

- If the person shows appetite loss, vomiting, diarrhea, hand trembling, slurred speech, unsteadiness on his or her feet or sleepiness a doctor must be contacted immediately. Also, it is important to know that, if the person is prescribed lithium, they ***must*** stay on the same brand.

CARBAMAZEPINE (BRAND NAME: TEGRETOL)
Carbamazepine is normally given for epilepsy but it can also be used to stabilize mood disorders. Although lithium is thought to be more effective, carbamazepine has the advantage of having fewer side effects. Sometimes if lithium is not effective at controlling mood fluctuations then carbamazepine is added. It is also sometimes used in the control of challenging behavior and epilepsy.

A common side effect is a generalized rash. This is not dangerous and goes away when the medicine is stopped. Some people get nausea and vomiting. Although rare, it is important for you to look out for signs of dizziness,

drowsiness, double vision, persistent fever, sore throat, bruising or bleeding. If these occur consult a doctor immediately.

What medications are used to treat depression?

- Depression is commonly treated with antidepressant medications.
  - Antidepressants work to balance some of the natural chemicals in our brains. These chemicals are called **neurotransmitter**s, and they affect our mood and emotional responses.
- Antidepressants work on neurotransmitters such as serotonin, norepinephrine, and dopamine.

	Major functions
Norepinephrine	Excitatory and inhibitory functions at various sites. Involved in neural circuits controlling learning, memory, wakefulness, and eating. malfunctioning Depression (undersupply)
Serotonin	Inhibitory at most sites. Involved in mood, sleep, eating, and arousal, disorders and may be an important transmitter underlying pleasure and pain. malfunctioning Depression, sleeping, and eating disorders (undersupply)
Dopamine	Inhibitory. Involved in voluntary movement, emotional arousal, learning, memory, and experiencing of pleasure or pain. Malfunctioning Parkinson's disease and depression (undersupply) Schizophrenia (oversupply)

  - The most popular types of antidepressants are called selective serotonin reuptake inhibitors (SSRIs).
    - **These include:**
      - **Fluoxetine (Prozac)**
      - **Citalopram (Celexa)**
      - **Sertraline (Zoloft)**

- **Paroxetine (Paxil)**
- **Escitalopram (Lexapro).**

Other types of antidepressants are serotonin and norepinephrine reuptake inhibitors (SNRIs).
SNRIs are similar to SSRIs and include

- venlafaxine (Effexor) and duloxetine (Cymbalta).
- Another antidepressant that is commonly used is bupropion (Wellbutrin).
    - Bupropion, which works on the neurotransmitter dopamine, is unique in that it does not fit into any specific drug type .
- SSRIs and SNRIs are popular because they do not cause as many side effects as older classes of antidepressants.
    - Older antidepressant medications include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs).
    - For some people, tricyclics, tetracyclics, or MAOIs may be the best medications.

What are the side effects?
Antidepressants may cause mild side effects that usually do not last long. Any unusual reactions or side effects should be reported to a doctor immediately.

- The most common side effects associated with SSRIs and SNRIs include:
    - Headache, which usually goes away within a few days. Nausea (feeling sick to your stomach), which usually goes away within a few days.
    - Sleeplessness or drowsiness, which may happen during the first few weeks but then goes away.

Sometimes the medication dose needs to be reduced or the time of day it is taken needs to be adjusted to help lessen these side effects.

- Agitation (feeling jittery).
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex.
- Tricyclic antidepressants can cause side effects, including:
    - Dry mouth.
    - Constipation.
    - Bladder problems.

It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected. Blurred vision, which usually goes away quickly. Drowsiness . Usually, antidepressants that make you drowsy are taken at bedtime.

- People taking MAOIs need to be careful about the foods they eat and the medicines they take.
- Foods and medicines that contain high levels of a chemical called tyramine are dangerous for people taking MAOIs. Tyramine is found in some cheeses, wines, and pickles. The chemical is also in some medications, including decongestants and over-the counter cold medicine.
- Mixing MAOIs and tyramine can cause a sharp increase in blood pressure, which can lead to stroke.
- People taking MAOIs should ask their doctors for a complete list of foods, medicines, and other substances to avoid.
- An MAOI skin patch has recently been developed and may help reduce some of these risks. A doctor can help a person figure out if a patch or a pill will work for him or her .

How should antidepressants be taken?

a. People taking antidepressants need to follow their doctors' directions.
    - The medication should be taken in the right dose for the right amount of time. It can take three or four weeks until the medicine takes effect.
    - Some people take the medications for a short time, and some people take them for much longer periods. People with long-term or severe depression may need to take medication for a long time. Once a person is taking antidepressants, it is important not to stop taking them without the help of a doctor.
    - Sometimes people taking antidepressants feel better and stop taking the medication too soon, and the depression may return.
    - When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose.

It's important to give the body time to adjust to the change. People don't get addicted, or "hooked," on the medications, but stopping them abruptly can cause withdrawal symptoms.

b. If a medication does not work, it is helpful to be open to trying another one.

Are herbal medicines used to treat depression?

- The herbal medicine [traditional has medicine] been used for centuries in many folk and herbal remedies.

- Today in Europe, it is used widely to treat mild-to moderate depression.
- In the United States, it is one of the top-selling botanical products.
- The National Institutes of Health conducted a clinical trial to determine the effectiveness of treating adults who have major depression with herbal medicine.
- The study included 340 people diagnosed with major depression. One-third of the people took the herbal medicine, one-third took an SSRI, and one-third took a placebo, or "sugar pill."
- The people did not know what they were taking. The study found that herbal medicine [St . John's wort] was no more effective than the placebo in treating major depression.
- A study currently in progress is looking at the effectiveness of St . John's wort for treating mild or minor depression.
- Other research has shown that St. John's wort can dangerously interact with other medications, including those used to control HIV. On February 10, 2000, the FDA issued a Public Health Advisory letter stating that the herb appears to interfere with certain medications used to treat heart disease, depression, seizures, certain cancers, and organ transplant rejection. Also, St . Johns wort may interfere with oral contraceptives. Because St . John's wort may not mix well with other medications, people should always talk with their doctors before taking it or any herbal supplement.

FDA warning on antidepressants

- Antidepressants are safe and popular, but some studies have suggested that they may have unintentional effects, especially in young people. In 2004, the FDA looked at published and unpublished data on trials of antidepressants that involved nearly 4,400 children and adolescents . They found that 4 percent of those taking antidepressants thought about or tried suicide (although no suicides occurred), compared to 2 percent of those receiving placebos (sugar pill) . In 2005, the FDA decided to adopt a "black box" warning label—the most serious type of warning— on all antidepressant medications . The warning says there is an increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants . In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through age 24 .

The warning also says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment . Possible side effects to look for are depression that gets worse, suicidal thinking or

behavior, or any unusual changes in behavior such as trouble sleeping, agitation, or withdrawal from normal social situations .

- Families and caregivers should report any changes to the doctor. The latest information from the FDA can be found at http://www .fda .gov . Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders . The study was funded in part by NIMH . Finally, the FDA has warned that combining the newer SSRI or SNRI antidepressants with one of the commonly-used "triptan" medications used to treat migraine headaches could cause a life threatening illness called "serotonin syndrome ." A person with serotonin syndrome may be agitated, have hallucinations (see or hear things that are not real), have a high temperature, or have unusual blood pressure changes.
- Serotonin syndrome is usually associated with the older antidepressants called MAOIs, but it can happen with the newer antidepressants as well, if they are mixed with the wrong medications.

Biological interventions for schizophrenia

Schizophrenia is a type of psychotic disorder. A person with a psychotic disorder loses some contact with reality. When this happens antipsychotic medication (also known as neuroleptics) can be prescribed to help. Antipsychotic medication can reduce or alleviate symptoms (voices, irrational beliefs and delusions) in up to 70 percent of people who suffer from a psychotic illness (schizophrenia, manic depression). Unlike tranquillizers, antipsychotics are **not addictive** – that is, people do not develop a craving for them. They differ in their sedative and antipsychotic properties and side effects. In recent years newer antipsychotics have come on the market such as risperidone and olanzapine. These tend to produce fewer side effects than older drugs.

- Clozapine (brand name: Clozaril) is used for people with treatment-resistant schizophrenia. It requires a monthly blood test to monitor the functioning of the immune system (white blood cells). Otherwise the person may become vulnerable to infection.
- Other antipsychotics include haloperidol (brand name: Serenace), chlorpromazine (brand name: Largactil) and trifluoperazine (brand name: Stelazine).

SIDE EFFECTS

Unfortunately, antipsychotics may have some unwanted side effects which must be weighed against their benefits. Sometimes, soon after someone starts

the medicine, the person may develop a tremor of their fingers, dribble saliva and find it difficult to move because they feel rigid. These symptoms are similar to those experienced by people who have Parkinson's disease and so they are called parkinsonian symptoms. Drugs such as procyclidine (brand name: Kemadrin) or orphenadrine (brand name: Disipal) may be given to treat them. The side effects may decline with time or if the dose of antipsychotics is reduced. It is therefore important to review medication regularly. Also the person may become restless and fidgety. This restlessness especially affects the legs and has been described as an inability to sit still. Some of these medicines can lower blood pressure. People will complain of feeling dizzy when they get up from their bed or chair, and may fall and hurt themselves. The elderly are particularly vulnerable. It is important for those who experience dizziness to take care. Fortunately, the dizziness usually disappears after the person has been on the medicine for a few weeks. Abnormal face and body movements may occur. People may clench their jaw, stick out their tongue or, rarely, have a severe reaction where their body is rigidly bent backwards, their head is bent backwards, their eyes are rolled upwards and their tongue is stuck out. In that case, the person will have to go to casualty and may require an injection of procyclidine.

People who are treated with these medicines can put on weight because the medicines increase appetite. Some antipsychotics make the skin sensitive to the sun, so sun screen must be applied before going out in the sun. Many people with intellectual disabilities suffer with epilepsy; antipsychotic medication may interfere with the control of this, so anti-epileptic medication may need to be reviewed. Antipsychotics should be taken at the lowest effective dose. Some people with schizophrenia need to be on them continuously. Sometimes it is better to give someone the medicine in the form of a depot injection. Anxiolytics are also used in the short term.

Psychological Interventions

Psychological interventions help people to deal with their feelings. They help people with mental, emotional and behavioral problems. Often when someone talks about being 'in therapy' or 'having psychotherapy', these are the types of therapies that they mean. There are many different types of psychological interventions. You might wish to know more about what is on offer, what the psychological approaches to mental health problems are and what each entails. **Psychological interventions** include the following:

- Cognitive behavioral therapy (CBT)
- Psychodynamic psychotherapy
- Counseling
- Behavior therapy and skills training methods

◎ Family therapy
◎ Therapy sessions in groups
◎ Other therapies ◎
Dramatherapy ◎ Art therapy ◎ Music therapy

Cognitive behavioral therapy (CBT)
Cognitive behavioral therapy (also known as CBT) is based on the idea that a person's beliefs about what they do, and their reasons for doing them, are as important as what they actually do. In other words a person's thinking, assumptions and beliefs about the world are as important as his or her actions. The main aim of this type of therapy is to change the way the person thinks about certain situations, which in turn could help him or her to cope better. For example, depressed people tend to think that they are not good at anything. This thought would affect the way they view a successful event (e.g.' it was pure luck')and how they cope with failure(e.g. self-blame:'I always fail'). In cognitive behavioral therapy the person will learn not to generalize these negative thoughts over all aspects of life(e.g. 'I have been unsuccessful in one area').

WHAT HAPPENS IN COGNITIVE BEHAVIOURAL THERAPY?
During the sessions the therapist will help the person to identify negative or irrational thoughts or thinking patterns (cognitive) and unhelpful patterns of acting (behavioral). For example the irrational fears of a person who suffers from agoraphobia (fear of open spaces) might cause them to stay at home all the time (unwanted behavior), which can have tremendous consequences on the person's quality of life. The therapeutic process depends on the collaboration between the therapist and the client. This is done during individual therapy sessions and then practiced at home. Usually it lasts for between 6and20individual sessions.

WHO IS COGNITIVE BEHAVIOURAL THERAPY FOR?
This kind of therapy has helped many people with mild to moderate depression, anxiety, obsessive compulsive disorders, bulimia, phobias and panic disorders. It is also used in schizophrenia, as most peoples till experience psychotic symptoms (e.g. voices), though less frequently and intensely when they are on medication. It is clear that the person must be motivated and able to communicate the content of their thoughts to the therapist, though this may need to include the use of non-verbal materials such as drawings and symbols.

Psychodynamic psychotherapy
The theory behind this approach has been around for a long time. It has been adapted for those with intellectual disabilities and mental health problems over

the last 20 years. It involves talking to a qualified psychodynamic psychotherapist who in turn will help the person to understand their feelings.

WHAT HAPPENS IN PSYCHODYNAMIC PSYCHOTHERAPY? The psychotherapist adopts a listening stance and allows the person to talk about what they want. The focus is on the person's conscious and unconscious assumptions about relationships and how these are played out with the therapist during the therapy session. Thus past experiences resurface and can be thought about in a live way. The therapist avoids imposing his or her view and the person in turn is asked to live with the uncertainty aroused by this.

WHO IS PSYCHODYNAMIC PSYCHOTHERAPY FOR?
People with anxiety or relationship problems might benefit from psychodynamic psychotherapy. To undergo therapy they must be able to tolerate anxiety during the therapeutic process and not act out their anxiety by resorting to behaviors such as self-harming or alcohol abuse.

Counseling
The counselor tries to help the person to overcome emotional problems through a combination of talking and listening.

WHAT HAPPENS IN COUNSELLING?
Listening to the person talking is important because the main purpose is to help the client understand him or herself more clearly. By thinking aloud the person can become aware of links between aspects of feelings and behavior that previously have been unrecognized. The counselor explains the rationale and that has the effect of making problems more understandable and therefore gives the person the confidence that he or she can solve the problems. The development of trust between the therapist and the person is important. It allows communication in words, and it promotes the understanding and integration of previously unacknowledged aspects of the self and relationships.

Behavioral therapy
Behavioral therapy suggests that apparent behavior has been learnt. Behavioral therapy aims to identify and directly change unwanted behaviors. Or, alternatively, unwanted behaviors are ignored whilst more positive socially valued behaviors are rewarded. Less attention is paid to what has actually caused these unwanted behaviors.

WHO IS BEHAVIORAL THERAPY FOR?
This kind of therapy can be used with people who have limited or no verbal communication skills, although the ability to communicate one's thoughts and feelings can give valuable information for behavior therapy. Again in order to

reach a successful result the person has to co-operate as much as possible with the intervention plan.

WHAT HAPPENS IN BEHAVIOURAL THERAPY?

Current behavior management combines the teaching of new skills together with the suppression of undesirable behaviors. There are several ways of encouraging and increasing new behaviors. Some carers might have used these techniques at home over the years without even realizing. **These techniques** are widely used and include the following:

- The ABC approach
- Positive reinforcement
- Prompting
- Shaping
- Chaining
- Relaxation training
- Role-playing
- Modeling
- Desensitization

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The ABC approach

In traditional behavior management, the problem is studied and then the environment is manipulated in such a way as to increase, decrease or maintain the behavior. This is known as the ABC approach. The problem or, as it is otherwise called, the target Behavior is described and then either the Antecedents and/or the Consequences of that behavior are maneuvered. This is described in the case of challenging behavior.

Relaxation training

Inrecentyearsresearchevidencehasshownthattheuseofrelaxationtechniques in people with intellectual disabilities and behavioral problems is beneficial. Behavioral relaxation training involves the demonstration of 'tense' and then 'relaxed' states in different body areas. During the session the therapist demonstrates first and the person just observes. Later the therapist provides prompting and feedback according to performance. It includes the following steps:

- Sitting in a relaxed posture
- Tension release cycles in the hands and face
- Breathing slowly and deeply

The person is asked to repeat the tension release cycles in different parts of the body. Alternative methods of relaxation include deep breathing exercises and listening to soothing music. Once the person has mastered these techniques it is hoped that they will use them in everyday life situations that they find difficult in order to counteract anger or anxiety and become relaxed and calm. Audiotaped instructions or soothing music may help self-initiated relaxation. People who have intellectual disabilities may experience a number of fears and anxieties in everyday life. The process of relocation from hospital to a community setting might cause anxiety for example, or the presence of behavioral difficulties might hinder the relocation process itself. Relaxation training might be part of a treatment plan aimed to make these difficulties easier to cope with.

Family therapy

Most people with intellectual disabilities live with their families or in 'family' groups such as group homes where they are supported by staff teams. Working with the person and their family can boost the therapeutic process.

