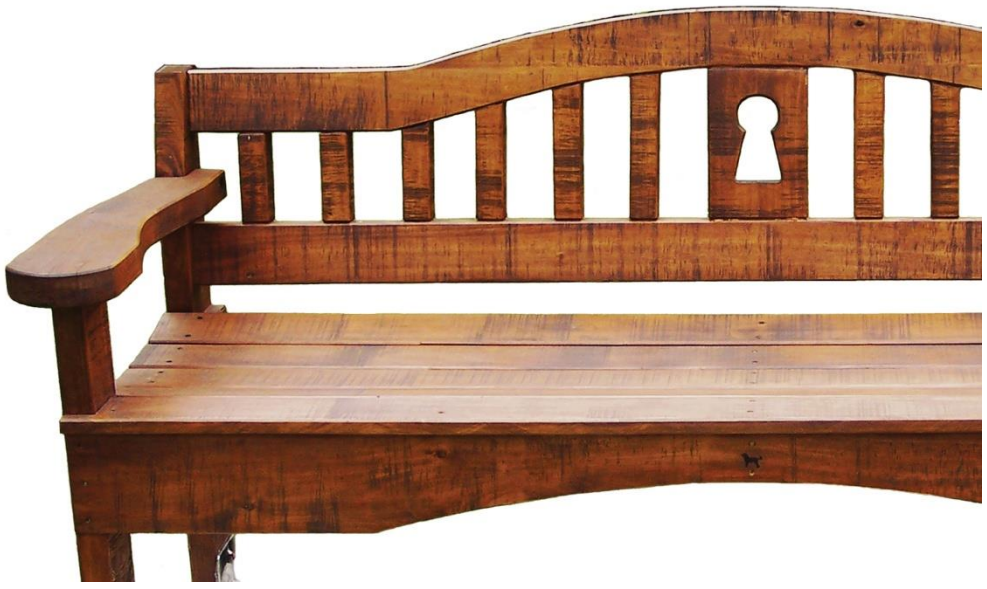
mydistance
LEARNING COLLEGE

COMMUNITY MENTAL HEALTH AND PSYCHIATRY



Community Mental Health and Psychiatry

Published and distributed by:
My Distance Learning College
Tel: 0800 622 6157

Publication date	July 2008
Edition Number	2008/01

The authors believe the contents of this book to be accurate and correct, and all possible care has been taken in producing this work, no guarantee can be given. You should take professional advice prior to making any decisions. This workbook should, however, provide you with good background information.

Tutor Information

Joshua Cole MBACP

Joshua Cole is a highly effective Mental Health Professional, specialising in the counselling and treatment of individuals with complex needs, including personality, eating and dissociative disorders. He is passionate about helping those who experience mental health issues, and possesses a unique blend of entrepreneurial skills and business acumen, combined with exceptional knowledge of the sector. He is regarded as an inspirational, visionary, leader amongst peers and a 'safe pair of hands' within the wider profession.

Joshua founded and established the Registered Charity BPDWORLD in 2003, a service designed and constructed to offer information, advice and support to those afflicted with Borderline Personality Disorder (BPD). He is trained and qualified to Post Graduate Diploma level in Mental Health (CBT), and is in the process of completing a Masters Degree in Mental Health with the University of the West of England. Alongside this worthy ideal, he is also currently in his final year of a Social Work Degree, on course to achieve a 2.1.

Having completed a Master Practitioner award from the National Centre for Eating Disorders, and Certificated in the Treatment and Diagnosis of Dissociative Disorders, Joshua is an inveterate self-improver. Joshua studied with Professors Anthony Bateman (Consultant Psychiatrist and Psychotherapist, and Honorary Senior Lecturer at University College, London (UCL), and Peter Fonagy (Freud Memorial Professor of Psychoanalysis at UCL), to become certified in MBT (Mentalisation Based Treatment). This is an innovative treatment for personality disorder which can be implemented by nurses and other generic mental health professionals, making it generalisable to other services in the NHS. He also studied Dialectical Behavioural Therapy (DBT) with Dr. Fiona Kennedy. DBT combines standard cognitive-behavioural techniques for emotion regulation and reality-testing, with concepts of distress tolerance, acceptance, and mindful-awareness largely derived from Buddhist meditative practice. It is the first therapy that has been experimentally demonstrated to be effective in the treatment of BPD.

Joshua was previously commissioned as an independent consultant in the role of care coordinator with the social services department of Gloucestershire County Council. He also provided specialist long term treatment as a psychosocial development worker for four years to a group of 15 women in a low secure hospital. The women, who self-harmed regularly, were diagnosed as having severe borderline personality disorder and considered a risk to themselves and others.

Joshua has organised conferences on BPD, which have included contributions from key speakers and subject matter experts such as Professor Anthony Bateman.

Contributions to various mainstream media presentations have included the BBC radio programme "All in the mind", with Dr. Raj Persaud (Consultant Psychiatrist and Gresham Professor for Public Understanding of Psychiatry), and a documentary on BPD, which investigated the theories, causes and treatment of the disorder.

Joshua is committed to promoting change within the mental health profession, and contributing to the further education of fellow professionals. He has authored several Open College Network-accredited training courses, delivering up-to-the-minute knowledge and direction, and providing expert commentary on key developmental issues and strategies, in the fields of both counselling and mental health up to HNC-level. He has designed, developed, and delivered distance learning courses for mental health professionals and students.

This experience has led to the establishment of his own distance learning establishment, MyDistance Learning College (http://www.mydistance-learning-college.com), a UK Limited Company. This venture further expands the much-needed flexible learning environment for people unable to attend full-time tertiary education. Joshua has been granted the NCFE Investing in Quality License, and the College has been awarded NCFE Approved Centre status.

Assignment 1

1.1 Analyse the principal functions of a Mental Health Worker.

1.2 Analyse the three principal types of advocacy and evaluate their importance's.

1.3 Evaluate the variety of job roles within Mental Health and their effectiveness.

Assignment 2

2.1 Analyse the importance of the Mental Health Act.

2.2 Evaluate the principal strengths and weaknesses of the Mental Health Act.

2.3 Analyse why a person might need to be sectioned under the Mental Health Act.

2.4 Summarise the principal aspects of the Mental Capacity Act.

2.5 Summarise the implications of the Human Rights Act in the context of Mental Health.

Assignment 3

3.1 Explain the main features of community outreach services.

3.2 Evaluate the functions of community outreach teams.

Assignment 4

4.1 Analyse why men are more likely to describe the physical symptoms of depression rather than the emotional ones when seeking treatment.

4.2 Analyse why women are twice as likely to suffer with depression.

4.3 Analyse why depression often carries social stigma.

4.4 Describe the principal factors which could contribute towards a child developing depression.

Assignment 5

5.1 In your own words, define what is meant by the term ‘eating disorder’.

5.2 Analyse the implications for the individual of having an eating disorder.

5.3 Analyse why Binge eating disorder is regarded as the most common eating disorder rather than anorexia and bulimia.

5.4 Evaluate the reasons why a person with an eating disorder might receive treatment for the physical symptoms of their disorder before the psychological ones.

5.5 Describe the five principal complications associated with eating disorders. Give reasons for your choice.

Assignment 6

6.1 Describe how you would explain personality disorder to someone who has recently been given the diagnosis.

6.2 Analyse why long-term therapy is no always useful for some personality disorders.

6.3 Analyse why some mental health professionals have such negative opinions of people diagnosed with personality disorders.

6.4 Explain the significance of the word ‘border line’ in borderline personality disorder.

Assignment 7

71. Explain the principal aspects of Obsessive Compulsive Disorder (OCD).

7.2 Analyse why so few people with OCD are in treatment.

7.3 Evaluate the assertion that people only develop OCD if they have a genetic disposition.

7.4 Analyse why treatment for OCD is more successful the earlier it is received.

Assignment 8

8.1 Analyse why people self-harm.

8.2 Evaluate the principal strategies that might be usefully employed when trying to prevent self-harm.

8.3 Explain the main signals that a client may be planning to commit suicide.

8.4 Explain the information you would need to gather from a client threatening suicide on a telephone helpline.

8.5 Explain the procedures that you should follow to deal with such a call.

Assignment 9

9.1 Analyse the difficulties in explaining abuse to young children and in giving them advice.

9.2 Explain the issues around the reporting of male abuse.

9.3 Define ‘ritual abuse’

9.4 Analyse why emotional abuse is more difficult to recognise than physical abuse and the common perceptions of their relative importance.

9.5 Analyse what should be done to reduce the number of children who are sexually abused and whether this should also be applied to those who are in foster care.

Assignment 10

10.1 Analyse the importance of good listening skills.

10.2 Explain the special significance of ‘validation’ in the context of mental health.

Assignment 11

Using the article provided on BPD and eating disorders, write a summary of the key points outlined. You should divide your summary into sections, using appropriate headings where necessary. What have you learned from this article?

Assignment 12

Read the case study below. Imagine you are acting as a support worker for Jennifer. What do you see as the main priorities in dealing with this case? What traits of her personality disorder are you able to recognise?

Case Study:

Jennifer is a 23 year old female. She has a child, named Lucy, aged 2, and a boyfriend of 2 years. She describes her relationship with her boyfriend as O.K., but she also mentions how she is fearful of him. This is because he has hit her in the past. She sees this as fine as he only ever does it when she provokes him. Her relationship with Lucy is good and she adores her and likes the attention and unconditional love she receives from her. This relationship is described as the only safe one she has.

Jennifer has no contact with her mum, whom she blames for the abuse she suffered from her father as a child. Her father used to sexually abuse Jennifer on a regular basis from the age of 6 to 16, when she left home.

Jennifer is scared of being on her own, as she feels no one likes her. When she moved out of home at 16 she lived in a council property for years until she met her boyfriend in a day hospital for those with mental health issues. During this period when she was on her own she was isolated and lonely, very desperate and had many attempts at taking her own life. She was a frequent self-harmer.

She has been admitted to hospital many times, but the longest amount of time she was admitted for was 6 months when she was 18, after a serious attempt to take her own life. Whilst in hospital for this period, she was diagnosed with Borderline Personality Disorder. She never really had the illness explained to her and was distressed by the name of the diagnosis. She paired the name

with some programme she had seen on television, where a woman stabbed her husband.

Jennifer's housing situation is unstable, as the landlord has asked her to leave the property within the next month. He wants to sell the property on, and has given her appropriate notice. She has become depressed by this and stays in bed daily. She is ignoring there is an issue.

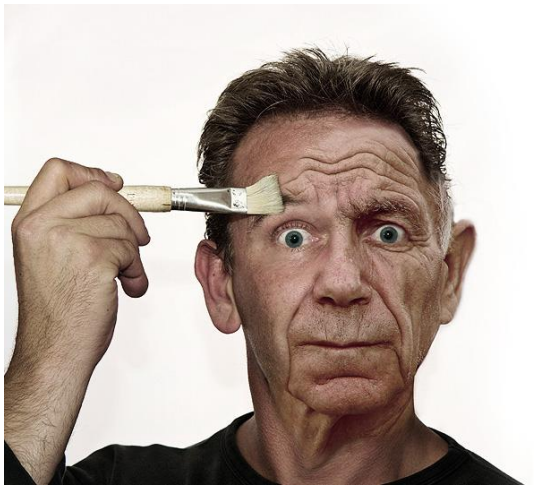
Due to her depression, the relationship with her boyfriend has become fragile. They are arguing constantly. Jennifer self-harms and uses alcohol as a way of coping with her life situation.

2. With the conditions outlined within this course, which do you feel you would find the most difficult to work with? Why? What could you do to help improve your confidence in working with the condition?

How has this course helped you, and how do you believe it will help you in your work with clients with mental health issues? How do you feel it will benefit your client?

For the following you should write at least 500 words:

You have just started working as a Mental Health Worker. You have been given a number of clients, all with a variety of mental health problems, including one with Borderline Personality Disorder, one with Dependent Personality Disorder, another with schizophrenia, and another with a anorexia. What skills will you need to develop in order to best work with these clients? How do you think working with them will affect you on an individual level, and how can you help deal with the issues raised for you?



MENTAL HEALTH EXPLAINED

UNIT 1

In this section:

What is a Mental Health Worker
Different Roles in Mental Health
Mental Health Advocacy
The Mental Health Act
Mental Health Terminology
The Mental Health System

What is a Mental Health Worker?

Mental health workers are those who provide additional, specialist support to those with mental health needs within primary care settings. Mental health workers cover three broad areas in their work which are: direct client work, practice team work and wider networking. Many have a background in psychology, nursing and social work, or possess other relevant experience in working in mental health. Those wishing to become a mental health worker must complete a one-year Postgraduate Certificate in Mental Health, which is a part-time course designed to equip applicants with the necessary skills they will need.

Mental health workers usually work with clients who are experiencing mild to moderate mental health problems. In their role, they assist clients through assessments and also help with anxiety management, problem-solving treatments and cognitive behaviour therapy (CBT). They also work with other health professionals, such as GP's and primary care trusts, to ensure that those with mental health conditions receive satisfactory treatment.

Different Roles in Mental Health

Within the mental health services, there are a wide number of roles which include:

- Care Co-ordinator
- Community Psychiatric Nurse (CPN)
- Psychologist
- Psychiatrist
- Social Worker

Care Co-ordinator (Key Worker / Case Manager)

A care co-ordinator is responsible for arranging the services a client needs and reviewing these to ensure they meet the client's needs. Care co-ordinators come from a variety of different professional backgrounds and include doctors, therapists, nurses and social workers.

Community Psychiatric Nurse (CPN)

A Community Psychiatric Nurse is responsible for assessing the needs of a client, as well as planning and evaluating programmes of their care. They are also responsible for monitoring the effectiveness of a client's medication, as well as providing psychological treatment and support.

General Practitioner (GP)

A GP not only deals with physical health problems, but can also help clients suffering with emotional difficulties. They provide clients with a place to discuss what is causing their current problems and, if necessary, they can prescribe medication. GP's are also responsible for referring clients to other health professionals, such as a counsellor or psychologist, should they feel this will be beneficial to them.

Psychologist

A psychologist is a highly trained professional who deals with human behaviour, mental health assessment, diagnosis and treatment, as well as behaviour change. They assist clients in changing problematic thought patterns and behaviours in order to help them develop coping strategies for difficult situations.

Psychiatrist

A psychiatrist is a professional involved in the diagnosis, treatment and prevention of emotional and mental health disorders, as well as some addictions. In addition to this they are also qualified in prescribing medication to treat these disorders.

Social Worker

Social workers assist clients in a number of settings and work with not only individuals, but also families, communities, organisations and groups. Their role is to address and improve stresses and hardships in a client's life.

Mental Health Advocacy

Advocacy aims to allow people to express their views about the services they receive, and to allow them to gain the appropriate information and support so that they can make choices about their treatment. The main aim therefore is empowerment - to allow clients to be listened to and to take control of their situation.

There are a number of types of advocacy which include:

Independent Professional Advocacy

In this form of advocacy an appointed person assists the client in putting forward their views more effectively. The advocate may be paid, or work voluntarily as part of an advocacy service.

Peer or Collective Advocacy

This involves a number of people coming together in order to explore ways in which they can have their stories and opinions heard.

Citizen Advocacy

In this form of advocacy, an unpaid citizen gets to know a client who is in a vulnerable situation, and works to promote the client's interests over a long period of time. The citizen advocate will initially receive support from an advocacy service, but this will reduce as the partnership between the advocate and client develops.

The Mental Health Act

Recent figures suggest that 95% of persons in receipt of treatment for a mental health problem whilst in hospital, are ‘informal' receivers of care and treatment. The remaining 5% of persons receiving treatment in hospital are compulsory detained, and are known as ‘formal' patients.

There are six categories, listed below, for which the Mental Health Act can be used to treat and care for somebody in hospital.

Definitions

‘Mental Disorder’

Means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.

‘Severe mental impairment’

Means a state of arrested or incomplete development of mind, which includes severe impairment of intelligence and social functioning, and is associated with abnormally aggressive or seriously irresponsible conduct.

Mental impairment

Means a state of arrested or incomplete development of mind (not amounting to severe mental impairment), which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct.

‘Psychopathic disorder’

Means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence), which results in abnormally aggressive or seriously irresponsible conduct.

‘Mental illness’

Is undefined, and its operational definition and usage is a matter of clinical judgement. Medical treatment includes nursing care, habilitation and rehabilitation under medical supervision.

Sections of the Mental Health Act

Section 2

How long does it last?	This is a 28 day section.
What is the reason?	The reason for this section is: “a patient suffers from a mental health problem, which warrants a period of assessment in the interests of their own health and safety or for the protection of other persons.
Who can issue a section 2?	An Approved Social Worker (ASW) or the nearest relative. Whoever is the person applying for the section; they must have seen the patient within the last 14 days.
Medical say so	The application must be back by two registered medical practitioners – usually a psychiatrist who knows the patient and preferably the patient’s GP. One of the two must be registered as a Section 12 doctor (having special experience in psychiatry).
Discharge procedure	Either by the psychiatrist, a mental health review tribunal, three members of the hospital’s management and rarely the nearest relative. The patient can apply to a tribunal in the first 14 days of admission.