Feeling **• feeling as if something terrible is going to happen to her** **• feeling scared**
Thinking **• worrying too much about her problems or her health** **• thoughts that she is going to die, lose control or go mad (these thoughts are often associated with severe physical symptoms and extreme fear)** **• repeatedly thinking the same distressing thought again and again despite efforts to stop thinking them**
Behaving **• avoiding situations that she is scared of, such as marketplaces or public transport** **• poor sleep**

Assessing someone with a mental illness

How can you carry out an interview to diagnose a mental illness?

. the main symptoms of mental illness and know how to manage difficult interviews, such as those in crowded primary care clinics or with people who refuse to talk.

- Ask questions to confirm the presence of a mental illness.

1. Can you examine a mentally ill person?

The assessment of mental health need not be done by a specialist. It requires nothing more than compassion, good listening skills and some basic knowledge.

Some health workers have mixed feelings about assessing a mentally ill person. They may experience:

- fear that the person may attack them;
- disgust with the person's lack of personal hygiene;
- frustration that the interview may take longer than a regular examination;
- amusement at the odd behavior shown;
- anger that the person is wasting their time with 'no real illness'.

- Such feelings will usually make it harder to provide help for mental illness.
- These attitudes will also make the person less comfortable and less likely to share feelings.
- A person with a mental illness should be treated with the same respect and compassion as anyone else.

Working with the mentally ill is a challenge that will be both fulfilling and rewarding. The most important aspect of assessing mental illness is to give the person enough time.

2. **Will you have the time to talk to someone who may have a mental illness? Two things:**
    - The first thing to remember is that time spent finding out why someone has come to see you may actually save you time later on. We know that many mental illnesses, especially common mental disorders and alcohol problems, are rarely recognized by health workers.
    - Health workers in a busy clinic will often simply accept someone's complaints and give medicines for them.
        - Thus, painkillers are prescribed for aches and pains, vitamins for fatigue and sleeping pills for sleep problems. However, this may mean that the real problem, the mental illness, has not been treated. Many of these people will keep returning to the clinic and will take up more time.
        - Thus, time spent finding the true problem may actually be a saving of time in the long run! Besides, you will get the reward of seeing the person improve rather than keep coming back for more pills.
        - The second important thing to remember is that it does not take a long time to ask about mental illness. The key to using time sensibly is to be well informed about how to ask about mental illness, and this is described below.

2. **Who will have a mental illness?**

- The commonest image of a mentally ill person is someone who is talking nonsense and behaving bizarrely.
- In reality, the vast majority of people with a mental illness look, behave and talk no differently from those with a physical illness.
- Mentally ill people are no more dangerous than physically ill people, and you should never feel that you are at risk of being harmed simply because you are talking to a person who is suffering from a mental illness.
- You should consider using some kind of screening procedure to identify people who may be suffering from a mental illness. Then you can spend more time with such people to find out what the problem is and start treatment.
- There are two approaches to screening people in a busy clinic.
    - First, there are some kinds of clinical presentations that are typical of mental illness. If anyone presents with these, you should suspect a mental illness (Box. 1).

Clinical presentations that suggest a mental illness
•When the person or relatives complain directly of mental illness, such as depression or alcohol problems. **•When the person or relatives suspect supernatural causes.** **•When a specific cause of mental illness, such as alcohol misuse and family violence, is obvious.** **•When you know that the person has relationship problems, such as marital and sexual problems.** **•When you know that the person has life problems, such as unemployment or the death of a close friend.**

•When there are many physical complaints (especially more than three) that do not fit into a pattern of any known physical illness. **•When there is a personal or family history of mental illness.**

Second, you can ask a set of 'golden questions' to help detect the two commonest types of mental health problems in general health care, namely the common mental disorders and alcohol dependence (Box 2.)

Box 2. Golden questions to detect mental illness in general health care settings **•Do you have any problems sleeping at night?** **•Have you been feeling as if you have lost interest in your usual activities?** **•Have you been feeling sad or unhappy recently?** **•Have you been feeling scared or frightened of anything?** **•Have you been worried about drinking too much alcohol recently?** **•How much money and time have you been spending on alcohol recently?**
If any of the answers are 'yes', ask more detailed questions to confirm the diagnosis.

4. What to ask a person with a probable mental illness

A standard form of interview can be used for people who, as a result of the screening process, you suspect have a mental illness (Box 3).

Box 3. Information to collect from people with a probable mental illness
General information
•Sex
•Age
•Occupation
•Marital status
History of current complaint
•When and how did it start?
•Is it getting worse?
•Are medicines (or other treatments) being taken?
•The person's beliefs about the illness – what the person feels the illness is and why it has happened. You may ask questions about beliefs regarding stress and supernatural factors causing the illness.
Other information
•Is there any history of mental illness (if so, ask for old prescriptions or old clinic notes)?
•Relevant medical history, such as recent head injury.
•Recent major life events, such as separation, death in the family, unemployment.
•Social support – specifically, who does the person live with, who cares for the person, and is there any form of support from outside the home, such as religious or spiritual support and friends?

There are three types of information you will need to understand the problem. This information should also suggest ways in which the person can be helped.

• Basic information on age, address, family details and employment should be collected for anyone who consults you.

• Information about the illness itself should begin with finding out about the symptoms, for example how long they have been present and how they affect the person's life.

• Then you should ask about the person's social situation. This should include who the person is living with and who are the main sources of social support. Questions about recent life events such as a death in the family may help explain why the person is suffering from a mental illness.

5. Symptom checklists to diagnose mental disorders

The following symptom checklists may be used for the diagnosis of three major types of mental disorders (depression or anxiety, and alcohol)

To diagnose a common mental disorder (depression or anxiety)

Common mental disorders consist of two types of emotional problems: depression and anxiety.

- *Depression* means feeling low, sad, fed up or miserable. It is an emotion that almost everyone suffers from at some time in their life.
  - To some extent it can be thought of as 'normal'. But there are times when depression starts to interfere with life and then it becomes a problem. For example, everyone gets spells of feeling sad but most people manage to carry on with life and the spell goes away. Sometimes, however, the depression lasts for long periods, even more than a month. It is associated with disabling symptoms such as tiredness and difficulty concentrating.

- The feeling starts to affect daily life and makes it difficult to work or to look after small children at home.
- If depression starts to get in the way of life and lasts for a long period of time, then we can assume that the person is suffering from an illness.

- **The key features of depression are shown in** Box **1.**

A person with depression will experience some of the following symptoms:
Physical **• tiredness and a feeling of fatigue and weakness** **• vague aches and pains all over the body**
Feeling **• feeling sad and miserable** **• a loss of interest in life, social interactions, work, etc.** **• guilty feelings**
Thinking **• hopelessness about the future** **• difficulty making decisions** **• thoughts that he is not as good as others (low self-esteem)** **• thoughts that it would be better if he were not alive • suicidal ideas and plans** **• difficulty in concentrating**
Behaving **• disturbed sleep (usually reduced sleep, but occasionally too much sleep)** **• poor appetite (sometimes increased appetite)**

• **reduced sex drive**

Anxiety **is the sensation of feeling fearful and nervous. Like depression, this is normal in certain situations. For example, an actor before going on stage or a student before an examination will feel anxious and tense. Some people seem to be always anxious but still seem to cope.**

- Like depression, anxiety becomes an illness if it lasts long (generally more than two weeks), is interfering with the person's daily life or is causing severe symptoms**.**

The key features of anxiety are shown in Box 2.

A person with anxiety will experience some of the following symptoms:
Physical • **feeling her heart is beating fast (palpitations)** • **a feeling of suffocation** • **dizziness** • **trembling, shaking all over** • **headaches** • **pins and needles (or sensation of ants crawling) on her limbs or face**

Most people with a common mental disorder have a mixture of symptoms of depression and anxiety. Most never complain of feeling or thinking symptoms as their main problem but instead experience physical and behavioral symptoms.

- This could be for many reasons. For example, they may feel that psychological symptoms will lead to them being labeled as 'mental' cases.

- Three varieties of common mental disorders may present with specific or unusual complaints:

  • *Panic* is when anxiety occurs in severe attacks, usually lasting only a few minutes. Panic attacks typically start suddenly. They are associated with severe physical symptoms of anxiety and make sufferers feel terrified that something terrible is going to happen or that they are going to die. Panic attacks occur because people who are fearful breathe much faster than usual. This leads to changes in the blood chemistry which cause physical symptoms.

  • *Phobias* are when a person feels scared (and often has a panic attack) only in specific situations. Common situations are crowded places such as markets and buses, closed spaces like small rooms or lifts, and in social situations such as meeting people.

  The person with a phobia often begins to avoid the situation that causes the anxiety, so that, in severe cases, the person may even stop going out of the house altogether.

  • *Obsessive–compulsive disorders* are conditions where a person gets repeated thoughts (obsessions) or does things repeatedly (compulsions) even though the person knows these are unnecessary or stupid. The obsessions and compulsions can become so frequent that they affect the person's concentration and lead to depression.

  Advice on the various ways depression and anxiety present in health care settings and how to manage these problems

- ***To diagnose a common mental disorder (depression or anxiety)***

The person must have had at least one of the following symptoms for at least two weeks:

- feeling sad;
- loss of interest in daily activities;
- feeling tense or nervous or worrying a lot.

Other symptoms that are frequently present and should be asked about include:

- disturbed sleep;
- tiredness;
- loss of appetite;
- poor concentration;
- suicidal thoughts;
- palpitations (heart beating fast), trembling, dizziness;
- aches and pains all over the body.

➢ 5. *To diagnose a severe mental disorder*

The person must have at least two of these symptoms:

- believing things that are untrue, for example that his thoughts are being controlled by outside forces or that people are trying to poison him (delusions);
- hearing or seeing things that no one else can (hallucinations); often these are frightening;
- agitation and restlessness or withdrawal and lack of interest.

If these symptoms have been present for less than a month, the diagnosis may be of an acute psychosis. If they have been present for more than a month, schizophrenia is possible. If there is a history of episodes in which the person seems to recover completely, bipolar disorder may be the diagnosis.

The 'high' or manic episode can be diagnosed on the basis of:

• increased speed of talking;

• restlessness;

• irritable mood (getting angry easily);

• grand ideas (out of keeping with reality).

➢ To diagnose alcohol (or drug) dependence

The person must have at least two of the following symptoms for at least one month:

• drinking (or drug use), which has led to personal problems such as losing his job or health problems such as accidents;

• difficulty in controlling the use of alcohol (or the drug) even though there are problems being caused by the use;

• alcohol (or the drug) is used throughout the day;

• feeling sick or unwell unless he drinks alcohol (or takes the drug);

• using gradually increasing amounts of alcohol (or the drug).

(in other chapters, we will look more details on how to diagnose alcohol dependence; for the diagnosis of other types of mental illnesses such as confusion, dementias and child mental health problems).

➢ What to look for during the interview

During the interview, you should note any of the following:

• facial expressions of sadness or fear (with schizophrenia and depression);

• restlessness, i.e. unable to sit relaxed (with psychoses, depression, drug and alcohol dependence and as a side-effect of some psychiatric medicines);

• strange movements (associated with schizophrenia and as a side-effect of some psychiatric medicines);

• irrelevant answers to questions (associated with all the psychoses);

• a very fast rate of talking (associated with the psychoses, especially mania);

• a very slow rate of talking (associated with depression, drug dependence and schizophrenia);

• the person's general hygiene and self-care (poor in depression, drug and alcohol dependence, and schizophrenia).

➢ How to conduct interviews

Here are some hints on how to help people feel comfortable discussing their feelings and symptoms:

• You should introduce yourself to the person. Some people may be confused or suspicious. You should clearly state your professional role and say that you wish to talk about the person's recent health.

• To establish rapport, you can begin the interview with a general subject such as a recent news event. Many people feel more comfortable discussing personal issues when they can identify with the health worker, for example speak the same language and live in the same area.

• Empathy simply means imagining what it must feel like to be in another person's place. Understanding a person's symptoms and the social and family situation will help you be more sensitive in dealing with illness and will help the person feel more comfortable in talking to you.

• The *golden questions* should be asked of anyone who consults you. Any positive responses should lead to a more thorough assessment, using the checklists.

• It is helpful always to keep in mind the main types of mental illnesses and their symptoms (☛). This is especially important because many sufferers

may not openly discuss emotional complaints unless specifically asked about them.

• You must not appear pressured for time, for example by constantly checking a wristwatch! Remember that just ten minutes is often all that is needed to understand a person's problem and guide treatment choices. Of course, it is better if you can spare more time.

• Give the person a chance to talk without the relatives present. Never consider people 'unreliable' simply because they suffer from a mental illness.

• Try to speak to the relatives as well. Some people with a mental illness may deny they have a problem. Some may not be fully aware of the nature of their behavior. Relatives and friends can often

5. *To diagnose a severe mental disorder*

The person must have at least two of these symptoms:

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• You must not appear pressured for time, for example by constantly checking a wristwatch! Remember that just ten minutes is often all that is needed to understand a person's problem and guide treatment choices. Of course, it is better if you can spare more time.

• Give the person a chance to talk without the relatives present. Never consider people 'unreliable' simply because they suffer from a mental illness.
• Try to speak to the relatives as well. Some people with a mental illness may deny they have a problem. Some may not be fully aware of the nature of their behavior. Relatives and friends can often give information that is valuable in making a clinical decision.
• Look at the person during the interview. Eye contact can help make people feel confident that a health worker is interested in what they are saying.
• Try to ensure privacy; this may be impossible in crowded clinics, but even here you can speak softly so that discussions of personal problems are not overheard by others in the room. Alternatively, ask the person to wait till the clinic is less crowded and then talk in private.
• Record key information for future reference, especially the main symptoms, current diagnosis and important information, such as the presence of any marital problems.

- How to reach a diagnosis

There are only a few types of diagnosis that need to be made in a general health care setting. We will later describe how you can diagnose various mental illnesses based on the problems people complain of to health workers.

Be familiar with the types of mental disorders and the questions to assess mental health.

- Practice the questions first with colleagues. Remember that diagnoses are important for two reasons:
  - to help guide you in selecting the right treatments;
  - to help explain to people the cause of their complaints.

- Special situations in assessment

There are some special situations in assessing mental illness. These include:

- assessing someone who refuses to talk;
- assessing physical complaints in a person with a mental illness;
- assessing someone on the telephone;
- assessing someone with the family present;
- assessing the violent person;
- assessing the confused person;
- assessing the suicidal person;
- assessing children with mental health problems.

The first four situations are discussed below. The remaining four situations are discussed in the other parts.

- Assessing someone who refuses to talk

Sometimes you may be faced with people who refuse to talk. This could be for many reasons. They may be angry for having been brought to the clinic. They may be scared that talking to a health worker might mean they will be labeled a 'mental case'. They may be suspicious of your motives.

  - The general advice in such situations is to allow more time. Interview the person in a private room if possible. If this is not possible, at least ask any relatives to stand far away so that the conversation cannot be heard by them. This may help the person feel more confident about sharing personal problems. Do not threaten the person, for example by saying that you do not have time to waste. Instead, reassure someone who refuses to talk that you are interested in their problems. If the person refuses to talk and you have other work to attend to, say you need to go to complete the work

and that you will return later when you have more time. This will allow the person some more time to think. It will also demonstrate your concern.

- 2 Assessing physical complaints in a person with a mental illness

  . Imagine that someone whom a health worker knows has a mental illness comes to the clinic with a new complaint of a headache. Often health workers will assume that the complaint is just another symptom of the mental illness. However, this attitude may lead to a serious physical illness being missed. It is important that the physical health of a mentally ill person is given due attention. Do not dismiss new physical complaints without properly assessing them and, if required, carrying out necessary tests.

  - Remember that mentally ill people may neglect their physical health. Some kinds of mental health problems are closely associated with physical health problems. The most important examples are:
    - alcohol and drug dependence, which can seriously damage physical health;
    - women who have been subject to violence or rape;
    - confusion and agitation, which can often be caused by physical health problems ;
    - disturbed behavior in elderly people

- 3. Assessing someone on the telephone

  Where telephones are available, people may call you for advice. In fact, this can save time for both you and the caller by avoiding unnecessary visits to the clinic. Sometimes, a person may call you with a problem that is related to mental health. Examples of such calls could be:

  - a person who wishes to die;
  - a child who is in need of help;

- a person who is drunk and confused;
- a person who is angry and abusive.

Avoid giving vague advice or reassurance on the telephone.

You should approach callers as follows:

• Find out their name, age, address and which telephone number they are calling from.

• Ask them to tell you exactly what the problem is, how it started, what has happened recently. Get an idea of the situation they are facing.

• Find out about any close friends or relatives to whom they can talk. Encourage callers to share their distress with them now.

• If they are abusive or confused, explain that you would like to help but cannot if they do not change their attitude. If callers remain difficult, hang up the telephone.

• Ask them to come to the clinic if you feel they are in need of a face-to-face assessment.

• With children in distress, immediately inform a local child welfare team or the local police. Ask children to stay where they are and say that someone will come to help them.

- Assessing someone with the family present

  Families are an important factor in assessing and treating people with mental illnesses. You must balance the need to involve the family in the assessment with the need to ensure the person's privacy. As a rule, it is important that you have a chance to speak to the person alone on at least one occasion. During this interview, you will have a chance to find out about family relationships and stresses. Later on you may discuss the problem with other family members. However, care must be taken not to discuss matters that the person has said should remain confidential.

- There are some situations when the family can be a key to providing information about the person. For example, some people with severe mental disorders or dependence problems cannot give a clear or accurate account. In such cases, talking to relatives can provide you with the information needed to reach a diagnosis. Relatives can play an important role in monitoring the health of the person and encouraging the taking of prescribed treatment.

Box 4. Things to remember when assessing someone with a mental illness

•The most important factors in assessing mental illness are to give enough time to talk to the person and to be able to listen patiently to the person.

•Most mentally ill people can give a clear and complete history of their problem. Relatives can also provide useful information.

•A systematic assessment interview can be the first (and a very important) step in the treatment of the person with a mental illness.

•Most common mental health problems can be easily diagnosed by asking questions about specific complaints.

•Mentally ill people may also suffer from a physical illness; never dismiss a physical complaint just because a person also has a mental illness.

The treatment of mental illness

- Many people think that mental illnesses are untreatable. Some people cannot understand how 'talking' to someone can be considered a 'medical' treatment.
- The truth is very different. Most mental disorders can be effectively treated.

- The real problem is that many people with mental disorders rarely see health workers.
    - Even when they do, they tend to receive treatments that are not effective or may even be harmful.
    - Like medicines for physical illnesses, medicines for mental illness work only when taken in the right doses for the right period of time.
    - 'Talking' can be as effective a treatment as a pill, depending on how the talking treatment is carried out and for what reason.

There are two important points for you to remember

- The treatment of the vast majority of mental illnesses can be done with confidence by any general health worker armed with the basic knowledge. Thus, the diagnosis of a mental illness does not mean that the person needs specialist care. It only means that you now know what type of treatment is needed.
- There are many effective ways of treating mental illnesses. The usual approach to mental illness, of treating only the different physical symptoms – for example sleeping pills for sleep problems, tonics and vitamins for tiredness, and painkillers for aches and pains – is often the least helpful in the long run.

Diagnosis of the type of disorder and providing specific treatments are just as important for mental disorders as they are for physical disorders.

Even today, mentally ill persons are treated inhumanely in many places.

The treatment of mental illness —

1 Drug treatments

- When to use medicines

- First, you must decide whether to use a medicine. Sometimes, medicines are prescribed even when a health worker feels they are not needed.
- Do not use a medicine only because the person expects a medicine. If some people expect medicines, it is often because they are used to getting medicines every time they consult a health worker. They may believe that the only way to help a sickness is by drugs and injections.
- They may not be aware of the important roles played by knowledge, lifestyle changes and emotional support.
- If you do not take this chance to educate them and, instead, use unnecessary medicines, the person's problem may take much longer to improve.
- In the long run the person may come to see you more often and for much longer and take up more of your time.
- On the other hand, some people are very reluctant to take medicines at all! They will offer many reasons and excuses.
- The most common reason for refusing medicines, though, is ignorance. Some health workers may feel that medicines for mental illnesses are too dangerous.
- There are different types of drug treatments available for different mental illnesses. There are some general rules that you should follow (see below Box 3.1).

1. The steps in using medicines for mental illness

•Try to identify the type of mental illness. Knowing the diagnosis can help make the choice of treatment much simpler.
•Depending on the type of mental illness, decide whether a drug treatment is required.
•Use the guidelines in this section to choose a specific medicine.
•Explain to the patient how to take the medicine and for how long.
•To limit side effects, some medicines may need to be started in a small dose which is increased in steps until the recommended average dose is reached.
•Always keep a close watch for side effects (although most psychiatric medicines are quite safe).
•Never exceed the maximum dose.
•Avoid using some drugs for too short a period (e.g. antidepressants) and some for too long a period (e.g. sleeping pills).
•Resist the temptation to continue medicines 'as before' in follow up clinics. If you see someone taking a medicine for years, review the person's health.
•Be aware of the common trade names and costs of medicines in your area.

If these are followed properly, then medicines for mental illness are as safe as any other medicines. Do not make the error of avoiding medicines when there is clear evidence that the person suffers from an illness that would benefit from them.

- As a rule of thumb, the following mental illnesses will benefit from medicines:

  • severe mental disorders, including schizophrenia, manic–depressive illness and acute psychoses;

  • common mental disorders, particularly when these have lasted more than a month and are seriously affecting the person's day-to-day life (☛);

  • acute stress situations, such as excitement and restlessness following a death of a close relative .

Lecture Four

Behaviors that cause concern

1. The person who is aggressive or violent

2 The person who is confused or agitated

3 The person who is suspicious has odd beliefs or is hearing voices.

4 The person who is thinking of suicide or has attempted suicide

When suicide becomes a crime

- What to do when the family is not interested
- The person who threatens or attempts suicide again and again …
- Loneliness and isolation
- Someone with seizures or fits
- The mother who becomes disturbed after childbirth

The elderly person with disturbed behavior

The person with multiple physical complaints

The person who worries, gets scared or panics

The person with sleep problems (insomnia)

The person who is tired all the time

The person who complains of sexual problems

The person who drinks too much alcohol

The person who is abusing drugs

The person with a gambling habit

- **The person who is aggressive or violent**
  - Aggression and violence are behaviors that hurt others. These terms include a variety of different behaviors.
  - **Verbal aggression** is hurtful through talking, such as shouting, abusing and using foul language.

- **Physical aggression** includes pinching, hitting, slapping, kicking and punching. More serious physical aggression can involve the use of weapons such as sticks, knives or guns.

Why do mentally ill people become aggressive?

- A common belief is that people with a mental illness are dangerous because they can suddenly become aggressive. In reality, they are no more dangerous than anyone else.
- It is true that, in some instances, the symptoms of a mental illness can lead to aggressive behavior, but this is rare.

Let us consider some important examples of how mental illness can lead to aggression.

• **Hearing voices and becoming angry**.

Imagine that you were hearing voices that said nasty things about you and made you feel that others were plotting to kill you. You would feel scared and attack those who you believed were trying to harm you. This is what can happen, sometimes, in people who have a **psychotic illness**.

• **Being stopped from carrying out your plans and dreams**.

Imagine that you had great plans and dreams to do things that would change your life. If someone tried to stop you, or told you that you were 'sick', you would probably be quite angry. This is what can happen, sometimes, in people with a **manic illness**.

• **Being unable to get a drink in time**.

Imagine that you were so dependent on alcohol (or a drug) that you began to feel physically sick because of your desire for a drink. You might become aggressive if someone tried to stop you from getting a drink.

• **Suffering from confusion**.

Imagine that you have difficulty remembering things. You do not know where you are, what time or day it is, or who is speaking to you. You may become frightened and feel you need to defend yourself from these strangers. Such a state of confusion can be caused by drinking too much alcohol, low blood sugar, brain infections and brain damage.

Like anyone else, those who have a mental illness usually have a reason for becoming aggressive. If you can find out why a person is angry, then you are more likely to find ways to help.

How to deal with this problem

Questions to ask the family or friends

• What happened? One person's description of violence may be quite different from another's. Find out exactly what happened.

• How did it start? Has the person been irritable for several days, or was this a sudden outburst? Sudden aggression is often caused by a specific trigger, such as an argument about drinking. Aggressive behavior without any warning is rare, but may happen in people with a severe mental disorder.

• Has this ever happened before? If so, then the chances are that further violence may occur.

• Has the person suffered from a mental illness in the past? Is he on any medication? This is of obvious importance since it may provide important clues for treatment.

• Whom does he trust? This person could be an important ally in helping him calm down.

• Does he have a drug or alcohol problem?

Questions to ask the aggressive person

• What happened? You may get a different point of view from the aggressive person than from friends and family. In particular, ask whether there were any reasons for her becoming violent.

• Do you still feel angry? If yes, ask her if she would prefer to spend some time alone before you ask any more questions.

• Have you been feeling under stress? Have you been feeling as if people around you were behaving strangely? That they were talking about you? Or doing things that could hurt you? These questions help assess whether she has a psychosis.

• Have you heard people talking about you? Can you hear voices even when there is no one around? ***Hallucinations*** are an important sign of psychoses.

• Have you been drinking alcohol (or, if appropriate, taking drugs) recently? How much? When was your last drink?

Interview suggestions

Be aware of the signs of impending violence. These include:

• talking louder or becoming abusive or threatening;

• fists opening and closing;

• breathing rapidly;

• fidgeting;

• tapping or punching or slapping tables, walls or the floor.

• Listen for signs that the person's speech is not making any sense or is too fast – this is a sign of intoxication or psychosis.

• Be aware of the smell of alcohol or of skin marks of injections (a sign of drug misuse);

• Look for signs that the person is losing balance or has slurred speech, which would suggest intoxication with drugs or alcohol.

- Be sensitive to your own feelings; if you feel scared, then you should stop the interview.
- Make sure that both the interviewee and you have access to the door of the clinic room. (Make sure that the door to the clinic room is accessible to you and the person you are interviewing).
- Speak in a clear, calm tone; do not shout in an attempt to calm the person.
- Never threaten the person. This can only worsen the situation.
- Ensure that another health worker is available during the interview. If this is not possible, get a trusted relative or friend to sit with you.
- If the person has a weapon, reassure him that you are a health worker and that there is no need for a weapon in the clinic. If he refuses to hand over the weapon, leave the room and call the appropriate security staff to disarm him.
- If the person becomes violent, first try to tell him to calm down by firm reassurance. If this is not possible, you will need to restrain him.

What is the mental illness?

When violence is associated with a mental illness, there are three major causes to remember:

- People can become violent either when they are intoxicated by a drug or when they are in a withdrawal state.
- People with a psychosis, whether they are suffering from schizophrenia or a manic illness, can become very agitated and, occasionally, aggressive
- People in an acute confusional state, such as that which follows an epileptic seizure, may become aggressive.

What to do immediately

First try to calm the person by talking, reassuring and listening to her. Do not be in a hurry to get the situation under control. The aim is to encourage the person to take a sedative and calm down.

- If she agrees, then try giving an anti-anxiety drug (e.g. lorazepam, 1–2 mg, or diazepam, 5–10 mg, orally) or an antipsychotic drug (e.g. haloperidol, 5 mg, or chlorpromazine, 50–100 mg, orally).
- If she refuses to take medicines orally and is becoming more disturbed, you will need to restrain her and give an injection.
- Always prepare the injection before you restrain someone. The drugs of choice are: diazepam, 5–10 mg, intramuscular or slow intravenous injection; haloperidol, 5–10 mg, intramuscular injection; chlorpromazine, 25–100 mg, intramuscular injection.

When to refer

If you suspect that the violence is associated with confusion and may be the result of brain injury or other brain disease, the person should be referred to a general hospital, preferably accompanied by a health worker.

What to do later

• Once the person is sedated, explain to the family or friends what happened.

• As he may become agitated when he awakes, ask someone who is familiar to him to stay with him.

• When he awakes, talk to him about what happened and explain the need to take oral medication (the choice will depend on what kind of illness he has).

• Offer him something to eat and drink.

• Refer to a mental health professional for further advice and treatment, particularly if he has a psychosis.

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Box 4.1. **Things to remember in dealing with an aggressive person**

•Mentally ill people are not 'naturally' violent; a number of different reasons can lead a person with a mental illness to become violent.

•Psychoses, alcohol and drug misuse are the important mental health problems that may be associated with violence

•Violence almost always affects friends and relatives. Remember to counsel those affected and explain what you are doing and why.

•While you should be concerned about the safety of others your primary goal must be to protect, understand and help the person.

•Use of medicines and restraining techniques may be required to calm someone with a mental illness who becomes aggressive.

2 **The person who is confused or agitated**

People who are confused or agitated are not fully aware of their surroundings. They do not make sense and cannot make sense of what you are saying. Confusion is also called ***delirium***.

The main features of a person who is confused are:

• she is not as aware of her surroundings as you would expect her to be;

• she is not able to remember things that happened recently;

• she does not know what day it is, or where she is;

• she does not sleep properly at night and may be drowsy in the day;

• she may be uncooperative or fearful;

- she may suffer hallucinations and be suspicious;
- she may be restless and aggressive.

Being confused is not the same as being muddled in thinking or talking about irrelevant matters. When people are muddled or irrelevant, they are still aware of what is going on around them. Examples of muddled thinking are discussed later.

However, sometimes it is difficult to make this distinction. Careful questioning and observations are the key to recognizing a state of confusion.

What are the causes of confusion and agitation?

Confusion and agitation are common conditions, especially in emergency or casualty settings and in medical and surgical wards in hospitals. Confusion is especially common in people who are physically sick.

The commonest causes are:

- side-effects of some medicines, especially in older people;
- withdrawal from alcohol in a dependent person;
- a brain illness, particularly strokes, head injury, epilepsy or infections;
- another medical illness, particularly high fevers, severe infections, dehydration, AIDS, breathing problems, kidney or liver disease;
- being drunk or high on drugs;
- severe anxiety or stress, such as after a sudden shock.

How to deal with this problem

Questions to ask the family or friends

- How did it start? Typically, confusion starts suddenly and the person is brought to the clinic quickly because the family is worried.

• Has it happened before? If there is a history of similar episodes, he may be suffering from repeated strokes, or from alcohol misuse.

• Has he been taking any new medicines recently? Which medicines?

• Has he been suffering from any physical illness recently? Has he had a stroke or heart problem? Has he had a head injury or a seizure recently?

• Does he have a drink or drug problem? If so, when was the last time he had a drink?

• Has he been sleeping well recently? Confusion is almost always associated with disturbances of sleep.

Questions to ask someone who is confused or agitated

• Begin by introducing yourself and clearly stating where you are (for example, "My name is Mary. I am a nurse. This is the clinic in your Kebele of …").

• Have you had any problems recently? The answer may give you a clue to whether the person is aware of what has been happening recently.

• Could you tell me what day it is? Could you tell me my name? Could you tell me where we are right now? These questions test whether the person is disoriented.

• Have you been drinking alcohol recently? When was your last drink?

• Do you have pain anywhere in your body? Where? Pain may be a sign of a medical illness.

• Do you feel worried for your safety? Are you hearing or seeing things that others cannot? Suspicious thoughts and hallucinations are typical features of confusion.

Things to look for during the interview

- The person's attention keeps wandering, for example she does not seem to pay attention to your questions and may not answer them sensibly.
- Her orientation is poor; she may make mistakes about what time it is, where you are or what your name is.
- Her talking may be difficult to follow and may not make sense.
- She may have unusual or suspicious beliefs (delusions).
- She may talk to herself or appear to be talking to an imaginary person.
- She may make movements that suggest she is seeing imaginary things.
- She may be restless and fidgety.
- Her emotions may suddenly change from laughter to crying for no reason.

Always perform a basic physical examination. This must include:

- pulse;
- temperature;
- blood pressure;
- check the person's breath for the smell of alcohol;
- look for signs of physical illnesses, particularly paralysis (due to strokes), injuries, especially on the head, swelling of the feet, jaundice.

What to do immediately

- Rule out an emergency that needs immediate medical attention. This would include serious infections, strokes or head injuries or alcohol withdrawal syndrome with complications such as fits. These conditions may need urgent transfer to a hospital.
- Place the person in a private room, if possible, with a health worker or relative to monitor him. The room should not be too dark or too brightly lit.

• Keep the family well informed about what is happening.

• Make sure the person is taking enough fluids; if there is any concern about dehydration, insert an intravenous line for fluids. This line can also be used for medication.

• Remind the person where he is, and what day and time it is. Reassure him that he is safe with you in the clinic.

• Some confused people can become aggressive or hurt themselves, for example, by pulling out their intravenous tubes. You may need to restrain them on a clinic bed. Drugs can also be used to calm them

–*When to refer*

Confusion is often a sign of a medical emergency, particularly in elderly people or children. It is best, if you have reasonably quick access to a hospital, to refer anyone with these symptoms to the hospital. If this is not possible, follow the steps described above, and once the person is stable, refer.