Section 3

How long does it last?	Months, may be extended for another 6 months and then annually (one year at a time)
What is the reason?	A mental health problem that is of such a nature or degree that it is appropriate for it to be treated in hospital. Also, if treatment can be used to alleviate and prevent deterioration of the problem. Can be used for the protection of the person or of other persons.
Who can issue a section 3?	An Approved Social Worker (ASW) or the nearest relative. Whoever is applying for the section must have seen the patient within the last 14 days.
Medical say so	Same as section 2 except that both certificates by the medical practitioners must contain one diagnosis / symptom in common.
Discharge Procedure	Mostly the same as Section 2. Patient can apply to a tribunal once during the first 6 months of admission, once during the second six months and once again during each subsequent year if no application is made after six months, the care will automatically be referred to a tribunal. Section 3 can also be used to detain a person who is deemed unable to care for himself, obtain the care he needs or to prevent exploitation.

Section 4

How long does it last?	72 hours
What is the reason?	If the compliance with the normal procedure of sections 2 and 3 would cause undesirable delay and increase suffering and risk.
Who can issue a section 4?	An Approved Social Worker or the nearest relative. The person applying for the section must have seen the patient within the last 14 days.
Medical say so	One doctor must determine that it is of utter urgency for the patient to be admitted under Section 2 and waiting for another doctor to confirm the need for section 2 would cause undesirable delay and increase suffering and / or risk. The patient must be admitted within 24 hours of request for detention or medical examination. The doctor must have seen the person within the last 24 hours.

Section 5 (4) and Section 5 (2)

Section 5 is divided into two categories and these are used by a doctor in respect of a person already in hospital.

Section 5 (4) - Nurses holding power

This section can be used if a person suffering a mental health problem whilst informally receiving treatment in hospital. If the problem becomes likely to impose on the health or safety of that person or for the protection of others should that person leave hospital and it is not possible to engage a medical practitioner to furnish a report under section 5 (2) then the registered mental health nurse can apply the section 5 (4) and await the doctor.

How long does it last?	6 hours
Who can issue a section 5 (4)?	Registered mental health nurse (first level)

Section 5 (2)

How long does it last?	72 hours
Who can issue a section 5 (2)?	An Approved Social Worker, or the nearest relative. The person applying for the section must have seen the patient within the last 14 days.
Medical say so	One doctor must determine that it is of utter urgency for the patient to be admitted under Section 2 and waiting for another doctor to confirm the need for Section 2 would cause undesirable delay and increase suffering and / or risk. The Patient must be admitted within 24 hours of request for detention or medical examination. The doctor must have seen the patient within the last 24 hours.

Section 37

How long does it last?	6 months can be increased to another 6 months and then a year at a time
What is the reason?	The Crown Court and Magistrates Court can order hospital admission in respect of any person who has been convicted of an offence that would normally be a prison sentence.
Medical say so	Same as section 2 except that both certificates by the medical practitioners must contain one diagnosis / symptom in common
Discharge procedure	Mainly the same as in Section 2. Patient can apply to a tribunal once during the first 6 months of admission, once during the second six months and once again during each subsequent year if no application made after six months, the care will automatically be referred to a tribunal. Section 3 can also be used to detain a person who is deemed unable to care for himself, obtain the care he needs or to prevent exploitation. The nearest relative cannot request discharge from the hospital.

Section 41

How long does it last?	Unlimited if necessary
What is the reason?	Same as section 37 and it can only be made if a section 37 has been made. Section 41 can only be made by a Crown Court. The court will consider, when making a section 41, the nature of the offence, the reasons behind the offence, the future risk of further offences being committed and protection of the public from serious harm.
Medical say so	Same as section 3 except one of the doctors must give spoken evidence in court
Discharge procedure	Only by the Home Secretary or a tribunal

Section 117

How long does it last?	Until such a time that the local care trust or health authority and the local social services authority are in agreement that the person no longer requires the services. There is no obligation for the patient to take up the after care services offered unless the services are provided under supervision.
What is the reason?	This section is for the provision of aftercare to people who have been detained in hospital: ➢ For treatment under section 3 ➢ Under a hospital order pursuant to section 37 (with or without a restriction order) ➢ Following transfer from prison under section 47 or 48
Who is responsible for providing the services under a section 117?	The patient's primary care trust and local social care authority are responsible for providing the appropriate services

Section 136

How long does it last?	72 hours
Who can issue a section 136?	A police officer
What is the reason?	When a police officer attends a person in a public place who appears to be suffering from mental health problems and is needing immediate care and a place of safety e.g. a police station, psychiatric hospital or other safe accommodation. There are some areas of weakness in this however, in the fact that police officers are often only given a days training in this area and therefore find it difficult to make a judgement on a person's well-being. Police stations are also regarded as a place of safety, but for many of those with mental health problems it can be a place which leaves them feeling more unstable that they were when they were first arrested, which as a consequence can make the situation worse.

Mental Health Terminology

For those unfamiliar with the mental health system, the terminology used can become extremely confusing. The following is a list of the most commonly used terms in mental health:

Accreditation: An endorsement of an individual practitioner's level of training or experience.

Anorexia Nervosa: Anorexia nervosa is an eating disorder characterised by unusual eating habits, such as avoiding food and meals, picking out a few foods and eating them in small amounts, weighing food, and counting the calories of all foods.

Antidepressant: Antidepressant medicine is used to treat depression. For example fluoxetine, paroxetine.

Antipsychotic: Antipsychotic medicines are used to treat schizophrenia, mania and bipolar disorder. For example, chlorpromazine.

Anxiety: Anxiety is an unpleasant feeling when you feel worried, uneasy or distressed about something that may or may not be about to happen.

Anxiolytic: Anxiolytic medicines are used to treat anxiety. For example benzodiazepines, busperone.

Behaviour Therapy: As the name implies, behavioural therapy focuses on behaviour-changing unwanted behaviours through rewards, reinforcements, and desensitisation.

Benzodiazepines: Benzodiazepines are a group of medicines used to help sleep, reduce anxiety and as a muscle relaxant. For example, temazepam.

Beta Blocker: Beta blockers are drugs that lower blood pressure and slow the heart rate by reducing the amount of oxygen that the blood needs.

Binge Eating Disorder: Binge-eating is an eating disorder characterised by frequent episodes of compulsive overeating, but unlike bulimia, the eating is not followed by purging.

Bipolar Disorder: Extreme mood swings punctuated by periods of generally even-keeled behaviour characterise this disorder.

Borderline Personality Disorder: Symptoms of borderline personality disorder, a serious mental illness, include pervasive instability in moods, interpersonal relationships, self-image, and behaviour. The instability can affect family and work life, long-term planning, and the individual's sense of self-identity

Bulimia Nervosa: Bulimia nervosa is an eating disorder characterised by excessive eating. People who have bulimia will eat an excessive amount of food in a single episode and almost immediately make themselves vomit or use laxatives or diuretics (water pills) to get rid of the food in their bodies.

Clinical Psychologist: A clinical psychologist is a professional with a doctoral degree in psychology who specialises in therapy.

Cognitive Therapy: Cognitive therapy aims to identify and correct distorted thinking patterns that can lead to feelings and behaviours that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behaviour.

Cognitive Behavioural Therapy: A combination of cognitive and behavioural therapies, this approach helps people change negative thought patterns, beliefs and behaviours so they can manage symptoms and enjoy more productive, less stressful lives.

Counselling: Counselling is guided discussion with an independent trained person, to help you find your own answers to a problem or issue.

Delusions: Delusions are bizarre thoughts that have no basis in reality.

Dependence: Dependence is a compulsion to continue taking a drug in order to feel good or to avoid feeling bad.

Depression: Depression is when you have feelings of extreme sadness, despair or inadequacy that last for a long time.

DSM-IV: An official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems

Electroconvulsive Therapy: Also known as ECT, this highly controversial technique uses low voltage electrical stimulation of the brain to treat some forms of major depression, acute mania, and some forms of schizophrenia.

Emergency and Crisis Services: A group of services that is available 24 hours a day, 7 days a week, to help during a mental health emergency.

Genetic Disorder: A genetic disorder is a disorder caused by a fault in the genes. It is usually hereditary (runs in the family).

Hallucination: Hallucinations are a sensory experience in which a person sees, hears, or feels something or someone that isn't really there.

Individual Therapy: Therapy tailored for a patient / client that is administered one-to-one basis.

Interpersonal Psychotherapy: Through one-to-one conversations, this approach focuses on the patient's current life and relationships within the family, social, and work environments

Mental: Mental refers to the processes in the mind.

Mental Health: How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.

Mental Health Problems: Mental health problems are real. They affect one's thoughts, body, feelings, and behaviour. Mental health problems are not just a passing phase. They can be severe, can seriously interfere with a person's life, and even cause a person to become disabled.

Mental Illness: This term is usually used to refer to severe mental health problems in adults.

Obsessive Compulsive Disorder: Obsessive Compulsive Disorder (OCD) is a chronic, relapsing illness. People who have it suffer from recurrent and unwanted thoughts or rituals. The obsessions and the need to perform rituals can take over a person’s life if left untreated. They feel they cannot control these thoughts or rituals.

Phobia: Phobias are irrational fears that lead people to altogether avoid specific things or situations that trigger intense anxiety.

Post-traumatic Stress Disorder: Post-traumatic Stress Disorder is an anxiety disorder that develops as a result of witnessing or experiencing a traumatic occurrence, especially life threatening events.

Prognosis: A prognosis is a prediction of the possible outcome of a disease or condition.

Psychiatrist: Psychiatrists are doctors who treat mental and emotional health conditions, using talking and listening methods.

Psychiatry: Psychiatry is health care that deals with the study, diagnosis and treatment of mental and emotional health disorders.

Psychotherapy: Psychotherapy is the treatment of mental and emotional health conditions, using talking and listening.

Schizophrenia: Schizophrenia is a mental disorder characterised by "positive" and "negative" symptoms. Psychotic, or positive, symptoms include delusions, hallucinations, and disordered thinking (apparent from a person's fragmented, disconnected and sometimes nonsensical speech). Negative symptoms include social withdrawal, extreme apathy, diminished motivation, and blunted emotional expression.

Seasonal Affective Disorder: Seasonal Affective Disorder (SAD) is a form of depression that appears to be related to fluctuations in the exposure to natural light.

SSRI: SSRI (Selective Serotonin Re-uptake Inhibitor) is a medicine used to treat depression.

Stimulants: Stimulants are substances that can change your mood, or produce a sense of alertness and energy. For example, caffeine.

Substance Abuse: Misuse of medications, alcohol or other illegal substances.

The Mental Health System

Outpatient Services

Outpatient services are designed to help those with mental health problems who both function well in many aspects of their lives but who require support in specific areas, and those with severe and enduring difficulties.

The aim of outpatient services is to help clients develop the skills they need to take responsibility for themselves and their circumstances, as well as bringing about a lasting significant change. Clients work with their therapist to agree a treatment plan which can be put in place to help bring about these changes.

Community Mental Health Team

This is a team of professionals from health or social services who work together to provide the relevant support to people who are suffering from a mental illness.

This service generally provides for people between the ages of 17 and 65, and has a close relationship with child and adolescent mental health and older people services.

When a referral is made to the Community Mental Health Team, they begin an assessment to establish a diagnosis, if one hasn't already been made, and establish a suitable care and therapy plan.

This is a multidisciplinary team and is usually made up of psychiatrists, community psychiatric nurses, therapists, psychologists, social workers and support workers.

Main access to the service is through referral. Assessments can take place at local health centres or GP's surgeries.

Outreach Team

Community outreach services are designed to help clients live independently in their own homes. Clients are assigned a care co-ordinator who will help to establish the client's needs, and agree on the care they will require.

To do this the Outreach Team concentrates mainly on personal or life skills in every day life, such as self-care and hygiene, general home maintenance, cooking and meal planning, shopping, socialising, general well being, educational and vocational training, and monitoring their mental health needs and sexual health.

The Outreach Team will discuss with the client what their aims are and what they would like to achieve. Once this core plan is established, the work will be carried out by a trained and qualified outreach worker.

The Child and Adolescent Mental Health Services (CAMHS)

This team is specifically designed for children and adolescents with mental health problems. The team will work together to diagnose, assess, and design an effective treatment programme to support the clients and their families.

This team works on a four tier structure, the first being practitioners who are not mental health specialists, the second being CAMH's specialists. Tier three is a multidisciplinary team, and the fourth is an essential tertiary level service for children and adolescents.

Day Centres

These are an important aspect of the service. They enable people suffering from mental illness to improve their quality of life by gaining independence. These centres also help with general life skills, which also expand to education and employment. This also helps clients to gain acceptance within their community. This is an important aspect of recovery, as it also encourages the development of socialisation skills, which are an essential part of recovery.

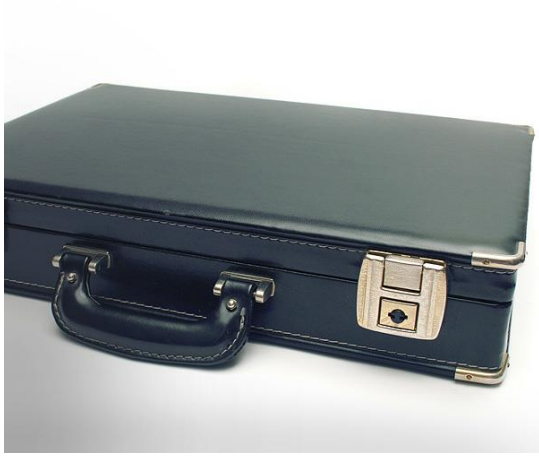
Inpatients

Voluntary:

Clients can request to be admitted into hospital under a voluntary section. When this is the case, they can choose to leave if they feel their condition has improved, as well as decide whether or not to take medication. However, if the client is still unwell and wants to leave, they may then be sectioned under the Mental Health Act.

Mandatory:

Many people in the mental health teams can influence a person to be sectioned under the Mental Health Act. These include social workers psychiatrists, psychiatric nurses, or the Crown Court and magistrates.



LEGISLATION

UNIT 2

In this section:

The Human Rights Act

The Mental Capacity Act

NHS and Community Care Act 1990

Suicide Act

The Disability Discrimination Act

The Human Rights Act

The Human Rights Act is one of the most important pieces of legislation in UK law. It incorporates the European Convention on Human Rights into UK law. This has therefore made it easier to enforce the rights people were given through the European Convention.

Under the Human Rights Act, the following are set out:

- The right to life.
- Prohibition of torture.
- Prohibition of slavery and forced labour.
- The right to liberty and security.
- The right to a fair trial.
- The right not to be held guilty of a criminal offence which did not exist in law at the time at which it was committed.
- The right to privacy, family life, home and correspondence.
- The right to freedom of thought, conscience and religion.
- The right to freedom of expression.
- The right to freedom of assembly and association.
- The right to marry.
- The right to protection of property.
- The right to education.
- The right to free elections.
- The right to the rights and freedoms set out above without discrimination of any ground.

It is important to note that, despite these ‘rights’, they are not all absolute and a person therefore may be denied them in some circumstances.

The Act affects people at all levels. On an individual level, for example, if a person believes that a public authority has breached their human rights they can take direct action against them in the courts. Public authorities, under the Human Rights Act, have a duty to ensure that their actions are compatible with the Act. A public authority in this sense is defined as any person or organisation which carries out tasks of a public nature, including those who are private companies, or charities. Courts and tribunals also have to ensure that any laws they are considering will be compatible with the Human Rights Act. This also extends to legislation in which a court, should a piece of legislation be deemed 'incompatible' with the Human Rights Act, should make a 'Declaration of Incompatibility', so that the Government can review it.

The Mental Capacity Act

The Mental Capacity Act 2005 came into force in October 2007. It is an Act mainly affecting people over the age of 16 who may lack the capacity to make certain decisions. This includes for example, those with mental health problems or learning disabilities, those who have suffered head injuries or stroke, as well as those with dementia. The Act therefore provides clear guidelines as to who is responsible for making decisions, should a person lack capacity to do so. It replaces the current statutory schemes for Enduring Powers of Attorney, as well as Court of Protection receivers, with updated and reformed schemes.

The Act is divided into five key principles. Section 1 of the Act sets out:

- A presumption of capacity – the right of every adult to make their own decisions, unless it is otherwise proven that they do not have the capacity to do so.
- Support for people to make their own decisions – this states that before a person can be regarded as incapable of making decisions, they must be given all forms of practical support.
- Unwise decisions – regardless of whether it is believed that a person has made an unwise decision, they should not be regarded as lacking capacity.
- Best interests – any decisions made, or actions taken, under the Mental Capacity Act, must be done in the individual's best interests.
- Least restrictive option – any decisions made, or actions taken, under the Mental Capacity Act, must be as least restrictive of an individual's basic rights and freedoms as possible.

Under the Mental Capacity Act, two situations are outlined in which a "designated decision-maker can act on behalf of someone who lacks capacity:

Lasting Powers of Attorney (LPA's)

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the current Enduring Power of Attorney (EPA) in relation to property and affairs, but the Act also allows people to empower an attorney to make health and welfare decisions. Before it can be used, an LPA must be registered with the Office of the Public Guardian.