What to do later

• If the person was on multiple medicines, reduce these to a reasonable number to reduce the chances of future drug-induced confusion.

• If the person has a drink problem, follow this guidance •

Box 6. **Drinking too much: how much is too much**? Using the chart, you can calculate the amount of alcohol the person is drinking.

•A man drinks too much if he has more than three standard drinks a day (or 21 drinks a week).

A single standard drink.

- glass of beer
- A glass of wine
- A 330 ml can of beer
- A shot of spirits

•A woman drinks too much if she has more than two standard drinks a day (or 14 drinks a week).

•People are drinking too much if they must have a drink in the morning when they wake up.

•People are drinking too much if they have one or more health or social problems related to the drinking.

If the person is elderly and you find that, even after the confusion has passed, there seem to be memory problems, follow this guidance.

Box 7. **Things to remember when dealing with a person who has had a seizure**

•Seizures are a sudden, and brief, change in the behavior or conscious state of the person.

•Epilepsy most often starts before the age of 30; someone with a first-ever seizure after the age of 30 may suffer from a serious brain or medical disorder and should be referred.

•Never try to restrain someone who is having a seizure; in most cases, the seizure will be over within minutes.

•Educate the person regarding the need to take the medicines regularly, to avoid driving or working with heavy machinery and to avoid alcohol.

•People with epilepsy may develop other problems, such as

depression and even psychoses.

•Refer the person to a specialist before starting anticonvulsant drug treatment. If this is not possible, learn more how to diagnose epilepsy and use drug treatments

Box 4.. **Things to remember when dealing with a confused or agitated person**

•Confusion is not being aware of one's surroundings.

•The most common causes of confusion are strokes, medical illnesses, brain infections and injuries, side effects of medicines and alcohol dependence.

•Confusion can be a medical emergency and often needs hospital admission.

•The elderly are at a greater risk of becoming confused.

•The key to treatment is to identify and treat the cause of the confusion, give medicines to calm the person and start intensive nursing care. If nurses are not available, ask a relative to stay.

4. The person who is suspicious, has odd beliefs or is hearing voices

- Sometimes, people think that others are talking about them, trying to hurt them, or plotting to harm them. Occasionally the thought lasts for a short time, especially when people are under stress.

- At other times, this thought lasts for a long time and becomes a firm belief. No matter how much you try to reassure them that there is nothing to worry about, the suspicious thoughts do not go away. Such thoughts are called **delusions**.
- People may try to protect themselves from the imagined people who are trying to harm them. Some people can also believe other sorts of odd things that make no sense either to you or to their family.
    - Examples include a person thinking that his thoughts are being interfered with by aliens or that the radio or television is making comments about him or that he possesses superhuman or special powers.

1 What is 'hearing voices'?

- 'Hearing voices' is when someone hears people talking even when there is no one around. This experience is called a **hallucination**.
    - Often, these voices take on an unpleasant character. For example, the voices may say nasty things about the person. Occasionally the voices may talk directly to the person and tell her to do things, such as to hurt herself or others.

Why do some people have these experiences?

- These experiences are not common. They are typically associated with severe mental disorders:
- • *Schizophrenia.* There will often be a long history of illness, usually more than six months.
- • *Manic–depressive illness*. Typically, there is a history of sudden onset and of similar episodes in the past.

- • *Drug psychoses*. These occur after intoxication with certain drugs, such as stimulant tablets and cocaine.
- • Confusional states and brief psychoses. Confused and agitated people may also hear voices and become suspicious

Can 'normal' people have these experiences?

- Yes. In some communities there are individuals who claim to have an ability to communicate with supernatural forces and spirits. These people may experience hearing of voices, particularly of spirits or God.
- They may also have beliefs which seem unusual, for example that the spirits are angry with someone. These beliefs may be appropriate for that community.
    - Examples of such people include the traditional healers in some societies and the charismatic priests in some evangelical churches.[A priest who is speaking in tongues – it is important not to confuse such experiences with an illness. An illness should be defined by its adverse effect on the person's life or that of the family].

- However, these people do not go to health workers for help, since they are using their experiences in a manner that is beneficial to their own health and may help others in distress.

How to deal with this problem

Questions to ask the family or friends

• When did it start? This will tell you whether the illness is sudden, which would be a sign of mania or brief psychoses, or long-standing, which would suggest schizophrenia.

- Have you noticed any odd behaviors? For example, the person appearing as if he is talking to himself?
- Has the person been saying odd things? For example, accusing you of trying to harm him?
- Has he been using drugs or alcohol recently?
- Has he been violent?
- Does anyone else in the family suffer from these sorts of problems? Schizophrenia and manic– depressive disorder can run in families.

Questions to ask the person who is suspicious or has odd beliefs

- Have you been feeling under stress recently? Start with a general question instead of asking a direct question about delusions or hallucinations.
- Have you felt as if something odd was going on around you? Have you felt as if others were talking about you? That some people were trying to hurt you? These questions will help identify delusions.
- Have you heard people talk about you behind your back? Have you heard people talk about you even when there is no one around? These questions will help identify hallucinations.
- Do you get thoughts of wanting to kill yourself? Remember that the risk of suicide is higher in a person with a psychotic illness.
- Have you been drinking or taking drugs recently? .

Things to look for during the interview

- The person's general appearance may indicate poor self-care.
- She may make strange movements with her arms or body.
- She may do things that suggest she is hearing voices, for example suddenly looking in a different direction as if someone is speaking to her from there.

• Her talk may not make sense to you; answers to your questions may not be relevant.

• She may talk far too much or may not talk at all.

• She may laugh or cry or talk to herself without reason.©

Special interview suggestions

• A person who is already suspicious needs to be approached in a gentle manner; the aim must be to win his trust by asking general questions first.

• Never confront him by challenging the beliefs. For example, do not say "Don't be ridiculous. No one is talking about you." The experiences that may appear ridiculous to you are very real to him.

• Never agree with the content of the beliefs; thus, even though you should not challenge them, you should not agree with them either.

• Never mock or laugh at the beliefs; the person will lose faith in you.

What to do

• If the person acts violently, treat as described in Box 4.1.

• Explain to the family that the symptoms are the result of an illness in the brain.

• Encourage the person to take the appropriate medication. Because he will often be convinced that his beliefs are real, it is not helpful to say that he needs medicines because he has a mental problem. Instead, you can reassure him that, because of his beliefs, he must be under stress and the medicines will help to calm him down.

• Antipsychotic medication is very helpful.

• Start on a low dose, say haloperidol, 5 mg once daily.

• Educate the person's family about side-effects and give them a supply of procyclidine or similar medicines to counter the muscle side-effects, such as sudden spasms of the neck or tremors.

Box 4.3. **Things to remember when dealing with someone who is suspicious or has odd beliefs**

•Suspiciousness and hearing voices are symptoms of a severe mental disorder.

•The commonest types of severe mental disorder are schizophrenia and manic–depressive disorder. Acute psychoses can also cause these symptoms.

•Such people often suffer discrimination and stigma by others in the community.

•Antipsychotic medicines are the best treatment for these illnesses.

•If the family wants to take the person to a traditional healer, encourage them to combine the traditional treatment with the medicines you will give.

•If possible, refer people with these symptoms to a specialist mental health

When to refer

• If you suspect the person is in a confusional state.

• If the person is suicidal; people who are suspicious and also have suicidal thoughts are at a high risk of harming themselves.

• If the person is violent; refer after taking steps to control the behavior (☛ Box 4.1).

• If the person develops a high fever or severe side-effects.

What to do later

• Call the person back to the clinic in a week to assess progress. You can increase the dose of the medicine if symptoms are not under control.

• If possible, refer to a specialist mental health team. Many people with a psychosis will need long-term care.

• If there is no mental health team, make a long-term plan to help the family and sufferer cope with the illness.

Schizophrenia and other psychotic disorders may last several years and may be often associated with considerable disability. These are some principles of care:

• If possible, allocate a particular health worker to the person's care. Since these are rare illnesses, it is likely that only a few cases of psychosis will need long-term supervision.

• Visit the person (or ask the person to visit the clinic) at least once every two months.

• Educate the family about the illness and the need to ensure compliance with medication.

• Medication is an essential part of long-term care. At each visit, check on compliance and side-effects.

• Rehabilitation, in the form of assisting the person to get a job, is often a key element in helping the person stay well. The kind of job suitable for the person may depend on education, previous work experience and the severity of the illness.

• If work outside the home is not possible, encourage the person to keep occupied in other ways, for example by helping in the house or garden, or being involved in church activities.

• Refer to organizations that work with mental disorders or disabilities (refer to resources in your area. In some places, organizations run sheltered workshops or facilities where a person can learn new skills and meet others.

4.4 The person who is thinking of suicide or has attempted suicide

- **Suicide is** ending one's own life. Only a small proportion of those people who try to end their life succeed. This section is about helping people who have been thinking about or have tried to end their life. The role of a social worker is to understand why the person wanted to end her life and to support her in the difficult period soon after a suicide attempt.
- ***Things to remember when dealing with a person who has attempted suicide***
- •Suicide is often due to mental illnesses such as depression or alcohol misuse.
- •Many people who attempt suicide have a severe life problem such as marital or financial difficulties.
- •Suicide is also associated with long-standing or serious physical illnesses.
- •Never take a suicide threat lightly.
- •Asking someone about suicidal thoughts does not make it more likely that they will end their life. On the contrary, most will feel relieved.
- •Emergency treatment of the suicide attempt is a priority. Once the person is medically stable, treat any mental illness and identify relatives or friends who can provide support.

Why do some people want to end their life?

- Many of us feel, at some time in our life, that we have had 'enough' of living. If you think of all the difficult situations in which you might not want to continue your life, you will find that these are the same reasons for the people who come to consult you with this complaint.

- There is one big difference, of course. For most of us, thoughts of suicide pass quickly, and are often a reaction to a recent unhappy event. Most of us will talk it over with friends or relatives, or work out solutions to our problems and the thoughts will go away. For some, however, suicidal thoughts or plans become more persistent and are associated with mental illnesses and severe life difficulties.

The following mental illnesses are associated with suicide:

• Depression. This is the most important cause of suicide. Depression can make a person feel miserable, lose interest in life and lose hope for the future.

Box 4.3. Things to remember when dealing with someone who is suspicious or has odd beliefs

•Suspiciousness and hearing voices are symptoms of a severe mental disorder.

•The commonest types of severe mental disorder are schizophrenia and manic– depressive disorder. Acute psychoses can also cause these symptoms.

•Such people often suffer discrimination and stigma by others in the community.

•Antipsychotic medicines are the best treatment for these illnesses.

•If the family wants to take the person to a traditional healer, encourage them to combine the traditional treatment with the medicines you will give.

•If possible, refer people with these symptoms to a specialist mental health team.

• Alcohol and drug misuse. Although many people drink alcohol and take drugs to feel better, in fact these substances act as depressants on the brain. The despair of not being able to stop the addiction, physical illness and financial problems make the person feel suicidal.

- Long-term health problems. Illnesses that cause pain or which are terminal are more likely to make the sufferer feel suicidal.
- Severe mental disorders. People with a psychosis are also at a risk of ending their life through suicide.

Social and personal factors play an important role in the cause of the mental illness. Important social factors that can make a person unhappy and suicidal include:

- unhappy relationships, particularly an unhappy marriage;
- poverty and economic difficulties, particularly when these happen suddenly, such as when a person loses a job;
- losing a loved one, for example through bereavement;
- not having friends with whom to share problems and feelings.

Teenagers may become suicidal when they fail in school or have fights at home with their parents.

Gender and suicide

Women are more likely to suffer from depression and the social stresses that can make a person unhappy. Thus women are more likely to attempt suicide. However, the risk of death by suicide is usually higher in men. This is particularly the case for older men with a drinking problem who are living alone or in unhappy marriages. One reason for this difference is that men may choose more dangerous methods of suicide and are, therefore, more likely to succeed in their attempt. However, women are also more likely to be discriminated against because of the suicide attempt. Take all suicide attempts seriously, whether by men or women.

A woman in an unhappy relationship may feel her situation is hopeless and believe she would be better off dead.

Poison

How to deal with this problem

Questions to ask the family or friends

• What happened? Was it a dangerous attempt? If someone tried to hang himself or take insect poison, it would be considered as a fairly serious attempt; on the other hand, if he scratched his wrist with a pen, it would be less serious.

• Has it happened before? People with a history of suicide attempts are more likely to attempt it again, and repeated attempts may be a sign of a long-standing difficulty or mental illness.

• Is there a history of a mental illness or a serious physical illness?

• Has he had a recent loss, for example separation from his spouse?

Questions to ask the person who attempted suicide

• What happened? Did you want to end your life? Why?

• Did you have a plan? How long were you planning it? Did you tell anyone else about your plan? Attempts that have been carefully planned and kept secret from others are more serious.

• How do you feel now? Many people are relieved that their attempt did not lead to death. Those who are not relieved are more likely to try again.

• Have you been feeling depressed recently? Have you lost interest in life? Ask these questions to detect depression.

• Do you feel you drink too much alcohol (or take drugs)? Ask questions about problem drinking.

• What reasons are there for you to continue living? This is an important way of trying to get the person to think of the good things in

life. Some people are so depressed that they cannot see anything positive. This is a sign of how serious the illness is; it does not mean there is nothing for them to look forward to!

Judging the likelihood of further suicide attempts

It is difficult to predict whether a person will attempt suicide again. Factors that should make you concerned about the risk of repeated attempts are:

- a serious, planned attempt, where there was an effort to hide the attempt from others and a dangerous method such as hanging was used;
- continued suicidal thoughts;
- hopelessness about the future;
- evidence of severe depression;
- evidence of severe life difficulties and losses;
- lack of social support;
- alcohol misuse or severe physical illness;
- previous suicide attempts;
- older age of the person attempting suicide.

Special interview suggestions

- Suicide is a sensitive and personal matter. Talk to the person in private. Give her enough time to feel comfortable and to share her reasons frankly.
- Do not make judgements about her character.
- Do not make reassuring statements without fully understanding her situation because this may make her feel even more hopeless.
- Talk to family or friends for their version of her recent life situation and health. You may need to form a trusting relationship with one person who can help support her at home.

What to do immediately

• Ensure that the person is out of immediate danger. If he has taken an overdose of tablets or poison or suffered a serious injury, emergency medical treatments must be given first.

• The person must be constantly in the company of someone, such as a relative, during the hours after a suicide attempt.

• If you feel he is at risk of harming himself again, ask relatives to spend time with him and ensure that he is not left alone.

• Ensure that all dangerous items, such as poisons or knives, are kept away from him.

• Give him time to regain his calm before sending him home.

• Always ask him to come back to the clinic to see you or make an arrangement for a home visit, within a couple of days.

What to do later

• Involve the person who has attempted suicide in regular counselling until she feels better and more in control of her problems.

• Try to identify social issues that may be causing her to feel depressed. Talk to important relatives, such as a spouse.

• If she has depression or misuses alcohol, treat accordingly.

• The drug treatment of depression takes three to four weeks to show effects; in the meantime, counseling and family support are essential.

• Many suicidal people face difficulties in their life which need to be tackled. Problem-solving can be very helpful.

• Depressed people tend to view their life in a negative way. You can suggest positive ways of looking at the same situation .

When to refer

The person who has attempted suicide should, where possible, be referred to specialist mental health services if:

- the suicide attempt was serious and life-threatening;
- there are persisting suicidal ideas despite counseling;
- there is serious mental illness, such as a psychosis;
- there is a repeated suicide attempt.

The medical treatment of suicide attempts

The general rule is that if you have a hospital nearby, rush a person who has attempted suicide there so that time is not wasted in case medical help is needed later.

Clinical problems

Hanging, stabbing, gunshot wounds, deep cuts or burns These are serious medical emergencies. While you are waiting for the person to be moved to hospital, monitor his breathing, blood pressure and pulse. Insert an intravenous line if the person's blood pressure is low and administer normal saline. Oxygen should be given. If there is an open wound, clean it and apply a pressure bandage to stop the bleeding.

Overdose of insecticide or other substances

This is a common method of self-harm. If the person is awake, make an effort to make her vomit. Vomiting can be induced by:

- drinking very salty water;
- one tablespoon of syrup of ipecacuanha.

Give powdered charcoal, which will help absorb the poison. If there are signs of severe poisoning, such as paralysis, unconsciousness,

convulsions or difficulty breathing, rush the person to hospital immediately.

When suicide becomes a crime

In some societies, attempting suicide is an offence and suicide becomes a legal or police case. Your first concern must be the person who made the attempt. If he has a supportive family and the suicide attempt was because of a minor stressful event, you may decide not to inform the police. However, it is sometimes the case that the suicide attempt is the symptom of serious harassment or problems at home. Typically, women who are being beaten by their spouse or abused by their in-laws may try and end their life. Informing the police, after discussing this first with the woman, may help. In more serious cases, an apparent suicide attempt by burning may ultimately turn out to be an attempt to kill the woman. These are difficult situations and you should discuss them with your colleagues. If you have a good link with the local police, you may be able to get their advice without registering a formal case.

What to **do when the family is not interested**

You will need to rely on the family for supporting the person, particularly during the period just after a suicide attempt. If, however, there is conflict or violence in the family or the family is not interested, you may need to think of alternatives. Remember that you should discuss these alternatives first with the person who made the attempt and then follow one or more of the following actions:

• Refer to a women's group or shelter. Contact the local women's groups or shelters. Ask them if they can arrange for temporary relief accommodation (your local resources.)

• Contact other family members. For example, if a woman is being harassed by her in-laws, you could contact her parents or other relatives.
• Contact friends, such as neighbors, or members of a religious group.
• Encourage the person to seek support through religious leaders.

The person who threatens or attempts suicide again and again … and again

This is the type of person who is brought to an emergency unit repeatedly. It is often easy to dislike such people because the suicide attempts are not dangerous and they are seen as 'acting' and wasting your time. However, these people are not acting; their lives are unhappy and they need help. This help may take the form of counseling with the aim getting the person to react to unhappy events by means other than attempting suicide. Identifying areas of strength, such as a supportive relationship or an occupational skill, may help the person to look on the 'brighter side' of life. Remember that such people are at higher risk of killing themselves. The best way of helping them is keeping in touch regularly and building up a trusting relationship so that, when upset or unhappy, they can talk to you rather than try to kill themselves.

Loneliness and isolation

Loneliness is often a cause of depression and suicide. This is particularly common among older people. Some solutions for the person are:
• to make contact with old friends, neighbors or relatives with whom the person has not been in touch;
• to contact relatives or friends and invite them for a meal or social occasion;
• to use community resources, such as clubs;

- to engage in activities that involve social contact, for example shopping in the market;
- to get involved in hobbies;
- to use time when alone in stimulating or enjoyable activities such as gardening or walking.

Someone with seizures or fits

Seizures or fits are when a person suddenly shows a change in behavior or consciousness lasting for a few minutes. In some seizures, there are shaking movements of the body (called convulsions), with loss of consciousness. There are also seizures in which the person may be fully or partly awake. The only changes may be short periods of losing touch with reality or repeated movements, such as smacking the lips. Epilepsy is an illness where seizures occur repeatedly. If a person has at least two seizures in a month, one can diagnose epilepsy.

What types of seizures are there?

Seizures in adults are different from those in children. Childhood seizures are well described elsewhere. In adults, three types of seizures are recognized:

- Generalized seizures. These are seizures (also called *grand mal* or major epilepsy) in which the person loses consciousness for a few minutes. His body becomes stiff and shakes in jerky manner. This seizure may be associated with biting of the tongue, passing urine and injury because of the sudden fall or the movements. Observers may describe him crying or screaming just before falling, the eyeballs rolling upwards, frothing at the mouth, and the person becoming blue (cyanosis) or pale. During the seizure, he is completely unconscious and will not respond to any verbal command. The seizure usually ends with him being drowsy or falling asleep. Some people may develop a temporary weakness of their limbs.

• Partial seizures. These may occur in an awake person or in a person who is confused or has lost touch with her surroundings. The seizures are very varied in their nature. Some can be entirely localized to one area of the body, for example jerky movements of the arm. Other seizures may involve complex behaviors such as smacking the lips and buttoning and unbuttoning a shirt. Many people experience a warning or 'aura' that the seizure is about to start. Examples of auras are an unusual feeling in the stomach area and hearing, seeing or smelling things that are unusual. Some people may have a partial seizure that then becomes generalized.

• 'Hysterical' or 'conversion' seizures. These are more common in young women and are associated with psychological stress. Their characteristic is that they do not follow any typical pattern described above.

Is epilepsy a mental illness? Epilepsy is not a mental illness. It is caused by electrical changes in the brain. However, epilepsy is often considered a mental health problem for many reasons. Many cultures consider epilepsy as being caused by supernatural forces, such as witchcraft, similar to some types of mental illness. In partial seizures, odd behaviors may be observed. Epilepsy can cause great stress on a person. Many people with epilepsy develop emotional problems. Psychoses, depression and suicidal behavior are all commoner in people with epilepsy. Finally, one type of seizure in adults (the conversion seizure) is entirely psychological in origin. Thus, it is important not to ignore the mental health needs of people with epilepsy.

The important medical causes of seizures

In some persons a specific medical problem can be the causer of their epilepsy. These are: • head injuries leading to bleeding in the brain;

• alcohol withdrawal;

• infections in the brain, such as meningitis, tapeworm, malaria, tuberculosis and sleeping sickness;

• AIDS, through direct infection by the virus, or secondary infections such as fungal infections, or tumors;

• brain tumors;

• low blood sugar levels;

• severe liver or kidney disease.

How to deal with this problem

Getting a clear account of what exactly happened is essential because many conditions can look like seizures. The main information you need to make a correct diagnosis is what an observer tells you about what the seizure looks like, and what the sufferer tells you about the experience of the seizure.

Telling a seizure from a faint

- A seizure starts suddenly whereas a faint is gradual.
- The duration of unconsciousness is usually only seconds in a faint, but at least a few minutes in a seizure.
- Convulsions (i.e. jerky movements) are very rare in a faint but common in seizures.
- Biting one's tongue, frothing at the mouth, passing urine and cyanosis (going blue) are seen only in seizures.
- People recover quickly after a faint, whereas they may be drowsy or complain of a headache and confusion after a seizure.

Telling an epileptic seizure from a hysterical seizure

- The epileptic seizure follows one of the patterns described earlier; the hysterical seizure is usually bizarre or variable in its pattern.

•Cyanosis, tongue bite, frothing, self-injury and passing urine are typical features of epileptic seizures, but not of hysterical seizures.

•People with hysterical seizures never lose consciousness. Even when they may appear to be unconscious, they resist attempts to comfort them, showing that they are still awake.

•Sometimes, the same person may have both types of seizure; in such situations, extra care is needed before determining which type of seizure the person has had.

Proceed as follows in dealing with the problem of a seizure:

- The first thing to be sure of is that the episode was not a faint
- Next, make sure that the episode was not a conversion seizure.
- If it is a seizure, determine whether it was the first one. A single seizure is not a rare event. For example, during severe infections, a person may have a seizure, but never have another seizure again.
- Determine the type of the seizure by interviewing both the sufferer and a person who observed the seizure, in order to identify the type of epilepsy
- Determine the age of the person. Most people with epilepsy have their first seizure before the age of 30. In such people, it is often impossible to find a cause for the epilepsy. If seizures start for the first time after the age of 30 (and especially after the age of 40), the chances that the person has another medical problem causing the seizures are high. Most of these diseases will also cause other symptoms, such as fever and headache, but sometimes the seizures may be the only sign of the disease.

What to do immediately

The vast majority of seizures are self-limited. Thus, even if you did nothing at all, the person will almost always completely recover after the seizure. During the seizure, your main objective is to ensure that the person does not injure herself.

Do the following:

- If possible, try to turn her on to her side.
- Do not try to force any object into her mouth.
- Do not try to hold or restrain her.
- Do not try to force her to take medicines or drink water.
- If the fit lasts more than five minutes, inject diazepam or phenobarbitone.
- After the seizure is over, she may be sleepy. Comfort her after she wakes.
- Once she is fully conscious and calm, the most important thing to do is to assess her carefully, as described earlier.

When to refer

Ideally, all people with seizures should be assessed at least once by a medically qualified physician, if possible by a specialist in neurology or psychiatry. This is especially important for people whose first seizure occurs after the age of 30. The main reason for this is to make sure the person does not suffer from a disease that is causing the epilepsy. Since the diagnosis of epilepsy often means that the person has to take medicines for a long time, and may be restricted from doing some activities, you need to be confident that the diagnosis is correct. Specialist doctors may have access to tests such as EEGs (which exam the electrical activity of the brain) or CT or MRI scans (special X-rays of the brain)..

What to do later

The key areas in the treatment of epilepsy are education and lifestyle changes and using medicines .

When fits don't stop: status epilepticus

This is a serious medical emergency which needs trained medical intervention. In this condition, the person has nearly continuous seizures without a break and without regaining consciousness. If left untreated, some sufferers may die or suffer serious brain damage. If emergency medical care is not available, then you should try to avert death or serious complications in this way:

• Remove false teeth and ensure an open breathing passage by inserting a plastic airway.

• Inject 100 mg of thiamine followed by a solution of 50% glucose (dextrose) rapidly, intravenously.

• Inject diazepam, 10 mg slowly, intravenously (over about two minutes).

• Wait for about five minutes.

• If seizures continue, set up an intravenous saline drip.

• Give diazepam intravenously at the rate of 5 mg per minute up to a maximum of 20 mg or until the seizures stop, whichever is first.

• Keep a close watch on respiratory rate; at any sign of distressed breathing, stop giving diazepam.

• If seizures continue, give phenytoin intravenously at the rate of 50 mg per minute up to a maximum of 1000 mg.

• Once seizures stop, immediately seek specialist medical help.

Advice to the person with epilepsy and family

• Epilepsy is a long-term illness which may need medication for many years.

• Epilepsy is not caused by witchcraft or spirits.

• The key to treating epilepsy is regularly taking the prescribed medicines.

• People with epilepsy can lead normal lives with some adjustments. They can marry, have children and work in most types of job.

• People with epilepsy should not drive (at least until they have had one year without a seizure and are continuing their medication), swim alone or work with or near heavy machinery.

• People with epilepsy should try to modify their lifestyle in the following ways:

• regular sleep;

• regular meals;

• strict limits on alcohol intake;

• avoiding extreme physical exercise;

• avoiding situations that can lead to tension or sudden excitement or stress.

Prescribing drugs for a person with epilepsy

• Select the drug of choice for the particular type of epilepsy. In general, carbamazepine is an effective and safe drug for both main types of epilepsy in adults. Sodium valproate is another effective drug. Phenytoin and phenobarbitone are useful mainly for generalised epilepsy.

• Cost and side-effects are both important issues in selecting drugs since the medicines have to be continued for a long period. If cost is not a

limitation, use carbamazepine or sodium valproate as the drug of choice. If cost is a factor, phenobarbitone may be considered.

• Use only one drug at a time. Start with a small dose and gradually increase until you reach the average recommended daily dose.

• If seizures continue without any benefit, try increasing the dose to the maximum recommended dose; if side-effects appear, do not go any higher.

• If available, use blood drug levels to help monitor the treatment.

• Educate regarding lifestyle changes before increasing drug doses.

How to use drugs for epilepsy:

(A) Choose the right drug depending on cost and type of epilepsy.

(B) Start with a small dose; monitor response by counting how many seizures and side effects.

(C) Change dose accordingly.

(D) If there is no response, increase dose to maximum of range.

(E) If there is still no response, add another drug or refer.

(A) (B)(C)(D)(E)

Things to remember when dealing with a person who has had a seizure

•Seizures are a sudden, and brief, change in the behavior or conscious state of the person.

•Epilepsy most often starts before the age of 30; someone with a first-ever seizure after the age of 30 may suffer from a serious brain or medical disorder and should be referred.

•Never try to restrain someone who is having a seizure; in most cases, the seizure will be over within minutes.

•Educate the person regarding the need to take the medicines regularly, to avoid driving or working with heavy machinery and to avoid alcohol.

•People with epilepsy may develop other problems, such as depression and even psychoses.

•Refer the person to a specialist before starting anticonvulsant drug treatment. If this is not possible, use the guidelines in this manual on how to diagnose epilepsy and use drug treatments.

• If seizures continue at an unacceptable frequency, add a second drug in a small dose and increase as required.

• Generally, do not consider stopping the medicine unless the person has been free of seizures for at least two years. Never stop the medicine suddenly; withdraw it slowly in small steps, for example a quarter of the total daily dose every month.

• Treat mental illnesses such as depression and psychoses as with anyone else.

POSTRUAMATIC STRESS DISORDER

Therapeutic Interventions

This lesson covers:
The mental health assessment process
What are therapeutic interventions?
Biological interventions
Psychological interventions
Social interventions
Helping the person to communicate
Carers' support with interventions
Resources

- Many people with mental health problems receive help from a variety of professionals including doctors, nurses, occupational therapists and clinical psychologists.
  - A thorough assessment is necessary to decide upon the most

suitable management plan.

- Mental health problems have biological, psychological and social components.
  - Just as physical, psychological and social factors working together contribute to the development of a mental health problem, various physical, psychological and social interventions are available to treat a mental health problem.
  - There are three main ways in which to help people with mental health problems:
    d. **Biological interventions**: different drugs aim to correct different chemical imbalances, which in turn have a beneficial effect on behavior. Newer drugs cause fewer unwanted effects.
    e. **Psychological interventions**: different psychological therapies help the person to deal with their feelings. Referrals are accepted from GPs or mental health professionals.
    f. **Social interventions**: different social interventions aim to change the person's environment or social circumstances.
- Interventions should be designed in the light of an assessment.

A therapeutic Intervention

A therapeutic intervention, also known as simply an intervention, can be any form of treatment, such as medication, counseling, or moving to improved accommodation. Interventions aim to cure an illness or at least reduce the suffering and make it more manageable.

- What are the different types of biological, psychological and social interventions used for mental health problems?

The mental health assessment process

Mental health professionals must complete an assessment with the person in order to decide what the problem is and to decide on the best therapeutic intervention to use. Before any mental health assessment or therapeutic intervention is made it is important that a person's informed consent is sought.

- A thorough assessment may mean the difference between success and failure of any plan. For example, an interview with the person who exhibits challenging behavior might reveal that the undesirable behavior occurs at certain times of the day.

- Observing the person directly around those times might reveal what makes that behavior happen. This will then help for developing strategies to be used to make the behavior less likely to happen again.

What are therapeutic interventions?

Most professionals believe that all illness has biological, psychological and social components.

There are three main ways in which to help people with mental health problems:

- **Biological therapies**: medication which acts on the physical or biological aspects of the problem
- **Psychological therapies** which help the person to deal with their feelings
- **Social therapies** that aim to change the person's environment or social circumstances

Therapeutic interventions can include biological interventions, psychological interventions and social interventions.

Biological interventions

Biological interventions for mental health problems consist of medication. There are many different types of medications that can be used for mental health problems. These are sometimes referred to as psychotropic medication. There are now different types of medication .

Names of medication

- Medications have two or more names and they can be difficult to pronounce. Two names for medications —the generic name and in parenthesis, the trade name.
  An example is fluoxetine (Prozac).
- One is the chemical name (from the compound it is made from) and the others are brand names (given to them by the companies that make them).
  For example:
  Chemical name: Chlorpromazine
  Brand name: Largactil

Why is medication prescribed?

Chemicals carry different messages from brain cell to brain cell. Sometimes if we have too little or too much of one chemical, it can lead to a mental health problem. Medication reverses these problems and restores the right amount of chemicals in the brain.

Side effects

As well as treating the mental health problem medications can also cause unwanted side effects. These side effects are caused because the medication affects other parts of the brain or body as well as the one it is trying to target. For example, a medication that is still sometimes given for schizophrenia is chlorpromazine.

Chlorpromazine reduces the build-up of the chemical 'dopamine' that causes psychotic symptoms. But it also affects parts of the brain that help control our movements, so some people might get tremors or shakes as a side effect.

What information should you get from the doctor or nurse?

When a drug is prescribed to the person you care for there is some information that you should know. Doctors and nurses will normally provide you with this information, but they might need to be reminded. You will need to know:

VII. What it is prescribed for
VIII. Why the doctor thinks it will be helpful for the person
IX. What the possible side effects are
X. What you should do if the side effects occur
XI. How the medication should be given (i.e. with water etc.)
XII. At what times it should be given

If you require further information, you could ask if there are any information leaflets available on medication. There are some leaflets that are available especially for people with intellectual disabilities on medication;

How will the medication be monitored?

Once a medication is started there should be a procedure to ensure it is monitored and regularly reviewed. Immediately after a new medication is started it would be normal for the doctor or nurse to want to see the person every four to eight weeks. Once the person is settled on the medication it should be reviewed at least every six months. You can help this process by providing information on the following:

- Is the person agreeing to take the medication and do they take it as prescribed?
- Have their views changed about taking the medication?
- Have the signs and symptoms of the mental health problem gone away or reduced?
- Have they had any side effects?
- Do you think it has improved their quality of life?