Court appointed deputies

The Act provides for a system of court appointed deputies to replace the current system of receivership in the existing Court of Protection. Deputies will be able to be appointed to take decisions of welfare, healthcare and financial matters, as authorised by the new Court of Protection, but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

The Act creates a new public body and a new official to support the statutory framework, both of which will be designed around the needs of those who lack capacity:

A new Court of Protection

The new Court will have jurisdiction relating to the whole Act. It will have its own procedures and nominated judges. It will be able to make declarations, decisions and orders affecting people who lack capacity, and make decisions for, or appoint deputies to make decisions on behalf of, people lacking capacity. It will deal with decisions concerning both property and affairs, as well as health and welfare decisions.

A new Public Guardian

The Public Guardian has several duties under the Act, and will be supported in carrying these duties out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPA's and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

The Act also includes three further key provisions to protect vulnerable people:

Independent Mental Capacity Advocate (IMCA)

An IMCA will be someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They will only be involved where decisions are being made about serious medical treatment or a change in the person's accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

Advance decisions to refuse treatment

The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if

life is at risk" which must also be in writing, signed and witnessed.
A criminal offence – The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years."[1]

NHS and Community Care Act 1990

The NHS and Community Care Act 1990 is described as "an Act to make further provision about health authorities and other bodies constituted in accordance with the National Health Service Act 1977; to provide for the establishment of National Health Service trusts; to make further provision about the financing of the practices of medical practitioners; to amend Part VII of the Local Government (Scotland) Act 1973 and Part III of the Local Government Finance Act 1982; to amend the National Health Service Act 1977 and the National Health Service (Scotland) Act 1978; to amend Part VIII of the Mental Health (Scotland) Act 1984; to make further provision concerning the provision of accommodation and other welfare services by local authorities and the powers of the Secretary of State as respects the social services functions of such authorities; to make provision for and in connection with the establishment of a Clinical Standards Advisory Group; to repeal the Health Services Act 1976; and for connected purposes"2.

[1] Department for Constitutional Affairs (2005) 'Mental Capacity Act 2005 – Summary'

[2] Office of Public Sector Information (2008) 'National Health Service and Community Care Act 1990'

Part I of the Act is set out in the following way:

- Local management
- National Health Service trusts
- Family Health Services Authorities
- Fund-holding practices
- Indicative amounts
- Funding, audit and liabilities
- Further amendments of the principal Act
- Interpretation

Part II is in relation to Scotland, which has a different system to that of England and Wales

Part III: Community Care

Provision of accommodation and welfare services
General provisions concerning community care services
Part IV is in relation to Scotland

Suicide Act

The Suicide Act was introduced in 1961 and no longer made it illegal for a person to attempt to commit suicide. Prior to this, if a person attempted to commit suicide and failed, they would be liable for prosecution. It is however, illegal for someone to assist a person in a suicide attempt; any such action would make them liable for prosecution and face a prison sentence of up to 14 years.

The Disability Discrimination Act

The Disability Discrimination Act is described as “An Act to make it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services or the disposal or management of premises; to make provision about the employment of disabled persons; and to establish a National Disability Council.

The Disability Discrimination Act defines a disabled person as someone with a “physical or mental impairment which has substantial and long-term adverse effect on his ability to carry out normal day-to-day activities”.

It was introduced in 1996 to prevent people with a disability from being discriminated against in employment or education. According to the Act, a person is discriminated against when they are treated less favourably than someone else because of their disability, the treatment is due to this disability, it cannot be justified or there is a failure to make reasonable adjustments for someone with a disability.

The Act covers:

- Disability
- Employment
- Discrimination in other areas
- Education
- Public transport
- The National Disability Council

DEPRESSION

UNIT 3

In this section:

Classifications

Depression

Symptoms of depression

Diagnosis of depression

Who is affected by Depression

Causes of depression

Classifications

DSM

The Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV), now in its fourth edition, is published by the American Psychiatric Association and is the handbook most commonly used in assisting mental health professionals to diagnose a range of psychiatric disorders. Since its initial publication, there have been five revisions to the DSM, with the next due to be published in 2011.

The DSM-IV organises psychiatric disorders into five axes:

Axis I:

Major mental and clinical disorders. This is typically the diagnosis (e.g. depression).

Axis II:

Developmental disorders and learning disabilities, underlying pervasive or personality conditions. E.g. developmental disorders such as autism and personality disorders.

Axis III:

Medical conditions which contribute to the disorder. E.g. brain injury.

Axis IV:

Psychosocial and environmental factors which contribute to the disorder. E.g. life events – bereavements, moving, job losses.

Axis V:

Global assessment of functioning. At this stage, the clinician will rate the client's level of functioning at the present time, and the highest level within the last year.

The DSM-IV has been designed for use by mental health professionals and so a warning has been included stating that it is possible for the contents of the manual to be misinterpreted if used by a person without clinical training. Therefore, those without training should use the DSM-IV for reference purposes only, and those who may have a mental disorder should seek treatment from the appropriate mental health professional.

ICD

The International Statistical Classification of Diseases and Related Health Problems (ICD), currently in its tenth edition, is published by the World Health Organisation (WHO) and is used by health professionals world wide. It is regularly updated with small annual updates, and more major updates occur every three years. The ICD provides codes which are used to classify diseases, as well as a wide range of signs, symptoms and external causes of injury and disease. Using the ICD, every health condition can be placed in a category and assigned a code consisting of up to six characters.

The ICD has become one of the most commonly used statistical classification systems by health professionals world wide. However, whilst some countries felt that the ICD was sufficient, others believed it did not provide adequate detail for diagnostic indexing. The most recent version of ICD can be used to classify diseases and a range of other health conditions which are recorded on different types of health and vital records, which include hospital records and death certificates. These records further form the basis of the national mortality and morbidity statistics by member states of the World Health Organisation.

Depression

The World Health Organisation (WHO) defines depression as:
"a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850,000 lives every year."3

Depression consists of extreme feelings of sadness which last for a prolonged period of time, often for more than a few weeks or months. The term refers to more than just feeling miserable or fed up for a short period of time; the symptoms can affect a person's ability to carry out basic daily activities, as well as their behaviour in social situations.

The National Health Service (NHS) has stated that "about 15% of people will have a bout of major depression at some point in their lives, and it is the fourth most common cause of disability worldwide"4. They continue to say however, that the true number of people affected by depression is difficult to estimate, due to a large number of people who do not seek help for the condition, or who are not formally diagnosed.

It has been suggested that up to two thirds of people who suffer from depression do not seek treatment, or receive the right treatment from health professionals, because:

their symptoms are not recognised as depression;
depressed people are regarded as weak or lazy;
social stigma causes people to avoid the treatment they need;

---

[3] World Health Organisation (2007) 'Mental Health' Depression

[4] NHS Direct (2007) 'Health Encyclopaedia' Depression

the symptoms suffered by the person are so disabling that they are unable to seek help;
individual symptoms are treated instead of the underlying cause; or
many of the symptoms are misdiagnosed as physical problems.5

According to the National Institute of Mental Health (NIMH), suicide which is closely related to depression is the third leading cause of death in people aged between 10 and 24 years old. This is often from depression being undiagnosed and symptoms therefore worsening.

Major (Clinical) Depression

Major Depression, also called 'Clinical Depression', 'Unipolar Depression' or 'Major Depressive Disorder', is the term given to define the experience of persistent sadness. People with the condition no longer find pleasure in activities they once found enjoyable, as well as experiencing symptoms associated with many depressive conditions, such as a loss of appetite and sleep problems. It is common for people with Major Depression to feel worthless and that they do not have the ability to fix things in their lives. The condition often lasts for six to nine months, and in some cases, even if it is left untreated, will improve by itself. Although it is not clear why this happens, it is believed that it is attributed to the body's tendency to correct abnormal situations.

[5] Psychology Information Online (2003) 'Depression' Information and Treatment

Atypical Depression

Clients with Atypical Depression respond to positive and negative external events; depending on the situation, they may be either deeply depressed or hopeful. When alone, they are likely to be depressed, whereas around others their mood will lift considerably.

It is common for this type of depression to occur after an interpersonal rejection. Those suffering with this type of depression are likely to oversleep, in which they feel 'paralysed' or find it too difficult to get out of bed due to extreme tiredness. Overeating is also likely.

Unspecified Depression

Unspecified Depression is the term given to a form of depression which does not fall into any of the other depression categories. This does not, however, indicate that it is a more serious form of depression; in some cases, Unspecified Depression is less severe and therefore easier to treat compared to other identifiable forms.

Postnatal Depression

Postnatal Depression affects around 1 in 10 women after childbirth. It can cause some women to feel like they should not be a mother after looking forward to having a baby during the months of pregnancy, and then feeling depressed after their child is born. There is often no cause for the condition, although it is believed to be due to changes in hormone levels after childbirth.

Postnatal Depression may last for several weeks or months, and vary in severity. With mild forms, the condition can be improved through the extra support of friends and family. In more severe cases however, support should also be provided from a GP, health visitor, or in extreme cases, mental health professionals, if suffering from postnatal psychosis.

Seasonal Affective Disorder (SAD)

Seasonal Affective Disorder (SAD) is often referred to as 'Winter Depression' or the 'Winter Blues'. People commonly suffer with the condition between September and April, due to the dark mornings and shorter days. The majority of people find that during the winter months they sleep longer and tend to eat more; however for some people, the symptoms of Seasonal Affective Disorder cause significant distress and impact negatively upon their daily functioning.

It is believed that around 2% of people suffer with severe symptoms of Seasonal Affective Disorder, with a further 10% suffering from milder symptoms. The occurrence of Seasonal Affective Disorder increases further away from the equator, except when there is snow on the ground, where the occurrence is less likely. Women are more likely to suffer with the condition than men, although both are affected, as well as children and adolescents.

Symptoms of depression

Depression can present itself through a wide range of psychological, physical and social symptoms. These symptoms can affect a person's ability to cope with everyday activities, including their behaviour in social situations. These symptoms may vary between men, women, children and the elderly, as well as depending on the type of depression the person is suffering from.

Psychological Symptoms

Typical psychological symptoms of depression include:

- Lack of motivation.
- Continuous low mood or sadness.
- Feeling irritable and intolerant of others.
- Lack of enjoyment in previously enjoyable activities.
- Feeling anxious or worried.
- Low self-esteem.
- Feelings of helplessness and hopelessness.
- Difficulty in making decisions.
- Suicidal thoughts, or thoughts of harming others.
- Reduced sex drive.
- Feelings of guilt.
- Tearfulness.

Physical Symptoms

Typical physical symptoms of depression include:

- Change in appetite, and weight loss or weight gain.
- Lack of energy.
- Slowed movement or speech.
- Changes to the menstrual cycle (in women).
- Constipation.
- Lack of interest in sex.
- Unexplained aches and pains.

Social Symptoms

Typical social symptoms of depression include:

- Reduced contact with friends.
- Less interest in hobbies and activities.
- Decrease in performance at work.
- Difficulties in home and family life.
- Taking part in fewer social activities.

Diagnosis of depression

Major Depressive Episode

Under the DSM-IV, in order for a diagnosis of Major Depressive Episode to be made, at least five of the following criteria need to have been present during the same two-week period, and represent a change from the client's previous functioning:

- A depressed mood which lasts most of the day, nearly every day, and is indicated through either feelings of sadness or emptiness, or from observations made by others.
- Loss of interest or pleasure in activities, most of the day, nearly every day.
- Change in appetite nearly every day, or significant weight loss when not dieting, or weight gain (body weight changes by more than 5% in a month).
- Insomnia or hypersomnia almost every day.
- Psychomotor agitation or retardation almost every day, which is also observable by others.
- Loss of energy or fatigue almost every day.
- Feelings of inappropriate guilt or worthlessness almost every day.

- Inability to make decisions or concentrate, which is observable by others, nearly every day.
- Recurrent thoughts of death (not just a fear of dying), recurrent suicide ideation, without a suicide attempt or specific plan.

In addition to these criterions, the symptoms:

- Do not meet the criteria for a Mixed Episode;
- Cause significant distress or impairment in social, occupational, or other areas of functioning which are important;
- Are not due to the use of substances (drugs or medication) or a medical condition; and
- Are not better accounted for by bereavement.

Manic Episode

Under the DSM-IV, for a diagnosis of a Manic Episode to be made, the client has to display a distinct period of persistently and elevated, expansive or irritable mood, which lasts for at least one week. In addition to this, during the period of mood disturbance, the following symptoms also need to have been persistent and present to a significant degree:

- Grandiosity or inflated self-esteem.
- Reduced need for sleep.
- More talkative than usual.
- Flight of ideas, feelings that thoughts are racing.
- Distractibility.
- Increase in goal-directed activity or psychomotor agitation.
- Excessive involvement in pleasurable activities which have a high potential for painful consequences.

In addition to these criteria, the following must also be taken into consideration:

- The symptoms do not meet the criteria for a Mixed Episode.
- The mood disturbance is severe enough to cause impairment in occupational functioning or in social activities or relationships. Hospitalisation may be needed to prevent harm to self or others, or there are psychotic symptoms.
- The symptoms are not the result of a substance.

Mixed Episode

Under the DSM-IV, for a diagnosis of a Mixed Episode to be made, the following symptoms need to be present:

- The criteria for both a Manic Episode and a Major Depressive Episode are met (with the exception of duration), nearly every day, during at least a one-week period.
- The mood disturbance is severe enough to impair occupational functioning in social activities or relationships. Hospitalisation may be required to prevent harm to self or others, or if psychotic symptoms are present.
- The symptoms have not resulted from the use of a substance.

Hypomanic Episode

Under the DSM-IV, for a diagnosis of Hypomanic Episode to be made, a distinct period of persistently elevated, expansive, or irritable mood, which is significantly different from the usual non-depressed state, needs to have been present for at least 4 days. During this time, at least three of the following criteria need to be met:

- Grandiosity or inflated self-esteem.
- Reduced need for sleep.
- More talkative than usual.
- Flight of ideas or feelings that thoughts are racing.
- Distractibility
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities which have a high potential for painful consequences.
-

Furthermore:

- The episode highlights a significant change in functioning that is uncharacteristic of the client when not symptomatic.
- The mood disturbance and change in functioning are observable by others.
- It is not severe enough to impact upon social or occupational functioning or to require hospitalisation, and there are no psychotic features.
- The symptoms are not the result of a substance.

Major Depressive Disorder

There are two listings for Major Depressive Disorder: Single Episode and Recurrent. For a diagnosis of Major Depression to be made, the following criteria need to be met, as stated under the DSM-IV:

- Presence of a single (two or more) Major Depressive Episode.
- The Major Depressive Episode is not better explained by Schizoaffective Disorder, and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- There has not been a Manic Episode, a Mixed Episode, or a Hypomanic Episode in the past.

Dysthymic Disorder

According to the DSM-IV, for a diagnosis of Dysthymic Disorder to be made, the client must present a depressed mood for most of the day, for more days than not, which is observable by others or subjective account, for at least 2 years. While depressed, at least two of the following criteria should also be present:

- Poor appetite or overeating.
- Insomnia or hypersomnia.
- Low energy or fatigue.
- Low self-esteem.
- Difficulty in making decisions or poor concentration.
- Feelings of hopelessness.

In addition to this:

- During the two-year period in which the client has suffered the disorder, they have not been without any of the symptoms previously listed for more than 2 months at a time.
- During the first two years of the disorder, there has not been a Major Depressive Episode present.
- There has never been a Manic Episode, a Mixed Episode or a Hypomanic Episode. Furthermore, the criteria have never been met for Cyclothymic Disorder.
- The disturbance does not occur exclusively during the course of a chronic psychotic disorder, i.e. schizophrenia or Delusional Disorder.
- The symptoms are not the result of a substance.
- The symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning.

Bipolar I Disorder

Under the DSM-IV, for a diagnosis of Bipolar I disorder to be made, the following criteria need to be met:

- The criteria, with the exception of duration, are currently met for a Manic, Hypomanic, Mixed or Major Depressive Episode.
- There has been at least one Manic Episode or Mixed Episode in the past.
- The symptoms cause significant distress, and impact negatively upon social, occupational, or other important areas of functioning.
- The symptoms described in points 1 and 2, are not better accounted for by Schizoaffective Disorder. Furthermore, they are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

- The mood symptoms described in points 1 and 2 are not the result of a substance or general medical condition.

Bipolar II Disorder

For a diagnosis of Bipolar II Disorder to be made, the following criteria need to be met as stated under the DSM-IV:

- Presence or history of one of more Major Depressive Episodes.
- Presence or history of at least one Hypomanic Episode.
- There has not been a Manic Episode or a Mixed Episode in the past.
- The mood symptoms highlighted in points 1 and 2 are not better accounted for by Schizoaffective Disorder, and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- The symptoms described cause significant distress or impact negatively upon social, occupational or other important functioning.

Cyclothymic Disorder

As stated under the DSM-IV, in order for a diagnosis of Cyclothymic Disorder to be made, the following criteria need to be met:

- For at least two years, the presence of a number of periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode.
- The symptoms described in point 1 are present during the two year period, in which the client will not be without them for more than two months at a time.
- During the first two years of the disturbance, there has not been a Major Depressive Episode, Manic Episode or Mixed Episode present.
- The symptoms described in point 1 are not better accounted for by Schizoaffective Disorder, and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- The symptoms are not the result of a substance, or general medical condition.
- The symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning.

Who is affected by Depression

Depression affects people of all ages and from all walks of life. It has been found that women are twice as likely as men to be affected: although men do still suffer from the condition, they are less likely to admit to feeling depressed. Instead they tend to describe the physical aspects of depression rather than the emotional.