Medications are used to treat the symptoms of mental disorders such as schizophrenia, depression, bipolar disorder (sometimes called manic-depressive illness), anxiety disorders, and attention deficit hyperactivity disorder (ADHD).

- Sometimes medications are used with other treatments such as psychotherapy. Can you describe:
  - Types of medications used to treat mental disorders
  - Side effects of medications
  - Directions for taking medications
  - Warnings about medications from the U .S. Food and Drug Administration (FDA).

- Choosing the right medication, medication dose, and treatment plan should be based on a person's individual needs and medical situation, and under a doctor's care.
- Information about medications is frequently updated.
- Check the FDA website (http://www .fda.gov) for the latest information on warnings, patient medication guides, or newly approved medications.

What are psychiatric medications?

Psychiatric medications treat mental disorders. Sometimes called psychotropic or psychotherapeutic medications, they have changed the lives of people with mental disorders for the better.

- Many people with mental disorders live fulfilling lives with the help of these medications. Without them, people with mental disorders might suffer serious and disabling symptoms.

How are medications used to treat mental disorders?

- Medications treat the symptoms of mental disorders. They cannot cure the disorder, but they make people feel better so they can function.
- Medications work differently for different people. Some people get great results from medications and only need them for a short time. For example, a person with depression may feel much better after taking a medication for a few months, and may never need it again. People with disorders like schizophrenia or bipolar disorder, or people who have long-term or severe depression or anxiety may need to take medication for a much longer time.
- Some people get side effects from medications and other people don't.
- Doses can be small or large, depending on the medication and the person.
- Factors that can affect how medications work in people include:
  - Type of mental disorder, such as depression, anxiety, bipolar disorder, and schizophrenia
  - Age, sex, and body size
  - Physical illnesses

- Habits like smoking and drinking
- Liver and kidney function
- Genetics
- Other medications and herbal/vitamin supplements
- Diet
- Whether medications are taken as prescribed.

Biological interventions for depression

A person suffering from depression may be prescribed medication to take. New antidepressant medication has fewer unwanted effects and is safer than older ones. Antidepressants are not addictive. They can be prescribed by a GP.

There are two main categories.

(3) SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

Low levels of a certain chemical in the brain called serotonin cause depression. These types of drugs increase the amount of it in the brain. Examples.

Table.1 Selective Serotonin Reuptake Inhibitors (SSRIs)

Chemical name	Brand name
citalopram	Cipramil
fluoxetine	Prozac
paroxetine	Seroxat
fluvoxamine	Faverin
sertraline	Lustral

The most common side effects of these drugs are nausea and headaches, although they may also cause restlessness, irritability, anxiety and some difficulty in getting off to sleep. These side effects are generally mild and usually only occur in the first few days of taking the medication. When coming off these tablets, it is important not to stop them suddenly, but to tail off the dose gradually with the advice of a doctor.

(4) TRICYCLIC ANTIDEPRESSANTS

These types of drugs interfere with two brain chemicals: serotonin and noradrenaline. This group includes the examples given below.

Table 2 Tricyclic antidepressants

Chemical name	Brand name
amitriptyline	Lentizol, Tryptizol
clomipramine	Anafranil

dothiepin	Prothiaden
lofepramine	Gamanil
imipramine	Tofranil

These drugs are more sedative than the SSRIs, and can cause more troublesome side effects, such as a dry mouth, blurred vision, dizziness, constipation and difficulty passing water, which can rule out their use in the elderly. However, they are effective antidepressants and suit some people well.

- If taken as an overdose these drugs can cause heart irregularities. Most people with an episode of depression respond to the first drug they try. For all antidepressants it takes about 3 to 4 weeks before any change in mood is apparent. The improvement in mood is gradual, and a person may still have 'bad days' even though they are significantly better. It is important that the drug is tried for at least one month, and is taken regularly as prescribed.

- Some depressed people require higher doses of the drug than is first prescribed. The doctor will gradually increase the dose, which usually results in the expected improvement in mood. If this does not happen, or if side effects are intolerable, the doctor will probably prescribe from a different group of antidepressants. Also, the doctor might do a blood test to check whether the drug is at the correct levels in the blood stream for it to work effectively.
- If a depressed person is experiencing delusions or hallucinations, the doctor may prescribe some antipsychotic medication such as chlorpromazine (Largactil), haloperidol (Serenace), olanzapine (Zyprexa) or risperidone(Risperdal).

One of these drugs may also be used in a low dose if the person is experiencing anxiety or irritability.

- Circumstances such as profoundly low mood and failure to eat or drink are life threatening. Overwhelming suicidal thoughts may mean a person needs 24-hour nursing care and more intensive treatment. Admission to a specialized mental health unit may be needed to provide appropriate assessment and treatment.

Biological interventions for manic depression: mood-stabilizing medicines

Manic depression is treated with mood-stabilizing medicines such as lithium.

LITHIUM (BRAND NAMES INCLUDE CAMCOLT, LISKONUM, PRIADEL)

People with manic depression get depressed and need antidepressants to lift their mood, but they may suddenly swing the other way to become manic,

needing sedation. To prevent these huge swings in mood, which are so disruptive, a person is prescribed lithium.

CARBAMAZEPINE (BRAND NAME: TEGRETOL)
Carbamazepine is normally given for epilepsy but it can also be used to stabilize mood disorders. Although lithium is thought to be more effective, carbamazepine has the advantage of having fewer side effects. Sometimes if lithium is not effective at controlling mood fluctuations then carbamazepine is added. It is also sometimes used in the control of challenging behavior and epilepsy.

What medications are used to treat depression?

- Depression is commonly treated with antidepressant medications.
  - Antidepressants work to balance some of the natural chemicals in our brains. These chemicals are called **neurotransmitter**s, and they affect our mood and emotional responses.
- Antidepressants work on neurotransmitters such as serotonin, norepinephrine, and dopamine.

	Major functions
Norepinephrine	Excitatory and inhibitory functions at various sites. Involved in neural circuits controlling learning, memory, wakefulness, and eating. malfunctioning Depression (undersupply)
Serotonin	Inhibitory at most sites. Involved in mood, sleep, eating, and arousal, disorders and may be an important transmitter underlying pleasure and pain. malfunctioning Depression, sleeping, and eating disorders (undersupply)
Dopamine	Inhibitory. Involved in voluntary movement, emotional arousal, learning, memory, and experiencing of pleasure or pain. Malfunctioning Parkinson's disease and depression (undersupply) Schizophrenia (oversupply)

- The most popular types of antidepressants are called selective serotonin reuptake inhibitors (SSRIs).
  - **These include:**
    - **Fluoxetine (Prozac)**
    - **Citalopram (Celexa)**
    - **Sertraline (Zoloft)**
    - **Paroxetine (Paxil)**
    - **Escitalopram (Lexapro).**

Psychological Interventions

Psychological interventions help people to deal with their feelings. They help people with mental, emotional and behavioral problems. Often when someone talks about being 'in therapy' or 'having psychotherapy', these are the types of therapies that they mean. There are many different types of psychological interventions. You might wish to know more about what is on offer, what the psychological approaches to mental health problems are and what each entails.
Psychological interventions include the following:

Cognitive behavioral therapy (CBT)
Psychodynamic psychotherapy
Behavior therapy and skills training methods
Family therapy
Therapy sessions in groups
Other therapies
Dramatherapy Art therapy Music therapy

Cognitive behavioral therapy (CBT)
Cognitive behavioral therapy (also known as CBT) is based on the idea that a person's beliefs about what they do, and their reasons for doing them, are as important as what they actually do. In other words a person's thinking, assumptions and beliefs about the world are as important as his or her actions. The main aim of this type of therapy is to change the way the person thinks about certain situations, which in turn could help him or her to cope better. For example, depressed people tend to think that they are not good at anything. This thought would affect the way they view a successful event (e.g.' it was pure luck')and how they cope with failure(e.g. self-blame:'I always fail'). In cognitive behavioral therapy the person will learn not to generalize these negative thoughts over all aspects of life(e.g. 'I have been unsuccessful in one area').

WHAT HAPPENS IN COGNITIVE BEHAVIOURAL THERAPY? During the sessions the therapist will help the person to identify negative or irrational

thoughts or thinking patterns (cognitive) and unhelpful patterns of acting (behavioral).

Common **Cognitive Distortions**
Cognitive Error Description

- *Absolute thinking*
  Viewing experiences as all good or all bad, and failing to understand that experiences can be mixture of both.
- Overgeneralization
  Assuming that deficiencies in one area of life necessarily imply deficiencies in other areas
- Selective abstraction
  Focusing only on the negative aspects of a situation, and consequently overlooking its positive aspects
- Arbitrary inference
  Reaching a negative conclusion about a situation with insufficient evidence
- Magnification
  Creating large problems out of small ones
- Minimization
  Making large problems small, and thus not dealing adequately with them
- Personalization
  Accepting blame for negative events without sufficient evidence they are not objectively true.
  ☐ Cognitive theory is a highly rational approach to human behavior. Even though the theory assumes that many of a person's beliefs are **irrational and distorted,** it also assumes that human beings have great potential to correct these beliefs in light of contradictory evidence. – - In clinical assessment, the social worker must assess the client's schemata, identify any faulty thinking patterns, and consider the evidence supporting a client's beliefs. - During intervention, the social worker helps the client adjust his or her cognitive process to better facilitate goal attainment. As a result, the client will also experience more positive emotions.

Four Behavioral Change Strategies
Strategy Description

- Desensitization
  Confronting a difficult challenge through a step-by-step process of approach and anxiety control
- Shaping

Differentially reinforcing approximations of a desired but difficult behavior so as to help the person eventually master the behavior

- Behavioral rehearsal

  Role-playing a desired behavior after seeing it modeled appropriately, and then applying the skill to real-life situations

  - Extinction

WHO IS COGNITIVE BEHAVIOURAL THERAPY FOR? This kind of therapy has helped many people with mild to moderate depression, anxiety, obsessive compulsive disorders, bulimia, phobias and panic disorders. It is also used in schizophrenia, as most peoples till experience psychotic symptoms (e.g. voices), though less frequently and intensely when they are on medication. It is clear that the person must be motivated and able to communicate the content of their thoughts to the therapist, though this may need to include the use of non-verbal materials such as drawings and symbols.

Psychodynamic psychotherapy

The theory behind this approach has been around for a long time. It has been adapted for those with intellectual disabilities and mental health problems over the last 20 years. It involves talking to a qualified psychodynamic psychotherapist who in turn will help the person to understand their feelings.

WHAT HAPPENS IN PSYCHODYNAMIC PSYCHOTHERAPY? The psychotherapist adopts a listening stance and allows the person to talk about what they want. The focus is on the person's conscious and unconscious assumptions about relationships and how these are played out with the therapist during the therapy session. Thus past experiences resurface and can be thought about in a live way. The therapist avoids imposing his or her view and the person in turn is asked to live with the uncertainty aroused by this.

WHO IS PSYCHODYNAMIC PSYCHOTHERAPY FOR?

People with anxiety or relationship problems might benefit from psychodynamic psychotherapy. To undergo therapy they must be able to tolerate anxiety during the therapeutic process and not act out their anxiety by resorting to behaviors such as self-harming or alcohol abuse.

Counseling

The counselor tries to help the person to overcome emotional problems through a combination of talking and listening.

WHAT HAPPENS IN COUNSELLING?

Listening to the person talking is important because the main purpose is to help the client understand him or herself more clearly. By thinking aloud the person

can become aware of links between aspects of feelings and behavior that previously have been unrecognized. The counselor explains the rationale and that has the effect of making problems more understandable and therefore gives the person the confidence that he or she can solve the problems. The development of trust between the therapist and the person is important. It allows communication in words, and it promotes the understanding and integration of previously unacknowledged aspects of the self and relationships.

Behavioral therapy

Behavioral therapy suggests that apparent behavior has been learnt. Behavioral therapy aims to identify and directly change unwanted behaviors. Or, alternatively, unwanted behaviors are ignored whilst more positive socially valued behaviors are rewarded. Less attention is paid to what has actually caused these unwanted behaviors.

WHO IS BEHAVIORAL THERAPY FOR?

This kind of therapy can be used with people who have limited or no verbal communication skills, although the ability to communicate one's thoughts and feelings can give valuable information for behavior therapy. Again in order to reach a successful result the person has to co-operate as much as possible with the intervention plan.

WHAT HAPPENS IN BEHAVIOURAL THERAPY?

Current behavior management combines the teaching of new skills together with the suppression of undesirable behaviors. There are several ways of encouraging and increasing new behaviors. Some carers might have used these techniques at home over the years without even realizing. **These techniques** are widely used and include the following:

- The ABC approach
- Positive reinforcement
- Prompting
- Shaping
- Chaining
- Relaxation training
- Role-playing
- Modeling
- Desensitization

The ABC approach

In traditional behavior management, the problem is studied and then the environment is manipulated in such a way as to increase, decrease or maintain the behavior. This is known as the ABC approach. The problem or, as it is otherwise called, the target Behavior is described and then either the

Antecedents and/or the Consequences of that behavior are maneuvered. This is described in the case of challenging behavior.

Relaxation training
Inrecentyearsresearchevidencehasshownthattheuseofrelaxationtechniques in people with intellectual disabilities and behavioral problems is beneficial. Behavioral relaxation training involves the demonstration of 'tense' and then 'relaxed' states in different body areas. During the session the therapist demonstrates first and the person just observes. Later the therapist provides prompting and feedback according to performance. It includes the following steps:

Sitting in a relaxed posture
Tension release cycles in the hands and face
Breathing slowly and deeply

The person is asked to repeat the tension release cycles in different parts of the body. Alternative methods of relaxation include deep breathing exercises and listening to soothing music. Once the person has mastered these techniques it is hoped that they will use them in everyday life situations that they find difficult in order to counteract anger or anxiety and become relaxed and calm. Audiotaped instructions or soothing music may help self-initiated relaxation. People who have intellectual disabilities may experience a number of fears and anxieties in everyday life. The process of relocation from hospital to a community setting might cause anxiety for example, or the presence of behavioral difficulties might hinder the relocation process itself. Relaxation training might be part of a treatment plan aimed to make these difficulties easier to cope with.

Family therapy
Most people with intellectual disabilities live with their families or in 'family' groups such as group homes where they are supported by staff teams. Working with the person and their family can boost the therapeutic process.

Feeling • **feeling as if something terrible is going to happen to her** • **feeling scared**
Thinking • **worrying too much about her problems or her health**

•thoughts that she is going to die, lose control or go mad (these thoughts are often associated with severe physical symptoms and extreme fear) **•repeatedly thinking the same distressing thought again and again despite efforts to stop thinking them**
Behaving **•avoiding situations that she is scared of, such as marketplaces or public transport** **•poor sleep**

Assessing someone with a mental illness

How can you carry out an interview to diagnose a mental illness?

. the main symptoms of mental illness and know how to manage difficult interviews, such as those in crowded primary care clinics or with people who refuse to talk.

- Ask questions to confirm the presence of a mental illness.

3. Can you examine a mentally ill person?

The assessment of mental health need not be done by a specialist. It requires nothing more than compassion, good listening skills and some basic knowledge.

Some health workers have mixed feelings about assessing a mentally ill person. They may experience:

- **fear that the person may attack them;**
- **disgust with the person's lack of personal hygiene;**
- **frustration that the interview may take longer than a regular examination;**
- **amusement at the odd behavior shown;**

• **anger that the person is wasting their time with 'no real illness'.**

- Such feelings will usually make it harder to provide help for mental illness.
- These attitudes will also make the person less comfortable and less likely to share feelings.
- A person with a mental illness should be treated with the same respect and compassion as anyone else.

Working with the mentally ill is a challenge that will be both fulfilling and rewarding. The most important aspect of assessing mental illness is to give the person enough time.

Box 2. Golden questions to detect mental illness in general health care settings
•Do you have any problems sleeping at night?
•Have you been feeling as if you have lost interest in your usual activities?
•Have you been feeling sad or unhappy recently?
•Have you been feeling scared or frightened of anything?
•Have you been worried about drinking too much alcohol recently?
•How much money and time have you been spending on alcohol recently?
If any of the answers are 'yes', ask more detailed questions to confirm the diagnosis.

- How to conduct interviews

Here are some hints on how to help people feel comfortable discussing their feelings and symptoms:

• You should introduce yourself to the person. Some people may be confused or suspicious. You should clearly state your professional role and say that you wish to talk about the person's recent health.

• To establish rapport, you can begin the interview with a general subject such as a recent news event. Many people feel more comfortable discussing personal issues when they can identify with the health worker, for example speak the same language and live in the same area.