Depression in Women

It is believed that many hormonal factors contribute to the increased occurrence of depression in women. Factors such as pregnancy, pre-menopause, menopause, miscarriage and menstrual changes are likely to contribute towards the condition. The pressures of work and family responsibilities can also be a contributory factor.

Depression after the birth of a child is also common, due to the physical and hormonal changes which occur. The extra responsibility of caring for a new baby on top of existing stresses can lead to depression, and therefore requires active intervention. In this case, emotional support from family and treatment from a sympathetic physician, if necessary, are vital in helping a new mother recover her physical and mental well-being, and helping her to care for her baby.

Depression in Men

Although men are less likely to suffer from depression compared to women, approximately 3 million men are still affected. Due to the differences in physical symptoms of depression in men and women, doctors are less likely to diagnose depression in male patients. Despite the depression rate being lower, men are around four times more likely to commit suicide than women. This figure rises further after the age of 70.

The symptoms of depression in men differ from those in women, due to the way they appear irritable or angry rather than feeling hopeless or helpless.

Despite recognising the symptoms of depression, men are often less likely to seek treatment due to the stereotypical view that depression is a “women’s disease”. Support from family and friends can therefore be an important factor in assisting men to understand that it is an illness which needs to be treated.

Depression in Children

Childhood depression has only been taken seriously by mental health professionals in the last 20 years. As with many conditions, it is not regarded as being the result of one specific cause; instead a number of factors, such as neglect, trauma, or the loss of a parent, can contribute towards the condition. A family history of depression may also increase a child’s risk.

It is common for children with depression to suffer from other mental health conditions, such as disruptive behaviour disorder, or bipolar disorder. It is believed children suffering with depression are also at a higher risk of substance abuse in adolescence or adulthood.

Depression in the Elderly

Depression in elderly people often becomes more common in the decade following retirement, due to the dramatic changes that occur: the adapting to a new routine in life, and sometimes moving to a care home, can often be difficult to adjust to. As people age, the loss of a partner and friends, as well as a loss of mobility and other health problems, can also contribute towards the onset of depression.

It is important that the symptoms of depression in the elderly are recognised and treated appropriately, as the condition can often lead to a long period of misery and, in some cases, suicide, from an illness which could be treated easily.

Causes of depression

Like many mental health conditions, depression does not have one specific cause. It is the result of a combination of factors which include genetics, trauma and stress, physical conditions, and other psychological problems.

It is important to note, however, that depression is also the result of physical changes in the brain. Imbalances of neurotransmitters are a contributory factor to the onset of depression, which is often treated through the prescription of antidepressant medication, such as Selective Serotonin Reuptake Inhibitors (SSRI's).

Genetic Factors

It is common for some types of depression, such as Major Depression, to run in families, which suggests that it may be inherited. Scientists, however, are not sure what is inherited, but it is believed to be related to hormones and changes in the brain structure or functions.

Trauma and Stress Related Factors

Major life events can contribute towards depression, such as the death of a loved one, or pressures from starting a new job. Past experiences can also affect the way a person presently feels if they have not had the opportunity at the time of the experience or event, to find a way of acknowledging and dealing with how they feel.

Physical Factors

There are many medical conditions which can lead to the onset of depression, due to the physical weaknesses and stress they create. Such conditions include cancer, heart conditions and HIV. It is also possible for depression to make these conditions worse, as it weakens the immune system. In some cases, the medications prescribed to treat physical conditions can lead to depression.

Additional Factors

In addition to the possible causes of depression outlined above, there are many other factors that can lead to its onset. Schizophrenia, eating disorders and anxiety disorders can also play a big part in its development. Substance and alcohol abuse is also often a factor in the cause of depression.

EATING DISORDERS

UNIT 4

In this section:

Types of Eating Disorders
Symptoms of eating disorders
Diagnosis of eating disorders
Complications
Who is affected
Causes of eating disorders
Prevention of eating disorders

Eating disorders

Eating disorders or severe disturbances in eating behaviour are a prevalent problem among women today (American Psychiatric Association; APA, 2000). It is estimated that five to ten percent of all women have some form of an eating disorder (National Eating Disorder Association, 2003). However, this number rises to even greater proportions in young women. It is estimated that 19–30% of college females can be diagnosed with an eating disorder and between 1% and 5% of adolescent females meet the criteria for the diagnosis of an eating disorder. (Fisher, Golden, Katzman, & Kreipe, 1995; Radar Programs, n.d.)6

What are Eating Disorders?

Eating disorders are defined as a distorted pattern of thinking about food and size / weight. There are very few people who can claim they eat a healthy balanced diet on a daily basis. The pressures of work and social commitments often result in people picking up a snack while they are 'on the go'. It is therefore hard in modern day society to define 'normal' eating. For the majority of people, however, food does not preoccupy their lives. Cultural ideas of perfection, which are heavily influenced through the media, can result in people feeling the need to be thinner, and increase their risk of developing an eating disorder. Biological and genetic factors are also thought to further affect a person's risk of developing certain types of eating disorders.

It is unlikely that an eating disorder will result from a single cause. It is more likely to be a combination of many factors, events, feelings or pressures that lead to the sufferer feeling unable to cope, resulting in this maladaptive coping mechanism. Examples of such factors include low self-esteem, problematic family relationships, trouble with friends, the death of someone special,

---

[6] Watson, Rebecca and Vaughn, Lisa M. , 'Limiting the Effects of the Media on Body Image: Does the Length of a Media Literacy Intervention Make a Difference?', Eating Disorders, 14:5, 385 - 400

difficulties at work, college or university, lack of confidence, and sexual or emotional abuse. They use food as a way of externally expressing their internal emotional pain - as a coping mechanism for this pain, which they cannot express in any other way. People with eating disorders tend to focus on what they look like, rather than who they are as a person.

Often people with eating disorders say that the eating disorder is the only way they feel they can stay in control of their lives, but as time goes on it becomes evident that the eating disorder itself is controlling them. It is common amongst those with eating disorders to experience feelings of despair and shame. They may also identify with feelings of failure or lack of control, due to an inability to overcome these feelings about food alone.

It has been estimated that 1.2 million people in the UK alone suffer from eating disorders7. This includes those who have been diagnosed with a disorder, as well as those who have not sought treatment and remain undiagnosed. Contrary to popular belief, eating disorders do not only affect women. Despite the figures being significantly lower, men can also suffer with anorexia, bulimia and compulsive or binge eating.

An eating disorder is an illness that permeates all aspects of the sufferer's life. It is a serious health condition that can be both physically and emotionally destructive. People with eating disorders need to seek professional help as soon as possible, as early diagnosis and intervention may enhance recovery. Eating disorders can become chronic, debilitating, and even life-threatening conditions.

[7] Beat – Beating Eating Disorders: Some Statistics

Common symptoms of eating disorders include:

- Obsession with weight.
- Obsession with the content of calories and fat in food.
- Dramatic change in weight within a short period of time.
- Hiding food.
- Feelings of anxiousness, loneliness or depression.
- Obsession with food and body image.
- Loss of sexual desire.
- Low self-esteem or confidence.
- Fear of eating around others.
- Mood swings.
- Feeling tired.
- Insomnia or poor sleeping habits.
- Unusual food rituals or eating secretly.

Types of Eating Disorders

Anorexia Nervosa

The onset of anorexia is usually, but not always, under the age of 20. Anorexia typically begins with the young girl trying to lose weight. This gradually develops into an obsession with dieting, losing weight and food. It is not a condition involving the loss of appetite, rather a serious perception disorder.

It is believed the condition affects approximately one in every hundred girls aged between 16 and 18, with a total of between 60,000 and 200,000 people suffering from the condition. It does not, however, affect only girls; there are a large number of men also suffering with the condition.

Anorexia causes people to see themselves in a distorted way. They regard themselves as overweight and needing to lose extreme amounts of weight. It is through this that they become obsessive about food and develop unusual eating rituals. They are often very secretive about food.

The condition is often diagnosed along with depression, anxiety disorder, personality disorder, or substance abuse disorder. They may check their weight more than once a day and carry out intense exercise regimes.

Bulimia

Bulimia is closely linked to anorexia, and shares many of its essential features. People with the condition may think about food constantly and experience extremely strong cravings. After a binge they may induce vomiting or use laxatives as a method of avoiding weight gain.

Someone suffering from bulimia is usually aware of their abnormal eating pattern, and there are feelings of guilt and self-loathing after vomiting. They typically fear that they will not be able to stop eating voluntarily.

Frequently vomiting can cause a vast number of side effects, such as tooth decay, mouth ulcers, heart problems and muscular weakness. The use of laxatives on a regular basis can also cause serious damage, and does not actually assist in weight loss. This is because calories are absorbed in the upper bowel, whereas laxatives work mainly by removing the fluid in the lower bowel.

Bulimia can be an easier condition for the sufferer to hide compared to anorexia, as people with the condition do not always lose weight.

Binge Eating Disorder

Binge eating disorder is regarded as the most common eating disorder, affecting around 2% of adults, yet it is less well known than anorexia and bulimia. The disorder is characterised by the person eating large quantities of food, but unlike bulimia they do not use laxatives or vomit afterwards. It is due to this that they are likely to gain weight. People with the disorder feel they are unable to control what they are doing.

Binge eating disorder has a number of characteristics, which include the sufferer eating secretly where there is no-one else around, eating quicker than usual, and eating even when they are full. They may also eat foods which are regarded as 'naughty', but they do not feel as though they can control their habit.

People with binge eating disorder tend to be overweight due to the nature of the disorder, although people of a normal healthy weight can also be affected. Although binge eating is usually followed by feelings of guilt and shame, sufferers often turn to food as a source of comfort when they are feeling sad or simply bored.

Due to the feelings of guilt and shame, many sufferers to not seek professional help, as it would involve having to admit to someone that they have a problem.

Symptoms of eating disorders

Anorexia

Symptoms of anorexia include:

- Weight loss of at least 15-25% of original body weight.
- Extreme fear of becoming fat.
- Ritualised eating habits.
- Self-induced vomiting, laxative abuse or abuse of slimming tablets, intense and strict exercise regimes.
- Hoarding or hiding food.
- Obsession with food preparation, recipe books and other people's eating habits.
- Denial of the severity of the illness and refusal to participate in therapy / rehabilitation.
- Hypothermia (drop in body temperature).
- Lanugo (neonatal-like body and facial hair).
- Menorrhea (menstruation stops).

Bulimia Nervosa

Symptoms of bulimia include:

- Intense exercise regimen.
- Blistering on the knuckles from forced vomiting.
- Frequent pain in the stomach.
- Frequently feeling tired and weak.
- Dramatic increase in food intake without a change in weight.
- Isolation from family and friends.
- Frequently going to the bathroom immediately after a meal.
- Dehydration.
- Frail hair or nails.
- Dry skin.
- Menstrual cycle ending.
- Depression.

Binge Eating Disorder

Symptoms of binge eating disorder include:

- Eating large quantities of food frequently.
- Low self-esteem / low confidence.
- Frequent changes in weight.
- Feeling out of control.
- Eating even when full.
- Eating for comfort when sad, bored or lonely.
- Feeling anxious or depressed.
- Obsessed with food and body.
- Eating quickly.
- Unable to stop binging, even when aware of the emotional distress it will cause.
- Feeling guilty after a binge.
- Secretly eating.
- Binging twice a week or more, over a period of months.

Diagnosis of eating disorders

Anorexia

Under the DSM-IV, in order for a diagnosis of Anorexia Nervosa to be made, the following criteria must be met:

- Refusal to maintain body weight at or above a minimally normal weight for age and height.
- Intense fear of gaining weight or becoming fat.
- Disturbance in the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation; or denial of the seriousness of the current low body weight
- Amenorrhea (the absence of at least three consecutive menstrual cycles) in postmenarcheal, premenopausal females.
- Other related eating disorders.

In addition to this, there are two sub-types identified under the DSM-IV:

Restricting Type

During the present episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behaviour.

Binge Eating Type or Purging Type

During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behaviour.

Bulimia

In order for a diagnosis of Bulimia Nervosa to be made, the following criteria must be met, as specified under the DSM-IV:

- Recurrent episodes of binge eating. Characterised by the following:
- Eating, in a fixed period of time, an amount of food which is definitely larger than most people would eat.
- A sense of lack of control over eating during the episode.
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge Eating Disorder

Under the DSM-IV in order for a diagnosis of binge eating disorder to be made, the following criteria need to be met:

- Recurrent episodes of binge eating which are characterised by:
- Eating a larger amount of food than normal during a short period of time (within a 2 hour period).
- Lack of control over eating during the binge episode.
- Binge eating episodes are associated with three or more of the following:
- Eating until feeling uncomfortably full.
- Eating large amounts of food when not physically hungry.
- Eating more rapidly than usual.
- Eating alone, due to embarrassment about the amount being eating.
- Feeling disgusted, depressed or guilty after overeating.
- Marked distress regarding binge eating is present.
- Binge eating occurs, on average, at least 2 days a week for 6 months.
- The binge eating is not associated with the regular use of inappropriate compensatory behaviour.

Eating Disorder Not Otherwise Specified

The DSM-IV also gives criteria for Eating Disorder Not Otherwise Specified, for those who have eating disorders which do not neatly fit in to any other category:

- All of the criteria for anorexia nervosa are met, except that the individual has regular menses.
- All of the criteria for anorexia nervosa are met, except that, despite substantial weight loss, the individual's current weight is in the normal or overweight range.
- All of the criteria for bulimia nervosa are met, except that binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 month.
- The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food.
- Repeatedly chewing and spitting out, but not swallowing, large amounts of food.

Complications

There are a large number of side effects and complications associated with eating disorders. It is therefore important that people with any form of eating disorder seek professional help as soon as possible, as this may help to improve the success of treatment and avoid long-term physical and psychological damage.

Side effects and complications associated with anorexia include:

- Feeling weak, tired and dehydrated.
- Menstrual period ending (in women).
- Loss of hair.
- Sensitivity to bruising.
- Dry, fragile bones and nails.
- Heart problems or a low heart rate.
- Anaemia.
- Infertility.
- Insomnia.
- Poor blood circulation.
- Death.

Side effects and complications associated with bulimia:

- Dry, fragile bones, hair and nails.
- Menstrual cycle disrupted (in women).
- Discolouration of teeth.
- Problems with teeth and gums.
- Dehydration.
- Feeling tired and weak.
- Stomach pain.
- Inflammation or tear of the oesophagus, due to forced vomiting.
- Broken blood vessels in the eyes.
- Heart problems or irregular heartbeats.

- Problems during pregnancy.
- Chronic irregular bowel movements.
- Kidney problems, even kidney failure.
- Death.

Side effects and complications associated with binge eating disorder include:

- Obsession with appearance.
- Feelings of anxiety or depression.
- Low self-esteem and confidence.
- High blood pressure.
- High cholesterol.
- Lack of energy.
- Feeling tired and weak.
- Mild breathing difficulties.
- Heart disease.
- Gall bladder disease.
- Some types of cancer.
- Liver problems.
- Kidney problems.
- Type II diabetes.

Who is affected

It has been stated that eating disorders are a widespread problem which has greatly increased over the last 30 – 40 years. Such disorders are responsible for a greater loss of life each year than any other psychological illness.

In the UK alone, there are 1.2 million people affected by an eating disorder, with the majority of those affected aged between 14 and 25 years old. This figure, however, does not include those who have not received a diagnosis of an eating disorder. Further statistics have stated that if the number of people affected included those responsible for caring for someone with an eating disorder, this figure would almost triple.

The UK charity Mind, for example, have found that, "as many as one woman in 20 will have eating habits which give cause for concern", and The Royal College of Psychiatrists have backed this further by stating that, "girls and women are 10 times more likely than boys and men to suffer from anorexia or bulimia". Overall, as found by the Independent on Sunday, "at least one percent of women are affected by eating disorders"8.

It is important to realise, however, that despite the number being significantly lower, men also suffer with eating disorders, and are believed to make up to 10 percent of those diagnosed with an eating disorder.

[8] Disordered Eating: Eating Disorders Statistics (UK)

Causes of eating disorders

It is difficult to specify a single cause for the development of an eating disorder; instead it is believed to be a combination of biological, genetic, psychological and social factors.

Psychological

There are a number of psychological factors which can contribute towards the development of eating disorders. Those with such disorders tend to be 'perfectionists', expecting the very best of themselves, with failure resulting in feelings of shame. They believe that things are either all good or all bad, without any middle-ground. Therefore they regard being fat as bad, and being thin as good. They are generally unhappy with their figure, and therefore develop eating disorders as a method of managing their weight without dieting.

Eating disorders can also develop due to traumatic events or major life changes. An example of this may be physical or sexual abuse.

Biological

Biological issues can also contribute to the development of eating disorders. It has been suggested that people are more likely to develop eating disorders if there is a family history of it. Further research has suggested that the levels of serotonin, in particular the 5HT2A receptor, in the brain can also contribute to the development of eating disorders, as those with high levels of this chemical are less likely to crave food.

Social

The media often present being thin as the only way in which people can appear to be 'normal'. Many magazines depicting celebrities as role models can also contribute towards the development of eating disorders, due to the pressure it places on individuals. These 'role models' do nothing to promote healthy eating.

Further social pressures also come from a person's occupation. Jockeys and dancers, for example, are encouraged to keep their body weight low as this can enhance their performance. The added pressure from family and friends regarding appearance can also contribute towards the development of an eating disorder.

Prevention of eating disorders

It is difficult to find a specific way to prevent eating disorders, but it is important that parents and those responsible for educating people on eating disorders focus on the following:

- Explain how dieting can have a negative impact on a person's health.
- Teach respect and tolerance for diversity of body sizes.
- Identify factors which could contribute towards the development of an eating disorder.
- Teach how to eat properly (i.e. eating when hungry, stopping when full, eating a balanced diet).
- Teach the negative effects diet pills or similar substances can have on the body.

PERSONALITY DISORDERS

UNIT 5

In this section:

What are Personality Disorders?
Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal personality disorder
Anti-social Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Common Misconceptions and Generalisations
Causes of personality disorders
Prognosis of personality disorders

What are Personality Disorders?

Definition: "Personality disorder, also called ‘character disorder’: mental disorder that is marked by deeply ingrained and lasting patterns of inflexible, maladaptive, or antisocial behaviour. A personality disorder is an accentuation of one or more personality traits, to the point that the trait significantly impairs an individual's social or occupational functioning. Personality disorders are not, strictly speaking, illnesses, since they need not involve the disruption of emotional, intellectual, or perceptual functioning. In many cases, persons with a personality disorder do not seek psychiatric treatment for such unless they are pressured to by relatives or by a court." — Encyclopaedia Britannica.

Personality disorders have further been defined as: “pervasive chronic psychological disorders, which can greatly affect a person's life. Having a personality disorder can negatively affect one's work, one's family, and one's social life. Personality disorders exists on a continuum, so they can be mild to more severe in terms of how pervasive, and to what extent, a person exhibits the features of a particular personality disorder. While most people can live reasonably normal lives with mild personality disorders (or more simply, personality traits), during times of increased stress or external pressures (work, family, a new relationship, etc.), the symptoms of the personality disorder will gain strength and begin seriously to interfere with their emotional and psychological functioning.

Those with a personality disorder possess several distinct psychological features, including: disturbances in self-image; inability to have successful interpersonal relationships; inappropriateness of range of emotion, ways of perceiving themselves, others, and the world; and difficulty possessing proper impulse control. These disturbances come together to create a pervasive pattern of behaviour and inner experience that is quite different from the norms of the individual's culture, and that often tend to be expressed in behaviours that appear more dramatic than society considers usual. Therefore, those with a personality disorder often experience

conflicts with other people and vice-versa. There are ten different types of personality disorders that exist, which all have various emphases."9

In the years prior to 1750, people held very simplistic attitudes towards those with mental health problems – they were seen as 'mad', or thought to be possessed by devils. They were generally poorly treated and received very little (if any) medical treatment. Instead, they were often confined to their homes or to an institution.

There has always been a divide regarding the underlying causes of mental illness. On one side, biological factors are seen to be the main cause; on the other side, however, social problems or personal stresses are seen as the main contributory factor. Throughout the 1800's, the biological viewpoint was considered the most accurate.

During the 19th century, the first attempts at classifying mental illnesses were made. This began in 1800, when William Cullen introduced the term "neurosis", and was further developed by Philippe Pinel, who divided mental illnesses into four categories:

- Mania
- Melancholia
- Dementia
- Idiocy

Pinel went on to describe patients who "lacked impulse control, often raged when frustrated, and were prone to outbursts of violence", through the term 'insanity without delusions', as he noted that such patients "were not subject to delusions".

In 1835 the term "moral insanity" (later to become known as 'personality disorder') was coined by J.C. Pritchard, who stated that moral insanity was "a morbid

[9] Life Watch – Personality Disorders
http://www.lifewatch-eap.com/poc/center_index.php?id=8

perversion of the natural feelings, affections, inclinations, temper habits, moral dispositions, and natural impulses…without any insane delusion or hallucination."

By the beginning of the 20th century, there was an increased awareness of personality disorders when Kraepelin identified six types of personality disorders:

- Excitable
- Unstable
- Eccentric
- Liar
- Swindler
- Quarrelsome

The introduction of the DSM in 1952 and its subsequent revisions, provided up-to-date definitions of personality disorders.

The DSM-IV defines a personality disorder as, "a lasting pattern of behaviour and inner experience that markedly deviates from norms of the patient's culture". Under the DSM-IV, ten personality disorders are specified, which are divided into three clusters, which are shown on the next page.

Cluster A – odd or eccentric

- Paranoid (pervasive mistrust)
- Schizoid (socially detached)
- Schizotypal (socially isolated, distorted perception)

Cluster B – dramatic, emotional, erratic

- Antisocial (discounts others, no empathy)
- Borderline (unstable, impulsive)
- Histrionic (dramatic attention seeking)
- Narcissistic (needs admiration)

Cluster C – anxious or fearful

- Avoidant (socially inhibited, inadequate)
- Dependent (submissive, separation fear)
- Obsessive-Compulsive (order, perfection)

Paranoid Personality Disorder

Those with Paranoid Personality Disorder possess an unjustified distrust and suspicion of others. They fear that others are exploiting or deceiving them. Innocent statements may be interpreted as a threat or attack on their character. People with Paranoid Personality Disorder display a need to be self-sufficient, and can often bear grudges for long periods of time.

Paranoid Personality Disorder usually presents itself by early adulthood and affects approximately 1% of the general population. However, those with the disorder rarely present themselves for treatment, due to their lack of trust in others.

A method which can be used to remember the diagnostic criteria for Paranoid Personality Disorder is 'SUSPECT':

S - Spouse is suspected of cheating.
U - Unforgiving – bears grudges.
S - Suspicious of others.
P - Perceives attacks.
E - Enemy in everyone.
C - Confiding in others feared.
T - Threats seen in benign events.

In order for Paranoid Personality Disorder to be diagnosed, the client will display at least four of the following:

- Unjustified suspicion that others are exploiting, deceiving or harming them.
- Preoccupation with unjustified doubts regarding the trustworthiness or loyalty of friends or associates.
- Reluctance to confide in others, due to unwarranted fears that information will be used maliciously against them.
- Reads hidden demeaning or threatening meanings into innocent events or comments.

- Perceives personal attacks on their own character or reputation, which are not perceived by others; they are quick to counterattack or respond angrily.
- Unjustified suspicions, without justification, about the fidelity of spouse or sexual partner.

Treatment Options

Clients with Paranoid Personality Disorder rarely seek treatment for their disorder, due to which, there is currently very little research into the best treatment options available to them. However, psychotherapy, as with the treatment of other personality disorders, is the most commonly used.

Those with Paranoid Personality Disorder frequently terminate therapy early, making it difficult initially to build a strong therapeutic relationship between the client and therapist. However, once a solid relationship has been established, it is generally believed that a supportive, client-centred approach is the most effective.

During therapy, it is important that the therapist takes an honest, open approach with the client, as this will more likely allow for a more successful result. It is also beneficial for the therapist to focus on the specific reasons which brought the client into therapy, such as current stresses in their life, which they are finding difficult to cope with.

Medication

The prescribing of medication to clients with Paranoid Personality Disorder should be carefully considered, as it may cause unnecessary suspicion. This in turn can result in the client refusing to comply, and terminating treatment early.

When the prescribing of medication is thought to be beneficial, it is common for anti-anxiety medications to be prescribed to help reduce symptoms of severe anxiety or agitation, which may be affecting the client's daily functioning.

Schizoid Personality Disorder

People with Schizoid Personality Disorder are typically seen as “loners” – they are uncomfortable with close relationships and often do not marry or form long-lasting romantic relationships. They sometimes appear to others as being cold and unsociable, and often prefer solitary jobs.

The disorder is common, affecting a few percent of the population; however, it is rarely diagnosed.

A method which can be used to remember the diagnostic criteria for Schizoid Personality Disorder is ‘SOLITARY’:

S - Shows emotional coldness.
O - Omits close relationships.
L - Lacks close friends or confidants.
I - Involved in solitary activities.
T - Takes pleasure in few activities.
A - Appears indifferent to praise or criticism.
R - Restricted interest in sexual experiences.
Y - Yanks themself from social relationships.

For Schizoid Personality Disorder to be diagnosed, the client will display at least four of the following:

- Does not enjoy or desire close relationships, including those within a family.
- Will choose solitary activities in the majority of cases.
- Little or no interest in sexual activities with another person.
- Enjoys very few, if any, activities.
- Very few close friends or confidants.
- Appears unaffected by praise or criticism
- Emotionally cold, bland or detached.

Treatment Options

Despite there being many treatment options which could be suggested for this disorder, it is unlikely that many of them will be effective. In most cases, individual psychotherapy is likely to be the preferred option. However, people with Schizoid Personality Disorder are unlikely to seek treatment unless they are experiencing increased stress or pressure. Psychotherapy is likely to be a short-term treatment, in which the individual is helped to solve any immediate crisis or problems. After this, due to the nature of the disorder, it is likely that the client will then terminate their treatment.

The building of a trusting and therapeutic relationship is likely to be a slow process, which may not fully develop due to the nature of the disorder. As people with schizoid personality disorder tend to distance themselves from people socially, as well as those close to them, the therapist should help to create a feeling of security in the form of a therapeutic relationship. The client will most probably have set boundaries, which the therapist should not try to confront.

Long-term psychotherapy usually has a record of poor treatment outcomes, can cause financial hardships due to the length of therapy, and should therefore be avoided. Psychotherapy should, instead, focus on simple goals with the aim of alleviating current issues in the client's life. In some cases, cognitive-restructuring activities may be beneficial in treating specific types of clear, irrational thoughts which are having a negative impact on the client's behaviour. In the treatment of a client with Schizoid Personality Disorder, stability and support are the most important factors, with a clear therapeutic framework established from the onset.

Although group therapy is a possible choice of treatment, it is not recommended as an initial treatment option. A client with Schizoid Personality Disorder will be more likely to terminate therapy at an early stage in group therapy, due to feeling uncomfortable in a social setting. However, if the client is progressing from individual to group therapy, they may have developed enough skills to tolerate a group-based therapy option. Clients with schizoid personality disorder often see little need to interact with others socially, and are therefore usually quiet in group work,

making little contribution. This, however, should be expected and the therapist, therefore, should not pressurise the client into taking a more participatory role in the group until they are ready to do so. It is also important that therapists do not allow other members of the group to criticise the client for their lack of participation in the group setting. If the group overall can accept the more reserved nature of a client with Schizoid Personality Disorder, the client may gradually begin to participate more, although this may take up to several months.

Therapists should also be cautious of too much isolation and introspection by the client, as the aim of treatment is not to keep the client in therapy for as long as possible. As is the case with group therapy, those with Schizoid Personality Disorder may demonstrate long periods of time in which they do not talk in therapy sessions, which may be hard for the therapist to tolerate. Phillip W. Long, M.D., has stated that the client may eventually "reveal a plethora of fantasies, imaginary friends, and fears of unbearable dependency - even of merging with the therapist. Oscillation between fear of clinging to the therapist may be followed by fleeing through fantasy and withdrawal." These feelings therefore must be normalised by the therapist and moved into focus in the form of the therapeutic relationship.

Medication

Medication is not usually a necessary treatment option for someone with Schizoid Personality Disorder, unless the client also has an Axis I disorder, such as Major Depression. The majority of clients do not show any additional improvement from taking an antidepressant, unless they are suffering from a major-depressive episode. Medication for Schizoid Personality Disorder should only be given for the relief of acute symptoms, with long-term use being avoided. Furthermore, the prescribing of medication may impact negatively upon the effectiveness of some psychotherapeutic treatments. The prescribing of medication should therefore be carefully considered when deciding on a recommendation for treatment.

Schizotypal personality disorder

Clients with Schizotypal Personality Disorder have a reduced capacity for closeness with others, which is present from an early age. They often have distorted or eccentric thinking, perceptions and behaviours that can make them appear odd.

A method which can be used to remember the diagnostic criteria for Schizotypal Personality Disorder is 'ME PECULIAR':

M - Magical thinking that influences behaviour, superstitions or the paranormal.
E - Eccentric behaviour or appearance
P - Paranoid ideation.
E - Experiences unusual perceptions.
C - Constricted affect.
U - Unusual thinking and speech.
L - Lacks friends.
I - Ideas of reference.
A - Anxiety (socially).
R - Rule out psychotic disorders & pervasive developmental disorder.

For a diagnosis of Schizotypal Personality Disorder to be made, clients will display at least five of the following:

- Ideas of reference.
- Magical thinking or odd beliefs, which are inconsistent with cultural norms.
- Unusual perceptions, including bodily illusions.
- Odd speech and thinking.
- Suspiciousness or paranoia.
- Affect that is inappropriate or constricted.
- Few close friends or confidants, other than relatives.
- Social anxiety which does not improve with familiarity; paranoid fears rather than negative self-judgements.

Treatment Options

As is the case with the majority of personality disorders, psychotherapy is the most commonly used treatment approach for clients with Schizotypal Personality Disorder. It is common for those with this disorder to hold a more distorted view of reality than those with Schizoid Personality Disorder.

As with Paranoid Personality Disorder, the therapist must demonstrate caution not to directly challenge the client's delusional or inappropriate thoughts; instead they should help to create a supportive, client-centred environment. Similarly to those with Avoidant Personality Disorder, the client may avoid the majority of social situations due to extreme social anxiety, in which they feel as though the do not "fit in", or that they are "different" and therefore lack an adequate social support network. Despite there being no simple solution to this, it may be beneficial for the client to undertake therapy in which they undertake social skills training and additional behavioural approaches in which there is a large emphasis on the learning of basic social relationships and interactions.

Although individual therapy is the preferred choice of treatment, group therapy may be beneficial in a group specifically for Schizotypal Personality Disorder. This should be considered an option as the client progresses; however, it may be difficult to find such a group in smaller communities.

Medication

Some medication may be beneficial for Schizotypal Personality Disorder during acute phases of psychosis, which are likely to occur during times of extreme stress in the client's life. These phases should be effectively treated through the prescribing of an appropriate anti-psychotic medication.

Anti-social Personality Disorder

People with Anti-social Personality Disorder; appear to experience a limited range of emotions, which can explain their lack of empathy regarding the suffering of others. Clients with the disorder may be prone to substance abuse or risk-seeking behaviour as a method of attempting to escape their feelings of emptiness.

It has been stated, through research, that a client's disregard for the consequences of their actions and their lack of empathy is related to the fact that they are indifferent to the possibility of physical pain or many punishments, and that they show no signs of fear when so threatened.

A method which can be used to remember the diagnostic criteria for Anti-social Personality Disorder is 'CORRUPT':

C - Cannot follow law.
O - Obligations ignored.
R - Remorselessness.
R - Recklessness.
U - Underhandedness.
P - Planning deficit.
T - Temper.

Before 15 years of age, for at least 12 months, the client has repeatedly violated rules, shown by at least three of the following:

- Failure to social norms – repeatedly performing acts that are grounds for arrest.
- Deceitfulness, indicated by repeated lying, conning others for personal profit or pleasure.
- Failure to plan ahead, or impulsivity.
- Aggressiveness and irritability, indicated through repeated assaults and fights.

- Reckless disregard for their own safety or that of others.
- Consistent irresponsibility, as indicated by continuous failure to sustain consistent work behaviour or honour financial obligations.
- Lack of remorse shown through indifference to having mistreated, stolen or hurt another.

Treatment Options

Clients with Antisocial Personality Disorder rarely seek treatment on their own unless ordered to do so by a court, or by family and friends. The majority of those referred for treatment have usually been so referred by a court. Once referred a therapist will undertake a thorough assessment, to check that the person does in fact have Antisocial Personality Disorder, as this is often confused with criminal activity. It is important to remember, however, that not all criminals have this disorder.

Due to the large number of people who may suffer from Antisocial Personality Disorder being in prison or similar settings, there may be little motivation towards treatment from the client. When this is the case, treatment should instead focus on setting goals and other life issues such as coping skills, and social / family relationships when they are released. These goals may also be focused upon in an outpatient setting, although therapy will also likely focus on the antisocial behaviour and feelings experienced by the client. There are a large number of clients with the disorder who describe a lack of connections between their feelings and their behaviour. The aim of therapy, therefore, is to help the client make this connection.

Making threats is not an appropriate method of motivating a client to participate in treatment, least of all with Antisocial Personality Disorder. If the therapist has had to resort to threatening to report non-compliance, it is highly likely that very little gain would have been made in therapy anyway. It is important to try to help the client with Antisocial Personality Disorder to find appropriate reasons why they may not want to work on a problem any further. An example of this would be to ensure that they do not come into contact with the law again and have to subject themselves to further psychological assessments.

The effectiveness of psychotherapy for those with Antisocial Personality Disorder is limited, and intensive, psychoanalytic methods are not appropriate. Instead, treatment which reinforces the importance of appropriate behaviour, and which attempts to make a connection between the client's feelings and behaviour, may be more successful. In the treatment of this disorder emotions are usually a key factor, due to the client often experiencing little or no significant emotionally-rewarding relationships in their past. This can therefore make a therapeutic relationship seem difficult to accept initially. A successful therapeutic relationship can only occur once the client has established a solid level of trust with the therapist.