• Empathy simply means imagining what it must feel like to be in another person's place. Understanding a person's symptoms and the social and family situation will help you be more sensitive in dealing with illness and will help the person feel more comfortable in talking to you.

• The *golden questions* should be asked of anyone who consults you. Any positive responses should lead to a more thorough assessment, using the checklists.

• It is helpful always to keep in mind the main types of mental illnesses and their symptoms (☛). This is especially important because many sufferers may not openly discuss emotional complaints unless specifically asked about them.

• You must not appear pressured for time, for example by constantly checking a wristwatch! Remember that just ten minutes is often all that is needed to understand a person's problem and guide treatment choices. Of course, it is better if you can spare more time.

• Give the person a chance to talk without the relatives present. Never consider people 'unreliable' simply because they suffer from a mental illness.

• Try to speak to the relatives as well. Some people with a mental illness may deny they have a problem. Some may not be fully aware of the nature of their behavior. Relatives and friends can often

Determinants of Practice:

What constitutes mental illness?

If we are uncertain about what constitutes mental health, there is no more clarity about what constitutes mental illness. It is possible to think of mental health and mental illness as a continuum: the Olympians at one end and the insane at the other, with most of us scattered somewhere around the middle. I am not convinced of the usefulness of this notion. While the Olympians would be regarded as exceptional, they would not be seen as 'abnormal', as mentally ill people typically are. There is a disjuncture somewhere along the line and the qualitative distinction would appear to be grounded in whether people can be held responsible for their actions or not. The problem is how to establish this.

In Britain, the law, for example, is very concerned about this issue of responsibility. It is a defence to plead insanity (in effect, 'I was not responsible for my actions'), though this plea will be tested in court. Responsible people are subject to the rigor of the law for illegal behavior: 'not responsible' people can be 'sentenced' to treatment.

- Diminished responsibility is a halfway-house plea which may end in punishment, but punishment that is less severe than it would otherwise have been. This dilemma, whether to punish or to treat, runs like a thread through many of our dealings with offenders and reflects society's uncertainty in some cases about culpability.
- Arguably, the probation service was originally called into existence to assist the legal system to handle this dilemma by offering help, even if it was by means of a 'sentence' through a probation order. The dilemmas have always been particularly acute in dealing with juvenile offenders: patently in determining the age of criminal responsibility and distinguishing between children, young persons and adults. Even if they have technically been found guilty of crime, policy over the years has swung between dealing with children and young persons on the 'treatment' model, based on the idea that offending was one expression of socio-emotional deprivation, and the 'justice' model, which focused on the offence, not the social background.
- In the distant past, the 'deprived' (treatment) view of delinquency predominated. In more recent times the 'depraved' (control) view seems to hold the greater sway as social tolerance of juvenile crime has eroded. For the treatment lobby this has raised dilemmas.

- Two constant criticisms have been made: the effectiveness of treatment methods have been questioned, while the indefinite duration and lack of discharge criteria for them have been regarded as incompatible with notions of social justice. Similar offences should merit a similar 'sentence' of predetermined length. Not that 'control' methods have had much better success if post-custodial relapse rates are any guide. A further dilemma has now emerged: whether treatment is possible in certain cases or not – at least where some adults are concerned.
- Some psychiatrists are arguing that, as a mental illness, severe personality disorder is untreatable and that as a consequence the 'criminal' provisions of the Mental Health Act cannot be used to detain 'dangerous' people. They have to be processed through the ordinary criminal justice system as though they were responsible for their actions. This leaves them to the vagaries of the prison psychiatric services, but more significantly it means that once their sentence has been completed they are discharged into the community whether considered still dangerous or not. The 'safeguard' of detention for treatment, that people will not be discharged until considered safe, cannot be applied. How to plug this gap in the supervision of people seen as a potential danger to the public has given rise to proposals (Dept of Health, 2000) that they could be detained compulsorily to a specialized service whether or not they have committed a crime.
- Moreover, as in the case of sex offenders, the appropriate public services would be notified when a detainee was returned into the community. To balance public protection against civil liberties (especially the provisions of the Human Rights Act) is a delicate matter not easily resolved; and these suggestions will be a source of contention. However, nobody would suggest that all misbehaviors could be attributed to a mental illness; especially if not just legal offences are included but all the objectionable, upsetting or out-of-the-ordinary behaviors we encounter from time to time in daily living.
- Apart from any differences we might have about what to include as 'misbehavior', we would ordinarily have a variety of explanations about what lay behind it. The explanations offered include poverty, social alienation, unemployment, hopelessness due to the lack of future prospects, the paucity of clubs and centers, poor housing, poor education, the lack of good parenting, the moral degeneration of society, Thatcherite materialism, organized criminality and downright evil. The judgments we make will be colored by our general ideas about 'people', personal experiences which seem to us to have some relevance, what we know (or think we know) about this situation and what engages our particular sympathies or revulsions. As a truism, what we can understand adds to our tolerance; what we find incomprehensible adds to our impatience. It

is a complex process by which we begin to formulate our ideas about the forces at work, who or what is responsible, where any fault or blame lies and consequently what ought to be done, by whom, to put matters 'right'. The more people involved in the discussion, the more diversity of view is likely.

Approaches to defining mental illness

If we do not ascribe all 'misbehaviors' to mental illness, we are still left to decide what we do include and what we attribute elsewhere. It seems to me there are basically three possible stances we can adopt:

- 1. The widest stance regards as mental health problems all breakdowns in coping and the associated pain. MIND (the National Association for Mental Health in the UK) uses the term 'mental distress' to define the focus of its concern, but no boundaries are put around the causation of that distress. Neuroses, psychoses, breakdowns in relationships, bereavement, discrimination, victimization, helplessness, lack of services, oppressive economic, political or social systems could be just some of the potential distress-creating factors. Though the range is still wide, mental ill-health can be considered to four broad areas of problem:

(a) social behavior (disabilities in social skills, making relationships, handling aggression and coping with social expectations);
(b) emotional behavior (where problems give rise to depression, anxiety, phobias and so on);
(c) health related issues (a diverse group including insomnia, pain control and destructive behaviors from smoking to drug abuse); and
(d) work-related issues (another extensive group ranging from boredom to burnout; from unemployment to 'workaholicism').

- Their approach seems to have more in common with the psychosocial approach familiar to social work students who have read their Hollis (1972) and Perlman (1957). What this widest definition seems to involve, in effect, is the problem of human living, but the sufferers are so diverse it is impossible to see them accepting a common 'I am mentally ill' identity. Even on a psychiatric hospital ward I have heard those patients suffering basically from neurotic conditions assert, 'I am not like them' – the sufferers from psychotic conditions. The variety of causations would require a variety of remedial methods and a range of organizational frameworks to implement them. Partialization would be the only way forward, with interested groups cohering around specific issues – such as the Mental Health Alliance responding to proposed changes to mental health legislation. It is doubtful whether the component elements would cohere as a mental health movement, particularly given the stigma still associated with mental illness. The temptation to identify elsewhere

would be strong: elements would see their problems as associated with such matters as politics, education or medicine – the more powerful and acceptable social institutions. People could share a common humanity and a common concern for a particular form of suffering – mental distress – but that would be as far as it went. This leaves a place for organizations such as MIND to identify issues, publicize, lobby, advocate and bring together those involved (whether service providers or service consumers; problem 'creators' or 'victims'), but I cannot see mental health ever becoming a popular mass movement. To take on a sea of troubles, call them mental health problems and expect a cohesive response is unrealistic.

- 2. A more limited view of the boundaries of mental ill-health is what we expect of psychiatry. The logic here is that, since psychiatrists are deemed to be the experts in mental disorders, what (Western) society expects them to take care of would be a reasonable guide to what society generally includes in its definition. One of the disorders psychiatry has been expected to deal with is mental impairment. I think this has helped to compound confusion in the public mind between impairment and mental illness. Even the quality media get the distinction wrong from time to time. Fortunately we are in the process of redefining impairment as a socio-educational matter rather than a medical one, so there is reason to hope this confusion will gradually clear. The process would be speeded if impairment was dealt with under separate legislation, as it was for many years after 1913, instead of being pushed in with the Mental Health Acts. For the purposes of this argument I am excluding mental impairment, except insofar as impaired people can also suffer from a mental illness. In terms of mental illness, it seems that psychiatrists are expected to contribute in the following situations:

(a) Emotional disorders. While these may be of any kind and patients of any age, two areas in particular have been developed: (i) child and family guidance; and
(ii) the treatment of certain syndromes which are generally regarded as emotionally-based and collectively identified as the neuroses, including acute and chronic anxiety states, eating disorders, phobias, obsessional compulsive disorders, hysteria and some sexual dysfunctions. I also think of reactive depression as an emotional disorder, different from endogenous depression which I regard as a psychosis.
(b) Disorders which are associated with emotional disturbance such as drug addiction and alcoholism, attempted suicide, sexual deviations and psychosomatic conditions.
(c) Aspects of social malfunctioning which also have connotations of emotional disorder in the sense that they are ascribed to a disorder of personality. The clear extreme here is the so-called psychopathic personality, but the range of disorder is wide, from dangerous criminality to people who seem to have blind

spots – areas of self-management which experience does not change and which produce recurring social difficulties.
(d) The psychoses, by which is meant schizophrenia (or the schizophrenias and including paraphrenia), the affective psychoses (endogenous depression, mania and manic depressive psychosis) and the dementias.

I am not convinced that the first three groups are illnesses in the usually accepted sense of that word. I sympathize with Eysenck's argument (1975) that disorders of function of this kind are not fundamentally medical matters. They became so perhaps by association (and in the process became 'illnesses') because of the pioneering work undertaken by doctors – Freud being the obvious example – at a time when there were no other recognized professions to whom treatment could be entrusted. Psychology and social work, for example, were recognized much later. Medicine's involvement with these disorders suited society.

- To be able to label some 'deviances' illnesses and hand them over to doctors to deal with has the semblance of being humane as well as solving the problem of finding other ways to deal with them. The notion that unhappy people are sick people goes back at least as far as Samuel Butler's Erewhon. Ivan Illich's warnings (1977) of the dangers of encroaching medicalization (still persisting in the view of Kutchins and Kirk, 1999) and the power it puts into the hands of a profession notoriously hard to bring to account are not to be ignored; but these conditions create much human misery and it is fortunate that there are trained doctors around to give their help.
- What I am arguing, though, is that *medicine now has no monopoly for work in this sphere, but shares it with psychology and social work*. It has devolved still further as other professional groups have made use of what has been developed: counselors, psychiatric nurses, occupational therapists, teachers (especially those in pastoral care posts), youth workers and many others share concerns and methods. This is a healthy development. It means that numerically there are more skilled people around (if still not enough), and there are far more channels by which people may gain access to a service.
- Psychiatry still suffers from the stigma of association with 'madness' and for this reason many people strongly resist a referral. With more socially acceptable access points there is more chance of getting at problems early, with a better chance of success.

The narrowest view (if we accept the argument that emotional and personality disorders are not the exclusive concern of medicine and are therefore at the least doubtfully illnesses) is that the only certain mental illnesses are the psychoses. The justifications for this are possibly twofold.

- First, even according to the psychiatry textbooks, the psychoses are qualitatively different. People suffering from the neuroses may see realities in a distorted way and react accordingly, but they are in touch with those realities. People suffering from a psychosis, in varying degrees and over a varying range of aspects of their lives, have lost contact with part, sometimes most, of that reality and are responding to an inner generated perception. This qualitative difference is not related to the severity of the condition, since for some people their neurosis is agonisingly, totally life-disrupting, while some with a psychosis experience but little pain or social disruption. The qualitative difference remains, however.
- Second, this qualitative difference seems to carry over into people's perceptions. Neuroses and personality disorders are seen as exaggerations of feelings and behavior but still connected to ordinary human experience. Psychotics are seen as in another world. The normal expectations do not apply and we are very uncertain how to deal with them. This perception of psychosis is a very mixed blessing. On the one hand uncertainty leaves us vulnerable to fears and fantasies about 'madness' – violence in particular – and these can be reinforced by media exploitation. People with psychosis are consequently misunderstood, isolated and stigmatized, together with their families. There are pressures around for 'something to be done': if they cannot be cured quickly, then remove them before 'something happens' – the origin of the 'not in my backyard' attitude (Dunn, 1999) which can sometimes make rehabilitation programs so difficult to implement. On the other hand, if people with a mental illness are seen as not being responsible for their actions, there is the possibility that merely odd behavior will be tolerated or indulged without the customary social sanctions being applied. It becomes possible for some people to retain a place in society which otherwise they might not have done.

Even if we accept that the psychoses are the true mental illnesses, we will still get disputes in borderline cases as to whether a particular individual is ill or not. In court, for example, defence and prosecution will call expert witnesses to support diametrically opposed points of view about the culpability of the accused. Moreover, even if it is agreed that people are suffering from a psychosis, there is no unanimity of view about the cause of it.

Influence on practice

Just as our attitudes to mental health will affect our perceptions of the nature of the difficulties, our goals and the means of attaining them, so will our views of mental illness. If we adopt parameter 1 above we have an enormously wide

choice of what we address, from what operational base, by what method and involving a selection of professional or occupational 'hats'. For instance, if I felt that unemployment was a primary determinant of mental illness, I could tackle it by getting involved in individual counseling, mutual support groups, groups which sought to develop interests and hobbies as alternative sources of satisfaction and esteem; through welfare rights work; through public or sponsored employment training schemes such as the Welfare to Work program; by assisting the setting up of worker co-operatives or by becoming an employer myself. If one of the explanations of unemployment was the powerful position of employers over employees, a logical choice would be involvement with the labor/trade union movement. You could campaign to get the government to do something about it, or you might, through the media, try to work up pressure on the issue. Unemployment is inevitable in a developing country like ours and the only real answer is direct action. All these activities are arguably relevant if the range of systems involved in the issue, from the individual to the societal, are to be tackled by appropriate means.

- For me, the primary social responsibility of social worker is to treat individuals. In that sense its scope and methodology are much more circumscribed than those inferred in society. Nevertheless social workers see a wide range of problems reflecting most of the 'public issues' confronting society as well as the 'private sorrows'. What will bring people the way of a social worker is not so much the problem as the symptoms or syndrome they are displaying as a result. The diversity of symptomatologies with their wider range of origins has pushed psychiatry in different ways – three in particular:

(1) ***Into specialization***. Even the three main fields (mental impairment, adult psychiatry and child and family guidance) have subdivided further into such areas as psychogeriatrics, addictions, forensics, and adolescent psychiatry; and into specialization by method, from relaxation to confrontation, from individual psychoanalysis to family and group therapy;

(2) ***Into disagreement***. The range of possible problems behind what appear to be a similar group of symptoms has led to considerable divergences of view about causation, and consequently what is the appropriate means of treatment. Again, we will be looking at this in more detail in the next chapter.

(3) *Professional practice*. Despite differences, psychiatry (like other professional groups) has individually and collectively spoken out on issues of public policy that have emerged in their professional practice.

Social workers who use this parameter of approach to defining mental illness cannot avoid similar issues. They will have to decide on their specialism and examine explanations of causation; and where they stand on professional issues, not just to establish a basis for their own work but to provide a foundation for orientation to the clinical team, since clinical team-work is a crucial characteristic of parameters 2 and 3. Teams have to work out a sufficient

unanimity of approach if they are not to reduce themselves, patients, families and others to confusion. Though more comprehensible than parameter 1 (distress), parameter 2 (psychiatry) is still very wide in its scope, remains hazy and ambiguous in various respects and has internal contradictions. It therefore remains an unsatisfactory basis for defining what we mean by mental illness. My own choice is parameter 3, the psychoses only, and I have five reasons to support this:

(1) There is very little dispute that these are mental illnesses, so the boundaries of concern are relatively specific and clear.

(2) To distinguish them in this way seems to reflect both the clinical and popular conceptions.

(3) It takes emotional and personality disorders clear of the stigma which persists around mental illness. At the same time, with only the psychoses to focus upon, it might well be easier to foster public understanding (as we have begun to do with Alzheimer's disease) and reduce the stigma anyway.

(4) The qualitative distinctions in the conditions suggest that qualitative distinctions are required in practice in response. We need to clarify what these are if we are to offer the best service.

(5) A recognition of its particular nature might raise the status of work with psychotically ill people. Work with people with neuroses currently seems to have pride of place. Need insists that sufferers from psychosis have parity. It is this stance towards defining mental illness that is adopted for the purposes of this course.