Trust further raises the issues of confidentiality. As in the majority of cases a client has been referred to the therapist by the courts, they may be suspicious of the therapist at first. This is due to the nature of the therapist having to report to the court on the client's progress. Although this can usually be done without providing specific details of the therapy, the client may still be concerned as to whether or not the court, or they themselves, have the highest priority. This suspicion can only be resolved if the therapist is honest as to what he or she will inform the courts of, and that what the client discloses in therapy does not become common-knowledge.

Therapy sessions should have a focus on the client's emotions, or lack of them. One of the first emotions which may be experienced by the client as they begin to learn the various emotional states is depression. As the client is unlikely to have experienced this before, it is important that the therapist is supportive during this time. Any emotions which are not demonstrating anger or frustration should be reinforced, as this is usually beneficial.

The experiencing of intense affect is most commonly a sign of progress in therapy. Although the idea of discussing real-life concerns may be beneficial, they are unlikely to be effective in regard to long-term behavioural change. Therefore, it is important to make an emphasis on the discovery and labelling of appropriate emotional states with the client.

Clients with Antisocial Personality Disorder commonly demonstrate difficulties with those in authority. It is important therefore that the therapist is seen as neutral in this

matter. Furthermore, the therapist should avoid engaging in arguments with the client over figures of authority, as this will provide very little progress. Instead it is beneficial for the client to learn to deal with the consequences of their actions. Although this can, in some cases, result in having to deal with courts and prison sentences, it may also be a motivating factor for the client in their treatment programme.

Hospitalisation

It is rare that inpatient care is seen as appropriate or necessary in the treatment of Antisocial Personality Disorder. As with other clients with different personality disorders, it is common for the client not to realise that they are having difficulties. When this is the case, it is more likely that the client will have had a history of difficulties with the criminal justice system. Those with Antisocial Personality Disorder may see the loss of freedom as a highly motivating factor in undertaking treatment. Some specialised treatment facilities have, therefore, begun to treat people with Antisocial Personality Disorder.

Medications

There has currently been no research undertaken to suggest that medication is effective in the treatment of Antisocial Personality Disorder. Therefore, medications should only be prescribed to those who have an additional, serious Axis I diagnosis.

Borderline Personality Disorder

The term ‘borderline’ was coined by Adolph Stern in 1938. This name was used to describe patients who were on a ‘borderline’ between neurosis and psychosis. However, the symptoms of BPD are not so simplistic as to be defined in terms of neurotic and psychotic. The diagnosis of BPD is based upon signs of emotional instability, feelings of depression and emptiness, identity and behavioural issues, rather than signs of neurosis and psychosis. However, the name ‘borderline’ has remained, even though the definition has changed. Throughout Europe, the same disorder has been given the more appropriate, and less misleading, title of ‘Emotionally Unstable Personality Disorder.’

One of the core signs and symptoms in BPD is the proneness to impulsive behaviour. This impulsiveness can manifest itself in negative ways. For example, self-harm is common among individuals with BPD, and in many instances this is an impulsive act. Sufferers of BPD can also be prone to angry outbursts and possibly criminal offences (mainly in male sufferers), as a result of impulsive urges. Other characteristics of this condition include reality distortion, tendency to see things in ‘black and white’ terms, excessive behaviour such as gambling or sexual promiscuity, and proneness to depression.

BPD is not usually diagnosed before adolescence, as the personality is said not to be fully developed. It has been suggested that BPD symptoms can sometimes improve as time goes on or even disappear all together. This is not always the case however as BPD can continue to affect sufferers well into later life.

A method which can be used to remember some of the diagnostic criteria for BPD is 'PRAISE':

P - Paranoid ideas.
R - Relationship instability.
A - Angry outbursts, affective instability, abandonment fears.
I - Impulsive behaviour, identity disturbance.
S - Suicidal behaviour.
E - Emptiness.

In order for a client to be diagnosed with Borderline Personality Disorder, at least five of the following criteria need to be met:

- Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
- A pattern of unstable and intense interpersonal relationships, characterised by alternating between extremes of idealisation and devaluation.
- Identity disturbance: markedly and persistently unstable self-image of sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
- Recurrent suicidal behaviours, gestures, threats, or self-mutilating behaviour.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Treatment Options

Psychotherapy is the main treatment option in helping clients with Borderline Personality Disorder. Although medications may help to relieve some of the symptoms related to this disorder, it cannot assist clients in learning new coping mechanisms or emotion regulation. In psychotherapy, assessment should be conducted regularly in regard to the risk of suicide. If the client's feelings of suicide are severe, hospitalisation and the prescribing of medication should be considered.

Dialectical Behaviour Therapy (DBT), designed by Marsha Linehan, is regarded as the most effective treatment for clients with Borderline Personality Disorder, as it was created specifically to treat those with the disorder. The aim of DBT is to teach the client to take control of their emotions and their life. It is frequently used through a group therapy setting, although it may not be an ideal treatment for those clients who struggle to learn new concepts.

Borderline Personality Disorder is regarded as difficult to treat, with therapy usually lasting for at least a year. During treatment it is important, as with the treatment of other personality disorders, that a structured and therapeutic setting is established from the onset. Clients with borderline personality disorder are often discriminated against by mental health care professionals and regarded as "trouble-makers". It is important that therapists take into consideration the fact that the client's behaviour, whilst sometimes regarded as inappropriate, is a result of their disorder. The main aim of therapy should be to provide a highly structured environment in which the client's ability to live more independently is improved.

Hospitalisation

Hospitalisation is frequent for those who suffer from Borderline Personality Disorder, due to the way they often present themselves to the mental health services suffering from severe depression or due to self-harm. In times of crisis, however, clients should be encouraged to seek support from other sources where possible, such as their therapist, or support help-lines.

Medication

The prescription of some antidepressants may prove beneficial at some points within the client's treatment, for example, when the client is experiencing suicidal feelings. However, when medication is prescribed for this reason, it should only be used in the short-term, as these feelings are often related to specific situations which may come and go quickly in the client's life.

Histrionic Personality Disorder

Clients with Histrionic Personality Disorder display a pattern of excessive emotionality and attention-seeking behaviour. Usually beginning by early adulthood, they display an excessive need for approval from others, as well as being inappropriately seductive. They have an excessive concern regarding physical appearance and need to be the centre of attention. Their rapidly changing emotional states may make them appear shallow, as well as them being easily influenced by others.

A method which can be used to remember some of the diagnostic criteria for Histrionic Personality Disorder is 'PRAISE ME':

P - Provocative or seductive behaviour.
R - Relationships, considered more intimate than they are.
A - Attention, must be at centre of.
I - Influenced easily.
S - Speech – wants to impress, lacks detail.
E - Emotional instability, shallowness.
M - Make-up – physical appearance used to draw attention to self.
E - Exaggerated emotions – theatrical.

For a diagnosis of Histrionic Personality Disorder to be made, the client must meet at least five of the following criteria:

- Not being the centre of attention makes them uncomfortable.
- Relationships with others are characterised by inappropriate, sexually seductive, or provocative behaviour.
- Emotions are rapidly shifting and shallow.
- Frequently uses physical appearance to draw attention to self.
- Speech style is vague and lacking in detail.
- Emotion is expressed over-dramatically.
- Easily influenced by others or circumstances.

- Considers relationships to be more intimate than they really are.

Treatment Options

Clients with Histrionic Personality Disorder are commonly difficult to treat for a number of reasons. Like those with other personality disorders, clients are unlikely to present themselves for treatment until there is an event in their life which they find difficult to cope with. However, they are more likely to seek treatment quicker than those with other personality disorders, and to exaggerate their symptoms. They are therefore more reluctant to terminate therapy.

As with most personality disorders, psychotherapy is the most common type of treatment. Due to the nature of the client exaggerating their symptoms and wanting to draw attention to themself, group and family therapies are not usually recommended. Clients with histrionic personality disorder frequently appear to others as being shallow in their interpersonal relationships with others.

Therapy should be supportive, and it is common for a good therapeutic relationship to be established early on in treatment. Therapists may often find that they have been given a rescuing role by the client, and that they are often asked to reassure and help the client with daily problems. It is also common for the therapist to be perceived as sexually attractive to the client, making it vital for boundaries and a clear therapeutic framework to be set from the onset of therapy.

Suicidal behaviour is often apparent in a client with Histrionic Personality Disorder, and therefore assessments on this should be carried out on a regular basis. There are times when suicide occurs when all that was intended was a suicidal gesture, so threats should not be ignored or dismissed by the therapist. It may therefore be beneficial for the client and therapist to establish a 'suicide contract' in which both decide on the conditions in which the therapist should be contacted if the client feels like hurting themselves. Self-harm may also be a factor in Histrionic Personality Disorder, and should also be an issue to discuss in therapy sessions.

In the treatment of Histrionic Personality Disorder, insight and cognitive-orientated approaches to treatment are generally seen as being ineffective, and should therefore be avoided.

Therapists may often experience reactions to treating Histrionic Personality Disorder due to the dramatic nature of the client. Like those with Borderline Personality Disorder, clients often find that they are discriminated against by the mental health services due to the nature of their disorder. It is important, therefore, that both clients and therapists are aware of the possibility of this discrimination.

Medications

Medications are not usually prescribed for this disorder unless an additional Axis I diagnosis is also present. However, if medication is prescribed, care should be taken due to the potential risk of the client using it to contribute towards self-destructive or other harmful behaviours.

Narcissistic Personality Disorder

The term 'Narcissistic Personality Disorder' was first coined by Heinz Kohut in 1971 and describes clients who have a grandiose sense of self-importance, a thirst for admiration and a lack of empathy.

People with Narcissistic Personality Disorder often make themselves appear "larger than life", and exaggerate their accomplishments. However, they also have a very fragile self-esteem and believe that they are flawed in some way, which they feel makes them unacceptable to others. It has been stated that "Psychologists commonly believe that narcissism results from an impairment in the quality of the person's relationship with their primary caregivers, usually their parents, in that the parents were unable to form a healthy, empathic attachment to them. This results in the child conceiving of themselves as unimportant and unconnected to others. The child typically comes to believe that he or she has some defect of personality which makes them unvalued and unwanted"10.

A narcissistic person's job performance may also be affected by the disorder. Despite the fact they are ambitious, they are unable to tolerate setbacks or criticism, which can make it difficult for them to work with others.

There has been very little research of this disorder carried out, but it is estimated that it affects less than 1% of the general population and affects more men than women.

[10] Johnson, Stephen M PhD (1987). Humanising the Narcissistic Style. New York: Norton, page 39

A method which can be used to remember the diagnostic criteria for Narcissistic Personality Disorder is “SPECIAL’:

S - Special (believes he or she is special and unique).

P - Preoccupied with fantasies (of unlimited success, power, brilliance, beauty, or ideal love).

E - Entitlement.

C - Conceited (grandiose sense of self-importance).

I - Interpersonal exploitation.

A - Arrogant (haughty).

L - Lacks empathy.

In order for Narcissistic Personality Disorder to be diagnosed, the client needs to meet at least five of the following criteria:

- Has a grandiose sense of self-importance.
- Preoccupied with fantasies of brilliance, power, unlimited success or beauty.
- Believes they are unique or “special”, and can only be understood by those of a high status.
- Needs excessive admiration.
- Possesses a sense of entitlement
- Tries to achieve personal goals through the exploitation of others.
- Lacks empathy.
- Is frequently envious of others or believes that others envy them.
- Haughtiness or arrogance in attitude or behaviour.

Treatment Options

Hospitalisation frequently occurs as a treatment option for those with severe Narcissistic Personality Disorder symptoms. Periods of time spent in hospital should be kept brief and involve the treatment of the specific symptom.

Psychosocial Treatment

In the majority of cases, therapists will usually treat purely the symptoms related to crises and other Axis I conditions, rather than the narcissistic personality disorder itself. Positive transference and a therapeutic alliance should not be relied upon by the therapist, as the client may not be able to acknowledge the therapist's humanness, but instead may see them as either superhuman or devalued.

Clients who do not terminate treatment early due to the relieving of a specific symptom, may want to continue therapy to try to resolve issues related to their personality disorder, including interpersonal difficulties or depression. It is important that the therapist has a good understanding of Narcissistic Personality Disorder for both interpretation to the patient and for use in combating counter-transference.

Group Therapy

The aim of group therapy is to assist the client in developing a healthy individuality, so that they can acknowledge others as separate persons. The structure of group therapy can control destructive behaviour. In a group setting, the role of the therapist is seen as less authoritative, as well as there being a lessening of intensity of emotional experience.

Avoidant Personality Disorder

Clients with Avoidant Personality Disorder are characterised by a complex pattern of feelings of inadequacy and extreme sensitivity to what other people think of them. People with the disorder frequently consider themselves to be personally unappealing and socially inept. They will often avoid social situations due to fearing humiliation or being disliked by others. It is believed that this stems from perceived or actual rejection by parents or peers during childhood.

The disorder usually manifests itself by early adulthood and is particularly common amongst those with anxiety disorders. It has been suggested that between 10 and 50 percent of people with panic disorder or agoraphobia, also have Avoidant Personality Disorder.

A method which can be used to remember the diagnostic criteria for Avoidant Personality Disorder is 'CRINGES':

C - Certainty (of being liked).
R - Rejection or criticism, fear of.
I - Intimate relationships (restraint in intimate relationships).
N - New interpersonal relationships (is inhibited in).
G - Gets around occupational activity.
E - Embarrassment (potential) holds them back.
S - Self viewed as unappealing, inept or inferior.

In order for a diagnosis for Avoidant Personality Disorder to be made, the client must display at least four of the following criteria:

- Fears disapproval, rejection or criticism.
- Unwilling to become involved with people unless they are certain of being liked.
- Restrained within a physical relationship due to fear of being shamed.
- Preoccupied with rejection or criticism in social situations.

- Experiences inhibitions in new relationship situations, due to feelings of inadequacy.
- Regards themselves as being socially inept, inferior or unappealing.
- Avoids taking personal risks or taking part in new activities, due to fear of embarrassment.

Treatment Options

The most common type of treatment used for Avoidant Personality Disorder is psychotherapy. In some cases, if the client agrees to attend a suitable number of sessions, group therapy can be beneficial. However, due to the nature of the disorder, it can be difficult to keep the client in group therapy, particularly early on in the treatment process. It can, however, be a possible treatment to consider as the client approaches the end of individual therapy.

Clients with Avoidant Personality Disorder are likely to have poor self-esteem and issues with social interactions. They frequently only see the negative aspects in life and struggle to look at things in an objective manner. This can further impact upon their initial evaluation with a therapist, as they may be prone to withholding important life history or similar information, as they feel that they are too unimportant. It is therefore important for the therapist to take a more detailed evaluation, but to do so in an unobtrusive way, by being aware of non-verbal cues the client may demonstrate. This is vital in ensuring that the correct diagnosis is made, as some disorders, such as Schizoid or Borderline Personality Disorder, may present themselves in similar ways, whilst being very different disorders. Like a large number of other personality disorders, clients are unlikely to present themselves for treatment unless there is a particular stress in their current lives which they find difficult to cope with.

Psychotherapy is again the most commonly used treatment for clients with Avoidant Personality Disorder. This has been found to be the most effective when the treatment is relatively short-term and mainly focused on solving specific life problems. As is the case with all therapy, a solid therapeutic relationship in which the therapist will listen to the client, is vital in the overall effectiveness of treatment.

It can be difficult to form a solid relationship initially, as clients with Avoidant Personality Disorder tend to terminate therapy at an early stage. In the majority of cases, however, once a good rapport has been formed, therapy tends to be stable, unless there are issues brought up which the client finds particularly difficult to discuss. It is therefore important that the therapist is careful when exploring new issues.

Medications

Like all personality disorders, medications should be carefully prescribed, usually only when there is an additional Axis I diagnosis. Therapists should demonstrate caution when prescribing medication to clients with Avoidant Personality Disorder as it is possible in some cases for medication to interfere with effective psychotherapy treatments.

Dependent Personality Disorder

Clients with Dependent Personality Disorder feel the need to be taken care of. They are fearful of separation or abandonment, which can lead to clingy behaviour. This behaviour in turn can lead to others taking advantage of them. As people with Dependent Personality Disorder require constant reassurance, they may find it difficult to make decisions and to complete tasks or projects on their own. They have a tendency to belittle themselves and to agree with people, even when they know the person is wrong.

A method which can be used to remember some of the diagnostic criteria for Dependent Personality Disorder is 'RELIANCE':

R - Reassurance required for decisions.
E - Expressing disagreement is difficult.
L - Life responsibilities (needs to have these assumed by others).
I - Initiating projects difficult.
A - Alone (feels helplessness and discomfort when alone).
N - Nurturance.
C - Companionship sought urgently when close relationships end.
E - Exaggerated fears of being left to care for self.

In order for Dependent Personality Disorder to be diagnosed, the client must meet at least five of the following criteria:

- Requires excessive reassurance from others in order to make decisions.
- Needs others to assume responsibility for major areas of life.
- Finds it difficult to express disagreement for fearing loss of approval or support.
- Finds it difficult to carry out projects on own.
- Will go to excessive lengths to gain nurture and support, even by volunteering for unpleasant tasks.
- When alone feels discomfort or helplessness.

- Urgently seeks another relationship after a close one is lost.
- Is preoccupied to an unrealistic extent with fears of being abandoned and left to take care of themselves.

Treatment Options

Psychotherapy is again the most commonly used treatment choice for those with Dependent Personality Disorder. Clients usually present themselves for treatment when stress or other particular problems in their lives have become too difficult for them to manage. Like most other personality disorders, it may initially appear that the client has a clear Axis I diagnosis, with the Dependent Personality Disorder only becoming apparent after a number of therapy sessions.

It has been found that the most effective psychotherapeutic approach is one in which the main focus is on finding solutions to specific life problems. Long-term therapy, while being beneficial for some personality disorders, may be counterproductive in the case of Dependent Personality Disorder as it only reinforces the dependency on the therapist. Although there will always be a form of dependency in treating someone with Dependent Personality Disorder, the shorter the treatment in this case, the better. The termination of therapy in the case of treating Dependent Personality Disorder will be of extreme importance, and will be an overall test as to how effective treatment has been.

The examination of the client's faulty cognitions and related emotions is an important aspect of therapy. Assertiveness training and additional behavioural approaches have all been found to be beneficial in the treatment of those with Dependent Personality Disorder. Group therapy may provide further benefits, although it is also important to ensure that the client does not use the group to form other dependent relationships. Initially, the therapist should avoid challenging dependent relationships which the client has with other people, which could be considered unhealthy.

When treating those with Dependent Personality Disorder, it is extremely important to consider the termination of therapy. While the decision to end therapy should be a joint decision between the client and therapist, people with the disorder are often

unaware of how much therapy is enough. When this is the case, the therapist may have to guide the client towards ending therapy. It is common for the client to re-experience feelings of insecurity and a lack of self-confidence which they initially experienced when beginning therapy. The therapist must deal with these feelings appropriately, but should not allow them to prolong the current therapy treatment programme. The main target is to jointly agree a time and way in which to end therapy, and the client should be encouraged to use the skills they will have developed through therapy sessions to manage their feelings of anxiousness.

Medications

Again, as with the majority of personality disorders, medication should only be prescribed to treat specific problems, such as an additional Axis I diagnosis. Therapists should also refrain from over prescribing medication to someone with Dependent Personality Disorder, due to the way in which they present a number of physical complaints or anxiety. In the case of anxiety this is frequently related to a particular situation, and medication therefore, may have a negative impact upon psychotherapeutic treatments.

Obsessive-Compulsive Personality Disorder

Clients with Obsessive Compulsive Personality Disorder are preoccupied with perfectionism and orderliness. Unlike Obsessive Compulsive Disorder (OCD), clients are not aware that their behaviour is problematic. Although the majority of patients with this personality disorder do not have any obsessions or compulsions, some may eventually go on to develop OCD.

Those with Obsessive Compulsive Personality Disorder place emphasis on perfectionism above anything else, and become anxious when things are not "just right". This can not only affect their jobs, but also place strain on friends, partners and children. Obsessive Compulsive Personality Disorder is a fairly common condition, which is more commonly diagnosed in men than women. It is believed that the condition runs in families.

A method which can be used to remember some of the diagnostic criteria for Obsessive Compulsive Personality Disorder is 'LAW FIRMS':

L - Loses point of activity (due to preoccupation with detail).
A - Ability to complete tasks compromised by perfectionism.
W - Worthless objects (unable to discard).
F - Friendships and leisure activities excluded.
I - Inflexible, scrupulous.
R - Reluctant to delegate (unless others submit to exact guidelines).
M - Miserly (toward self and others).
S - Stubbornness (and rigidity).

For a client to be diagnosed with Obsessive Compulsive Personality Disorder, at least four of the following criteria need to be met:

- Preoccupation with lists, organisation, schedules, rules or details.
- Perfectionism that interferes with completing tasks.
- Workaholic tendencies.

- Excessively conscientious, inflexible or scrupulous about morals, ethics or values.
- Inability to discard worn-out items which have neither real, nor sentimental, value.
- Does not like to delegate tasks to others unless things are completed in his or her own way.
- Hoards money for future needs.
- Stubborn and rigid.

Treatment Options

Clients with Obsessive Compulsive Personality Disorder usually do not present themselves for treatment until a specific issue in their life has become too difficult for them to manage on their own. A client's coping skills may be limited, due to the nature of their disorder. Although these skills may be effective enough to cope with the majority of stresses and emotional difficulties, during times of increased pressure these skills may not be enough, making the disorder more evident.

Treatment for Obsessive Compulsive Personality Disorder is usually a short-term therapy for symptom relief and to develop existing coping mechanisms, as well as to teach new ones. Long-term treatment is not usually an option, as it is above the majority of therapists' skill level and the budgets of most patients.

Short-term therapy is likely to be beneficial when the client's existing support system and coping skills are examined in more detail. Social relationships should also be examined, in which the client and therapist build on reinforcing strong and positive relationships, and also re-examine negative or harmful relationships. The therapist may give the client some homework, which may include the client writing down their feelings as they notice them. Encouraging the client to properly identify and realise their feelings can bring about a significant change.

Clients who are suffering from Obsessive Compulsive Personality Disorder are often out of touch with their emotional states, as much as their thoughts. It may be beneficial for the client to move away from purely describing situations, to instead

explaining how particular situations made them feel. Although some clients may claim that they cannot remember how a particular situation made them feel, at this point it becomes apparent as to how useful the homework, in which the client is required to write down their feelings, may be.

Therapy for those with Obsessive Compulsive Personality Disorder is likely to be effective when it is focused on short-term difficulties that the client is currently experiencing. It is often less effective when the main aim of therapy is complex, long-term personality change.

Although a group therapy treatment may be a beneficial treatment option, the majority of clients may not be able to withstand the minimum social contact necessary to gain a healthy group dynamic. Further problems may arise when other members of the group criticise the client for picking out other people's "faults".

Hospitalisation

It is rare that a client with Obsessive Compulsive Personality Disorder will require hospitalisation, unless there is an extremely stressful situation currently being experienced by the client, which increases their compulsive behaviours to a point in which daily activities are affected. Hospitalisation may further be necessary when the obsessive thoughts they have do not allow the client to conduct basic activities.

Medications

As with the majority of personality disorders, medication is not usually prescribed unless there is an additional Axis I diagnosis. However, medications such as Prozac and other SRRI's have been approved as a method of treating obsessive compulsive personality disorder, and may provide some symptom relief. It has been found, however, that long-term use is neither appropriate nor beneficial.

Common Misconceptions and Generalisations

All too often it is a consultant psychiatrist who has very limited knowledge of the specific area of personality disorders who diagnoses someone with a personality disorder. The way in which the illness is explained is nothing short of installing hopelessness into their already hopeless patient.

Often, newly diagnosed patients are told that they have a personality disorder, it is very complex, and there is no cure. A lot of psychiatrists believe that medication does not work on people with personality disorders and therefore should not be prescribed, so patients are often also told there is no medicine available that will help. Due to the behaviour of someone who has a personality disorder, they are commonly called manipulative, attention seeking, demanding, and obstructive. I would like to go through these individually.

Manipulative

Dictionary Definition: 'To manage or influence skilfully, esp. in an unfair manner: to manipulate people's feelings'

This is a very harsh comment to make about someone who is using the best skills they have available. Try to imagine what someone with a personality disorder has gone through, and then think to what extremes you would go to protect yourself. Isn't it true that life is a fight for survival, or would it be seen that way through the eyes of someone with a personality disorder?

Attention Seeking

Dictionary Definition: 'Seizing the attention'

There are many people with personality disorders; they may be considered attention seekers, but let me ask you, if you had a cold, what is it you look for from your partner or friends? Isn't it comfort, reassurance and attention? So why would it be any different from someone suffering from severe emotional distress? The other point to note on this is that people with personality disorders have often had their

behaviours reinforced. As an example, should someone with a personality disorder threaten to cut themselves with a knife because their partner was going out for a drink with a mate, and in turn the partner said, “O.K. I won’t go”, this reinforces the behaviour and makes it more likely to occur again.

Demanding

Dictionary Definition: ‘Requiring more than usually expected or though due; especially great patience and effort and skill.’

Imagine having a broken leg: you know there is treatment, and with a little patience you will be better before you know it. With a personality disorder you are likely to experience the problem for many years, with no real hope of a cure, but your symptoms are likely to lessen as you grow older. Unlike a broken leg, you can not exactly see what is wrong, but you can definitely feel it. I am sure everyone will agree, this would make anyone quite demanding and impatient.

Obstructive

Dictionary Definition: ‘To impede, retard, or interfere with; hinder.’

People with mental health issues have often been through mental health services for years. Having a personality disorder you are likely to be involved with services for much longer than the standard mental health patient. You are offered so many services and therapies that have different names but often mean the same. I suppose you end up feeling like a bit of a guinea pig, and reluctant to continue with another service or therapy.

Causes of personality disorders

There is no single agreed cause of personality disorder. It is believed that some disorders may be inherited, whilst others may be caused by temperamental factors in childhood, which can later affect adult life. Other causes are believed to be linked to the relationship as a child with parents, "education, moral teachings, life experiences and adolescent socialisation"11. These theories, however, have very little scientific backing. The main causes of personality disorder are linked to physical, verbal and sexual abuse, neglect, loss or separation during childhood, and, lastly, brain abnormalities.

These causes will now be looked at in more detail:

Developmental

In people with BPD there is often a history of childhood sexual abuse, physical abuse, witnessing violence in the home, emotional abuse and neglect. BPD patients often come from a background of dysfunctional family relationships. This suggests that trauma and suffering of this kind could be a key factor in why people may go on to develop BPD.

This cannot be considered the sole reason as to why BPD occurs. However, it cannot be ignored, due to such a high percentage of sufferers reporting the aforementioned types of childhood experience. It has been suggested that BPD may be a form of, or similar to, post traumatic stress disorder; so much so, that there was some talk about Borderline Personality Disorder being renamed 'complex post traumatic stress disorder'.

A very large number of people diagnosed with Borderline Personality Disorder have reported being sexually abused, usually by a non-caregiver. Studies / reports have shown up to 71%.

[11] PDR Health Personality Disorders

From one such study into the relationship between childhood abuse and personality disorders, it was stated:

A study of almost 600 male college students, averaging almost 30 years of age, and who were not drawn from a clinical sample, examined the relationship between childhood experiences of sexual and physical abuse and presently reported personality disorder symptoms. Childhood abuse histories were found to be definitively associated with greater levels of symptomatology. Severity of abuse was found to be statistically significant, but clinically negligible, in symptomatology variance spread over Cluster A, B and C scales. (Miller and Lisak, 'Journal of Interpersonal Violence', Jun 1999).

Childhood abuse and neglect consistently demonstrate as risks for personality disorders in adulthood. In this study, efforts were taken to match retrospective reports of abuse with a clinical population that had demonstrated psychopathology from childhood to adulthood, who were later found to have experienced abuse and neglect. The sexually abused group demonstrated the most consistently elevated patterns of psychopathology. Officially verified physical abuse showed an extremely strong role in the development of antisocial and impulsive behaviour. On the other hand, cases of abuse of the neglectful type that created childhood pathology were found to be subject to partial remission in adulthood.

(Cohen, P., Brown, J., Smailes, E. 'Child Abuse and Neglect and the Development of Mental Disorders in the General Population', 'Development and Psychopathology', 2001. Vol. 12, No 4, pp981-999)12

Further research into the role of abuse and neglect by parents, as well as the role of peers in the later development of personality disorders, has been looked at by

[12] Wikipedia – Personality Disorder

Charlotte Huff. In her article, entitled ‘Where Personality Goes Awry’, Huff discusses the role of abuse with Patricia Hoffman Judd, PhD, Clinical Professor of Psychiatry at the University of California, San Diego:

"*There is a pretty high prevalence of maltreatment by caregivers across all personality disorders," she notes. "One of the key problems appears to be neglect. Probably more of an emotional neglect--more of a lack of attention to a child's emotional needs.*"

Judd points to several studies by Johnson, including one published in 1999 in the ‘Archives of General Psychiatry’ (Vol. 56, No. 7) that followed 639 New York state families and their children for nearly twenty years. Children with documented instances of childhood abuse or neglect were more than four times as likely to develop a personality disorder in early adulthood, according to the research.

Another study, led by Johnson and published in 2001 in ‘Comprehensive Psychiatry’ (Vol. 42, No. 1), came to a similar conclusion when examining maternal verbal abuse in the same New York group of families, involving this time 793 mothers and their children. The prospective study asked mothers a variety of questions, including whether they had screamed at their children in the previous month, and whether they had told their child they didn't love them or would send them away. Offspring who experienced verbal abuse in childhood - compared with those who did not - were more than three times as likely to be diagnosed as adults with Borderline, Narcissistic, Obsessive-Compulsive and Paranoid Personality Disorders.

Shea cautions, however, that at this point research into childhood neglect and abuse, albeit intriguing, has largely been suggestive, because prospective studies remain limited.

"*It's likely that these childhood abuse factors do play an important role," he explains. "It's hard to say what and how big that role is, more specifically*."

The Parent-Blame Problem

The role of abuse is particularly controversial among family members of people with a borderline disorder, who say they are being unfairly blamed - similar to what happened in the early days of schizophrenia research. Emphasising maltreatment and abuse is misleading and has a devastating effect on families, says Valerie Porr, President of a New York-based non-profit group, 'Treatment and Research Advancements National Association for Personality Disorder' (www.tara4bpd.org/tara.html).

Porr doesn't deny that parental behaviour can play a role in borderline PD. "But it's not like it's the evil mother beating her children," she says. Rather, she explains, the child's "behaviour is so off the wall [that] the family's responses are off the wall."

Porr, who has a family member with borderline personality disorder, points to emerging research, including that of Harvard University-based psychologist Jerome Kagan, PhD, identifying the high sensitivity to outside stimuli of some children as significant. Family members of people with borderline PD report unusual responses, even in the first months of life, Porr says, noting that, "They say, 'The light bothers them. They are sensitive to noise. Texture bothers them.'"

But Kagan, in a 2002 'Dialogues in Clinical Neuroscience' article (Vol. 4, No. 3), says that the role of high reactivity in infancy is far from clear-cut. It's true, he says, that highly reactive infants are more likely to develop shy, timid or anxious personalities. Still, there are puzzling questions, including the significant gap between the percentage of children (20 percent) who are highly reactive infants, and the prevalence (less than 10 percent) of those who develop social phobias.

"This fact suggests that many high reactives find an adaptive niche in their society that allows them to titer unpredictable social encounters," Kagan writes.

In the end, says Johnson, the goal of research into environmental influences is not to blame, but to help parents. "We must understand what parenting behaviours are

associated with greater risk to the child," he says. "When we identify those parenting behaviours, we can use them to design intervention."

The Role of Peers

Psychologists' findings also suggest that caregivers, teachers and even peers may play a role in PD's - both in positive as well as negative ways. Even a single strong positive relationship - say a close bond with a grandmother - can offset negative influences in a dysfunctional household.

"The child with a predisposition toward developing a personality disorder doesn't need the perfect teacher or the perfect friends to not develop the disorder," says Judith Beck, PhD, Director of the Beck Institute for Cognitive Therapy and Research in suburban Philadelphia. "If the child is in an extreme environment, such as one of abuse or neglect, that may make the difference in terms of developing a personality disorder."

And life events can help tip the balance, Beck says. For example, a child with obsessive-compulsive tendencies who has alcoholic parents may assume the responsibility of caring for their younger siblings - a move that may amplify their propensities until they meet the diagnosis of a disorder. "It's the fit between your environment and your personality," Beck explains.

Over time, researchers will continue probing that fit, and will likely identify more than a few causes even for a single personality disorder, says Millon, Dean of the Florida-based Institute for Advanced Studies in Personology and Psychopathology. Narrowing down potential causes will help psychologists more quickly isolate what might be influencing a particular patient, he says.

Millon explains: "Once you identify the one cause that seems most probable and most significant, then you can design your therapy in order to unlearn what seemed most problematic for that individual."13

---

[13] Huff, C. Personality Disorders: 'Where Personality Goes Awry'

Biological

Another accepted theory is that BPD may be a result of biological and genetic factors.

According to research, there is evidence to suggest a genetic component. Parents with BPD have an increased likelihood of having children who are prone to BPD and other psychiatric disorders. Genetic factors may cause a slight susceptibility to a person developing BPD. This susceptibility may only result in a disorder when nurtured in a triggering environment, i.e. that of abuse or neglect.

It has been theorised that there may be a chemical dysfunction in the brains of BPD patients. Hormonal and chemical imbalances found in some BPD subjects may explain some of the BPD symptoms. Investigations have shown BPD patients to have imbalances of several chemicals including serotonin, dopamine, norepinephrine (noradrenaline) and acetylcholine monoamine oxidase.

The article below looks further into how genetic factors play a significant role in the development of personality disorders:

“Over the years, few large-scale prospective studies have targeted the causes of personality disorders (PD’s). But recently, a new body of research has begun to explore the potential influences of several factors, from genetics and parenting to peer influences, and even the randomness of life events.

Indeed, says Patricia Hoffman Judd, PhD, Clinical Professor of Psychiatry at the University of California, San Diego, research into the origins of PD’s is just beginning to take off. "I think for years people thought, 'It's just personality--you can't do anything about it,'" she explains. "There's also been moralism [that people with such disorders] are evil, that they are lazy," adds Judd, author of ‘A Developmental Model of Borderline Personality Disorder’ (‘American Psychiatric Publishing’, 2003).