1.1 **Social work services and service users**

There are numerous perspectives about mental health and you need to get a good understanding of the various 'models' that are in current use. In reference to social work role, it is true that the social work processes (associated with, for example, poverty, unemployment, poor health, disablement, lack of education and other sources of disadvantage) that lead to marginalization, isolation and exclusion and their impact on the demand for social work services. ◎

- Explanations of the links between definitional processes contributing to social differences (for example, social class, gender and ethnic differences) to the problems of inequality and differential need faced by service users. ◎
- The nature of social work services in a diverse society (with particular reference to concepts such as prejudice, interpersonal, institutional and structural discrimination, empowerment and anti-discriminatory practices).

1.2 Values and ethics◎

These include moral concepts of rights, responsibility, freedom, authority and power inherent in the practice of social workers as moral and statutory agents. ◎

- The complex relationships between justice, care and control in social welfare and the practical and ethical implications of these, including roles as statutory agents and in upholding the law in respect of discrimination.
- The conceptual links between codes defining ethical practice, the regulation of professional conduct and the management of potential conflicts generated by the codes held by different professional groups. ◎
- Aspects of philosophical ethics relevant to the understanding and resolution of value dilemmas and conflicts in both interpersonal and professional contexts.

The importance of values

Social work is fundamentally a moral activity. Social workers often refer to values although the word is used indiscriminately when principles or ethics would be more accurate. Clark (2000) suggests that there are four core values:

1. The worth and uniqueness of each individual.
2. The entitlement to justice.
3. The essentiality of community.
4. The claim to freedom.

These values are given statutory force in various practice guidance notes in many countries and are well upheld by practitioners. Values, knowledge and skills are interconnected in everyday practice even though this is not always apparent. Figure 1 shows how these are connected to each other.

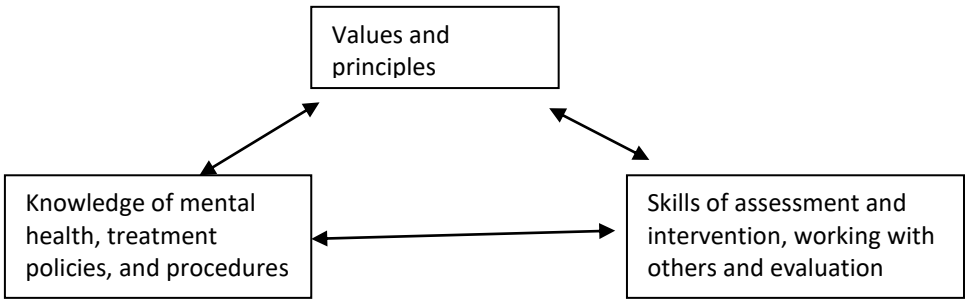

Figure 1.1 Values, knowledge and skills: the foundations of good practice

Although in Ethiopia there is no a statutory body to approve the qualification of social work professionals, in the future like in many other countries, all social care workers will be required to register with an accredited body. Very recently, a National Association of Social Workers has been established in Ethiopia. The existence of such association will allow the registration of social workers and determine external confirmation that a member of staff is registered and suitably qualified. This association in the future can play a key role in the process of regulating who can and who cannot enter the profession and can be

considered necessary in order to drive up the standards of social work and social care practice.

Like in many other fields of professional practice which have their own codes of practice and conduct, the need for a Code of Professional Practice becomes apparent when you begin to learn about the role that social workers have alongside other professionals who deliver mental health services. Generally the codes of practice and conduct have three common themes:

- *the avoidance of possible harm to services users;*
- *the promotion of possible good to service users;*
- *the protection of the profession and the resolution of conflicts.*

The importance of these codes of practice is quite clear since at times people with mental health problems can be in such a vulnerable state that they may even require admission to hospital against their wishes. They need to be assured that nationally agreed standards of service delivery are being adhered to and that the service provider can be held accountable when services fall short.

How are you going to be guided by values and ethics?

The Code sets out the responsibilities for both employers and employees as follows. Social care workers must:

- Protect the rights and promote the interests of service users and carers.
- Strive to establish and maintain the trust and confidence of service users and carers.
- Promote the independence of service users while protecting them as far as possible from danger and harm.
- Respect the rights of service users whilst seeking to ensure that their behavior does not harm themselves or other people.
- Uphold public trust and confidence in social care services.
- Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.
- Look at your Code of Practice which sets out the kind of professional conduct and practice that is required

ACTIVITY 1.1

Look at the Code of Practice in the Field Practice Agency you are assigned to and identify which kinds of professional conduct and practice are set relevant to your social work values. Be sure that you are aware of the contents of this Code and what social work values are by taking all the aspects reorder them to fit into the framework proposed earlier: ones that avoid possible harm to service users; ones that promote possible good to service users; ones that protect the profession and resolve conflicts.

Values in action

Implicit in the Code of Professional Social Work Practice is the importance of recognizing and respecting diversity. This is more than valuing people irrespective of their ethnicity, color or ability. It also involves valuing and respecting that people think and behave differently. People of all ethnic backgrounds and countries experience mental disorder and the service user population is made up of people just like you and me. Conventionally and stereotypically medical practice has remained the dominant partner through its claim to be a series of technical activities. Advances in medication have reinforced the idea that an individual's mental disorder can be managed and that the key process is diagnosis followed by treatment monitoring and evaluation. In this process the danger is that the treated are subservient to those in charge of treatment.

Social workers need to work with medical and health colleagues to provide an effective service but they also need to be at the forefront of processes that empower service users. Implicit in this approach are some ordinary but powerful principles.

- The first is that in order to empower someone we need to work with them rather than do things to them. Empowerment means partnership, openness and honesty.
- The second principle is that the service user has an explanation of their disorder. That needs understanding and to achieve this we need to find ways of active listening that respect the user and enable us to do our job. This may mean having to use imaginative ways of communicating. It might mean trying to use a common language, which could be sign language. It should mean engaging in clear, uncomplicated language that everyone can understand.
- The third principle is that service users value being able to engage with professionals on a personal level. This could mean that social workers should learn to use 'limited' self-disclosure to help build up professional relationships that are also person-to-person, not expert to amateur (Blackburn and Golightley, 2004). Being able to walk in the other person's shoes is an important part of an empowering approach.
- The fourth principle is that the service user is the expert in their own mental health problem. They may not know the answers but they certainly experience the effect or symptoms. They alone have experienced the disintegration of 'normality' as they know it and their explanation should be put alongside the professional view and the two views evaluated against each other. If your world is upside down or inside out it cannot be understood by people who only see things one way up or

right side out. If a service user is hearing voices the social worker must not dismiss these but try to understand when they arrive, what they feel like and how best they can be managed. This is not to collude with delusional behavior as this could be unhelpful and possibly run the risk of missing dangerous behavior. By working with service users to value their experiences, and by seeing the problem through their eyes, the prospect is opened up to work in a manner that is holistic and empowering.

Ethical dilemmas

Health and social care workers work with dilemmas on a daily basis. There are usually two components that help us to think about ethical dilemmas.

- First there may be competing views about what should be done. How would you respond to a service user when they want to stop taking their medicine? This is an ethical dilemma and people would argue strongly for one position or the other. This contrasts with a view that medicine should be given with or without service user consent, if it were necessary to prevent death or serious harm occurring. In this instance this is not an ethical issue as there is widespread agreement. (Even so some people claim this should not happen, usually on religious grounds.)
- The second characteristic is that it must have a distinct moral component to it, such as the avoidance of lying, the primacy of life, self-determination and confidentiality. These are sometimes referred to as 'normative principles'.

Resolving ethical dilemmas takes more than just referring to these normative principles or the various codes of conduct. It requires professional judgments after weighing up one principle against another. The following activity will help you to think further about the ethical dilemmas.

ACTIVITY 1.2

Samson is a long term service user who has recurring bouts of depression, which are serious enough to warrant his treatment with antidepressants. In the past when his mood has been very low he has talked about 'ending it all'. As his social worker you visit regularly and he tells you in confidence that he has stopped his medication and is going to experiment with herbal medicine which is more usual in his culture. He has asked your opinion about this action and told you to keep this conversation confidential. Should you respect his wishes? Jot down what your response would be and what the issues are. Now compare with the following paragraphs.

If anyone wants to stop taking medication then this is their right under certain circumstances, unless the law forbids them or treatment against their wishes is

illegal. Some can stop their medication although whether this is a good thing is open to debate. Arguments against keeping confidences or keeping matters confidential derive from different sources.

- First there is a principle of paternalism usually derived from the possession of 'expert' knowledge. Put crudely the professional knows best.
- Second there is a principle of autonomy where the person has freedom over his or her own body, which is essentially a moral principle.

Individuals are experts in their own mental health condition and as such they know best. Resolution of this requires you to balance the strength of one principle against the other. In practice you would probably seek to encourage the client [patient] to sit with the others involved in his treatment and to talk through his and your concerns and try to get to a position where his shift to herbal remedies is informed by evidence, monitored and reviewed.

You would need to take into account the extent to which the service user has the capacity to be able to make such a decision, the quality of the information on which this is based, if there was any coercion on the service user when making this decision and any legal issues that could change the nature of the discussion. One way that service users can be helped to make good quality decisions is through patient advocacy services. By using advocates who are independent of the mental health team, but who have specific knowledge of mental health and mental health services, the quality of service user decisions can be enhanced.

Ethnicity and mental health

The discrimination that is experienced by people with mental health problems can be intensified if that person happens to be from a minority ethnic community.

Though the following example does not typically explain the Ethiopian situation, it may help highlight what it means when someone is from a minority ethnic group. The example is that a service user talks about her experience of using mental health services as a black person:

> *Coming to mental health services was like the last straw … you come to services disempowered already, they strip you of your dignity … you become the dregs of society*. (Keating and Robertson, 2002, p.18)

This is a commonly held experience of black service users. When put together with the perception that when black people are seen as difficult they are likely to be over medicated there is little wonder that this has become a priority area.

Discrimination has been a source of concern to many practitioners over the years. Evidence has suggested that on the one hand the UK's black and minority ethnic population are over-represented in secondary care (hospital admissions

etc) and on the other hand underrepresented in primary care that specifically addresses the needs of black and minority ethnic communities. Of particular concern has been the over-representation of Caribbean and black African people who have been detained against their will and who are being treated in Medium Secure Hospitals (MSUs). Evidence collected by the Mental Health Act Commission shows that 30% of the population resident in MSUs were from predominantly black African or Caribbean ethnic groups, which is well over the proportion that might be expected when compared with the population at large.

Fundamental to developing better social work practice is having better quality of information and using it more intelligently than is evident at present. A starting point is for you to become familiar with population data and information about ethnic minorities, refugees, drug users, inmates.

James Nazroo (1999) suggests that different rates of diagnosis of mental illness between black and minority ethnic people represents one of the most controversial issues that present day services face. In practical terms you need to examine the reasons why minority groups are more likely to be depressed than their white counterparts and why minority ethnic groups are less likely to seek early help from primary care.

Anti-oppressive practice

Social work has a history of attempts to practice in ways that are anti-oppressive. One of the key figures in the literature is Dominelli whose book Anti-Racist Social Work (1988) not only provides well-argued discussion about these issues but also gives strategies for the implementation of anti-racist social work. These ideas, although nearly two decades old, still have relevance for you as a practitioner as mental health care is the only aspect of care provision and treatment that, if refused, can result in that person's compulsory admission to hospital through a legally authorized pathway.

Social workers, after suitable post-qualifying training, can be a major part of such procedures and can also be involved in other aspects such as providing advocacy, reports for tribunals, arranging diversion into community resources, etc.

ACTIVITY 1.3

Think of a situation where in practical terms you will have to take culture into account when working with someone from a minority ethnic background, or from a culture different from yours.

Some of the social work practices, at least in other countries, reveal the perils of professional practice that is not culturally relevant, or appropriate to their cultural and religious beliefs and responsive to their needs. The evidence shows the extent to which stereotypical views can permeate professional practice and it highlights the dangers of seeing people only by the color of their skin, or by their language or religion. Looking beyond this in a critical manner is the hallmark of good practice. At this point it is appropriate to examine the ways in which our practice can be transformed. It should be clear that services need to become more relevant to the needs of minority ethnic groups and other minority groups such as people who are deaf, blind, or having developmental disabilities.

- Service users frequently point out that the services that they are receiving show little understanding of their culture. But changing this is not a simple matter. You also need to recognize that this is a sensitive issue influenced by your own ethnicity and skin color.
- Social workers who are skilled in anti-oppressive practice and using a values based practice approach are clearly further on than those who are not, but there is no room for complacency as many of the explanations of service variability show that racism permeates organizations.
- It is questionable whether we can be competent in cultures that are not our own and in any case the range of diverse cultures in our country makes competence in all cultures an unrealistic proposition.
- An alternative to understanding different cultures is to recruit more social workers and other professionals from these minority communities to ensure cultural congruence or, in other words, proportionate representation of professionals from all groups. However this can only be a limited strategy, for although positive action strategies when recruiting staff and adopting equal opportunities interview methods are vitally important, they are in themselves insufficient.
    - But what if you are a minority social worker working with mainstreamed service users or the other way around? What kind of approach can you adopt? To what extent do your stereotypes distort your assessment and decision-making processes? The National Institute for Mental Health England (NIMHE) has recommended that all staff working in this area receive compulsory training in cultural awareness to help eradicate racism and discrimination. Although there are many such courses around quite a few of these promote awareness rather than competency. Awareness is just one stage in developing culturally competent practice.

The inquiry team concluded that: The added factor of his blackness may have contributed to the diffident manner in which some professionals treated him and it may have caused them to defer against his best interests, to his own

expressed wishes. (Ritchie et al., 1994, p.4) and Young black males should not be type-cast as suffering from schizophrenia unless the clinical indications warrant it and clinicians and others who care for black mentally ill people should not be too ready to ascribe odd behavior to the abuse of drugs. (Ritchie et al., 1994, p.129)

Components of culturally competent practice

The idea of being able to work with a diverse range of cultures is not entirely new but has gained momentum and acceptance of late. Walker (2003) uses the idea of cultural competence building on the work of Kim (1995), while Patel et al. in Engaging and Changing (2003) refer to practice as being 'culturally sensitive', whereas Fulford (in MHAC 10th Biennial 2001–2003) describes 'value based practice'. Some of the common themes are blended together into five components of culturally competent practice and each of these is explored below.

1. **Capacity for your own cultural awareness**
   This should start with an honest understanding of your own culture and the impact that this has on your professional practice. You need to be aware of your own attitudes, values and beliefs before you can be aware of the attitudes and beliefs of others.
2. **Capacity for awareness of other cultures**
   It is a widely held view that self-awareness is one of the core components of a practice that is culturally competent (O'Hagan, 2001; Poole, 1998, etc.) but after that it is necessary for you to develop your own capacity for understanding the other cultures and putting this understanding into practice. This requires you to make a realistic assessment of your knowledge and understanding of working with people and of their cultures.
3. **Understanding of diversity and difference**
   Community engagement is currently being promoted as the main way that professionals can increase their understanding of specific needs of communities. Social workers should respect diversity and build upon people's strengths and the collective strengths of the communities. Effective work with and across cultures requires that you understand and value difference both at the individual and at the community level. This also means recognizing and accepting your own personal and professional limitations.
4. **Transferring skills from one service user culture to another**
   At the heart of much of professional practice is the idea that skills that are learned from work with one type of problem can be transferred to another. This means that the skills that you have in assessing white people who have depression can also be used when working with Asian

people who have depression. But as we have seen earlier effective assessment requires you to understand the context in which the person is living. However social work skills such as empowering practice are key components of this transforming practice.

5. **Being able to recognize the impact of structural racism and discrimination**

   Section 11 of the Health and Social Care Act 2001 places a duty on local health services to consult with services users and the public in the planning and development of services and this is an important step in the development of better and more appropriate services. Services are required to work with vulnerable groups and individuals at risk and to tackle social exclusion. This means that all providers of mental health services, including GPs and primary care workers, will be involved in some way or other in helping to deliver a service that is culturally appropriate and responsive to all groups in society.

Is it possible to achieve cultural competence? As you can see from the list set out earlier this is a difficult task and not everyone thinks this will be achieved. There is some healthy skepticism about the evidence. Many think that the picture is of 'a lot of fragmentation, different approaches and different models'. She says: 'There is no agreed definition of cultural competence and no evidence that it works in producing better services for black and minority ethnic users. We should be looking at structural processes and power relationships in the way services are delivered.' In evidence, there is a warning against services focusing on 'cultural matching' in favor of staff spending more time talking to patients and their families.

- Taking time to respect an individual, and ask what is troubling him and what he needs, is likely to be more effective than 'talking about culture, ethnicity and cultural competence' (Guardian Wednesday, 2006 April 12)

Achieving cultural competence may well require more than individuals alone can achieve.