But research is helping to turn such misconceptions around. Genetics researchers, for example, are closer to identifying some of the biological underpinnings that may

influence PD's. Last year, for example, a team located - and described in 'Molecular Psychiatry' (Vol. 8. No. 11)--a malfunctioning gene they believe may be a factor in Obsessive-Compulsive Disorder. Other researchers are investigating genetic links to aggression, anxiety and fear - traits that could be influential in the later development of a personality disorder.

However, genetics doesn't work in a vacuum. Studies continue to indicate that abuse, even verbal abuse, can amplify the risk of developing a personality disorder.

For some disorders, such as Antisocial Personality Disorder, the evidence suggests that genetic factors play a significant role, while others, such as Dependent Personality Disorder, appear to be more environmentally influenced, says long-time PD researcher Theodore Millon, PhD, DSc, editor of an ongoing book series, 'Personality-guided Psychology' (APA).

But regardless of the specific disorder, researchers increasingly observe a back-and-forth interplay between genetic and environmental influences.

"We see a paradigm shift taking place in the field now toward a more interactionist perspective," says Jeffrey G. Johnson, PhD, Associate Professor of Clinical Psychology in Columbia University's Psychiatry Department. "I think the field is getting away from genetics versus environment - it's a major change."

The Genetic/Environmental Convergence

One of the largest efforts to look at PD's, the Collaborative Longitudinal Personality Disorders Study (CLPS), is attempting to gain insight into a cross-section of the disorders' characteristics, stability and progression. The multi-site study, funded by the National Institute of Mental Health until 2005, has, since 1996, enrolled 668 people with the diagnoses of Avoidant, Borderline, Obsessive-Compulsive or Schizotypal Personality Disorders. A summary of the study's aims appeared in the 'Journal of Personality Disorders' (Vol. 14. No. 4).

Although the study is not looking directly at causes, it's collecting historical information that may one day provide some insights, says Tracie Shea, PhD, Associate Professor in The Department of Psychiatry and Human Behaviour at Brown Medical School, and one of CLPS's principal investigators. "I like to think of it as generating hypotheses that can be tested," she says.

Shea co-authored a 2002 study in the ‘Journal of Nervous and Mental Disease’ (Vol. 190, No. 8) that looked at CLPS data and found an association between the severity of specific PD’s and the number and type of childhood traumas. In particular, people with borderline PD’s reported particularly high rates of childhood sexual trauma - 55 percent detailing physically forced, unwanted sexual contact. The researchers note, however, that the type of analysis couldn't determine if the personality adaptations occurred in response to the trauma, or whether the individuals' underlying character pathology predisposed them.

Among those exploring the genetic and environmental influences linking normal and abnormal personality is Robert Krueger, PhD, Associate Professor of Psychology at the University of Minnesota. In 2002, Krueger co-authored a study in the ‘Journal of Personality’ (Vol. 70, No. 5) that looked at the personality traits of 128 twin pairs who had been raised apart. The study found that the identical twins were more similar in personality traits than the fraternal twins.

Thus, although both genetics and environment contributed to the association between normal and abnormal personality, genetics appeared to play the greater role overall, Krueger says. "The predominant reason normal and abnormal personality are linked to each other is because they are linked to the same underlying genetic mechanisms," he explains.

With borderline PD, for example, ongoing research indicates that there may be a genetic base for the problems with impulsivity and aggression, says the University of

California's Judd. But environmental influences are significant and can extend deep into childhood, even infancy, Judd adds.14

Physical Causes

It has been stated by Dr Leland Heller, an American psychiatrist, that:

”BPD is a 'neurological illness', probably a form of epilepsy, and that it can be managed with appropriate medication and talking treatments”15

Some medical professionals also believe that physical problems in the brain may be a contributing factor or cause of BPD. It has been suggested that BPD can be attributed to brain damage caused to a baby in the womb, or during or after birth. There is also some evidence of organic lesions in the brains of people with BPD. Brain imaging has reportedly seen abnormalities in the brains of BPD sufferers.

Research conducted into the connections between brain abnormalities and Borderline Personality Disorder have found that in some cases there are problems in the amygdala and the hippocampus, both of which have an effect on the regulating and expression of emotions, and more specifically the expression of automatic reactions, rage and fear.

These studies have also found that the volume of the amygdale and of the hippocampus are smaller in clients with BPD, to a significant extent, compared to those who do not suffer from any form of mental illness. This therefore creates a link between a dysfunctional amygdale and hippocampus, to BPD.

[14] Huff, C – Personality Disorders: ‘Where Personality Goes Awry’

[15] Mind Understanding Borderline Personality Disorder

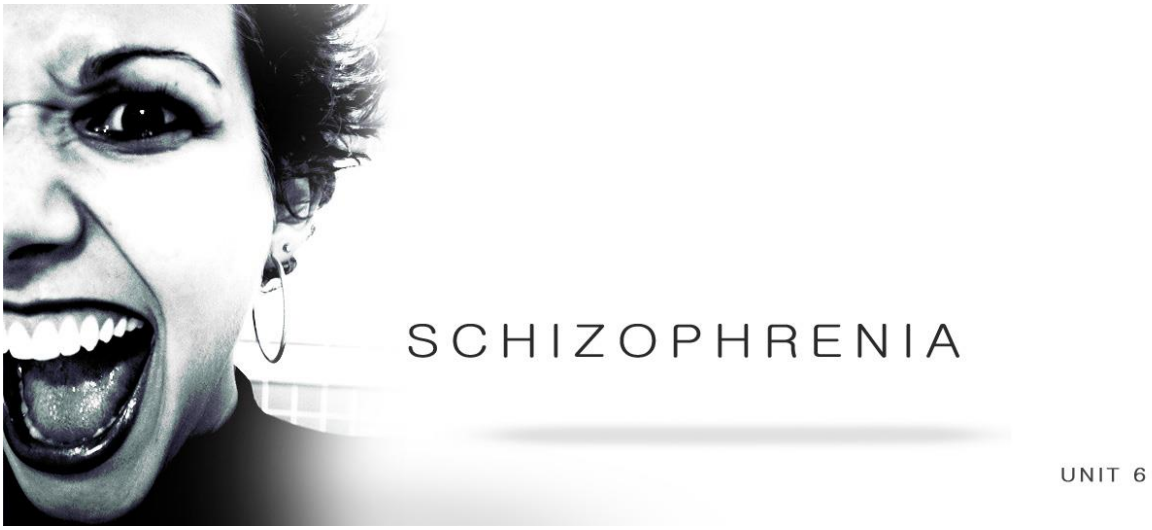
Key Points:

- There is no single known cause of personality disorder.
- Combinations of biological, social and psychological factors are implicated in the development of personality disorders.
- Personality disorders consist of manifestations of extreme forms of normal behaviours / emotions / beliefs.
- Many individuals are resilient to the bio-psychosocial stress associated with the development of personality disorders; they would appear to possess resilient temperaments and/or have experienced adaptive socially environments and/or sought alternative positive attachments.
- Stress vulnerability would appear to be a mediating factor in the development and maintenance of personality disorders.

Prognosis of personality disorders

Personality disorders are regarded as lifelong conditions with periods of improvement and worsening. It is believed that clients with personality disorders within clusters A and B have symptoms that become less intense and severe by the time they reach middle age. Those with personality disorders within cluster B (such as Borderline Personality Disorder) however, are particularly prone to substance abuse and suicidal behaviour, which may have a direct impact on their life span. Figures suggest that 80% of Borderline Personality Disorder clients who are hospitalised will attempt suicide at some point during their treatment, from which 5% will succeed.

Despite the obvious negativity surrounding the prognosis of personality disorders, due to them being regarded as 'incurable', there are a number of treatment options available to clients which can help to improve the symptoms of personality disorders, and help make life for clients more manageable. These treatments encourage clients to develop the necessary skills required to manage both the 'highs' and 'lows' associated with personality disorder, and enable them to lead as normal a life as possible.



SCHIZOPHRENIA

UNIT 6

In this section:

Schizophrenia
Symptoms of schizophrenia
Diagnosis of Schizophrenia
Causes of schizophrenia
The facts

Schizophrenia

Schizophrenia and schizophrenic disorders have been defined by the World Health Organisation as being:

"Characterised in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include: thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms."

Schizophrenia is a severe and debilitating disease that can be found worldwide. People who suffer from this disorder are usually very frightened and confused by the symptoms they experience.

There are many misconceptions about schizophrenia, and people who suffer from it are often stigmatised due to people's lack of education and understanding about the disorder. Even if a person no longer suffers from schizophrenia, they often find it hard to get on with their life due to the stigma and judgements people make about them.

Symptoms of schizophrenia

The symptoms of schizophrenia can vary from person to person, although the main ones are generally indicated through:

- Paranoia.
- Social isolation.
- Unusual emotional reactions.
- Unusual sensitivity.
- Hostility.
- Hyperactivity or inactivity.
- Deterioration in personal hygiene.
- Inability to concentrate.

The symptoms of schizophrenia are divided into three sections:

- **"Positive" symptoms** – the presence of symptoms which are not normally noted in the general population.
- **"Negative" symptoms** – the absence of what is generally noted in the general population.
- **"Cognitive" symptoms** – problems with attention, certain types of memory and executive functions, which allow planning and organisation.

Positive Symptoms

- Delusions **-** Ideas the person has about him or herself or surroundings, which are false.
- Disrupted thoughts and behaviour **-** Difficulty maintaining train of thought or concentrating, unpredictable or erratic behaviour.

- Hallucinations **-** Sensations which are heard, seen, smelt or felt that a person experiences but others do not.
- Grossly disorganised behaviour **-** Behaviours which appear bizarre and lack purpose, inability to suppress impulsive behaviours and emotions, inability to perform goal-directed tasks, unpredictable agitation.

Negative Symptoms

- Catatonic behaviour - Apparent unawareness of the environment, lack of self-care, bizarre postures, decreased motion or excessive and aimless motions.
- Flattened or blunted affect - Reduction of, or lack of emotional expression.
- Alogia - Difficulties with speech, lessening of fluency, inability to hold conversation.
- Avolition - Difficulty in creating goal-directed behaviour, social withdrawal, lack of interest or enthusiasm for activities which were previously enjoyable.

Cognitive Symptoms

- Inability to sustain attention
- Difficulties with “working memory”.
- Poor executive functioning.

Diagnosis of Schizophrenia

As stated in the DSM-IV, in order for a diagnosis for schizophrenia to be made, at least two of the following criteria need to be met and should have been present for a significant period of time during a month:

- Delusions.
- Hallucinations.
- Disorganised speech.
- Grossly disorganised or catatonic behaviour.
- “Negative” symptoms (as described previously).

It is important to note that only one of the criteria indicated above is required for diagnosis if delusions are bizarre, or the hallucinations consist of a voice which is keeping a running commentary on the client's behaviour or thoughts, or there are two or more voices conversing with each other.

In addition to the criteria outlined above, the following should also be met:

Social / occupational dysfunction

For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve the expected level of interpersonal, academic, or occupational achievement).
Duration

Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms), and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms, or two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

Schizoaffective and Mood Disorder exclusion

Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either: (1) no Major Depressive Episode, Manic Episode, or Mixed Episode has occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

Substance/general medical condition exclusion

The disturbance is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication), or a general medical condition.

Relationship to a Pervasive Developmental Disorder

If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Sub-types of schizophrenia

1. Paranoid Type - A type of schizophrenia in which the following criteria are met:

- Preoccupation with one or more delusions, or frequent auditory hallucinations.
- None of the following is prominent: disorganised speech, disorganised or catatonic behaviour, or flat or inappropriate affect.

2. Catatonic Type - A type of schizophrenia in which the clinical picture is dominated by at least two of the following:

- Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor.
- Excessive motor activity (that is apparently purposeless and not influenced by external stimuli).
- Extreme negativism (an apparently motiveless resistance to all instructions, or maintenance of a rigid posture against attempts to be moved), or mutism.
- Peculiarities of voluntary movement, as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures).
- Stereotyped movements, prominent mannerisms, or prominent grimacing.
- Echolalia or echopraxia.

3. Disorganised Type - A type of schizophrenia in which the following criteria are met: (All of the following are prominent)

- Disorganised speech.
- Disorganised behaviour.
- Flat or inappropriate affect.
- The criteria are not met for Catatonic Type.

4. Undifferentiated Type - A type of schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganised, or Catatonic Type.

5. Residual Type - A type of schizophrenia in which the following criteria are met:

- Absence of prominent delusions, hallucinations, disorganised speech, and grossly disorganised or catatonic behaviour.
- There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms, or two or more symptoms listed in Criterion A for schizophrenia, present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

Causes of schizophrenia

Schizophrenia is not believed to be caused by a single factor; it is regarded as being due to a combination of issues, such as brain abnormalities, genetic factors and developmental factors.

Brain Abnormalities

There are differences in the brain chemistry of people with schizophrenia which are regarded as being a possible cause of the condition. These are imbalances of:

- Specific amino acids.
- Certain proteins.
- Specific neurotransmitters.

Additional factors regarding the brain are related to the brain structure. The loss of brain tissue, for example, and abnormal activity in the parts of the brain which are responsible for emotion, reasoning and memory, can lead to the onset of schizophrenia. Furthermore, MRI scans have indicated that there are some differences between the brain structures of those with schizophrenia compared to non-schizophrenics. The circuitry of the brain, such as disruptions in the communication between the left and right hemispheres, is also believed to be a contributory factor.

Genetic Factors

It has been stated that schizophrenia more commonly occurs in people who have a family history of the condition. However, 60% of people do not have such a history, making it more likely, therefore, to be the result of other factors.

Developmental Factors

There are a number of developmental factors which are believed to contribute towards schizophrenia, which include:

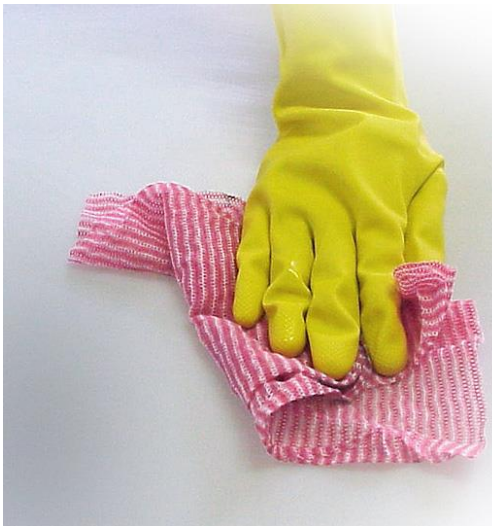
- Exposure to a virus during infancy.
- Prenatal exposure to a viral infection.
- Early parental loss / separation.
- Low oxygen level due to prolonged labour, premature birth or low birth weight.

Additional Factors

Further factors which may lead to the onset of schizophrenia include environmental stresses, hormonal changes which have an effect on the chemistry in the brain, and side effects from some drugs.

The facts

- Schizophrenia affects one in one hundred people.
- Schizophrenia occurs all over the world.
- Some patients with schizophrenia only ever suffer from one psychotic episode, and some have many over the years.
- Although very rare, children of over five years old can develop schizophrenia.
- The most common type of hallucination experienced by schizophrenia sufferers is auditory, but patients can also have visual, tactile, gustatory (taste) and olfactory (smell) hallucinations.
- Only one third of suffers have paranoid-type symptoms.
- Approximately ten percent of schizophrenia sufferers will commit suicide.
- Young male sufferers are more likely to commit suicide than females.
- Signs and symptoms of schizophrenia usually first manifest in young adulthood and adolescence.
- The rates of schizophrenia are similar in most countries.
- Both sexes are at the same risk of developing the disorder.
- Males usually develop the illness earlier in their lives than women.
- The majority of schizophrenia patients suffer throughout their lives, whether it is ongoing or recurring.
- Only approximately one in five individuals recovers from their schizophrenia completely.



OBSESSIVE COMPULSIVE DISORDER

UNIT 7

In this section:

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder (OCD) is an anxiety disorder characterised by the presence of unwanted thoughts and behaviour patterns, known as obsessions and compulsions. A person diagnosed with OCD will have displayed persistent patterns in their thoughts / behaviours that affect their daily life for at least 1 hour a day.

People who have OCD usually start showing symptoms in childhood or early adulthood. Some people recover completely with treatment, which usually involves a combination of pharmaceutical medications and behavioural therapy. For others, OCD can become manageable, where the obsessions / compulsions no longer affect their daily life to such an extent.

Adults who suffer with OCD usually know what they are doing is 'unusual' or 'strange', but cannot control the overwhelming urges to carry out the thoughts. Children, however, tend not to know the behaviour is not 'normal'.

There are many different ways OCD can present itself; the most common obsessions / compulsions types are:

Checkers

Checkers believe that great harm will be brought to someone, either themselves or others, if they do not carry out their obsessions. Examples of these would be making sure all the plugs are switched off, or all the doors are locked. Checkers often develop a complex routine of what they check and in what order.

Hoarders

Hoarders tend to collect things that others would consider of little value. They tend not to be able to throw things out, therefore their houses may be considered 'cluttered' due to their collections.

Obsessionals

Obsessionals turn to repetitive actions and thoughts such as counting, or repeating words or phrases in order to distract themselves from negative unwanted thoughts of violence and harming others.

Orderers

Orderers like everything in its place; everything must be 'just right', they are perfectionists. They can spend hours arranging things until they are exactly right, and if they are moved they can become very agitated and distressed.

Washers and Cleaners

Washers and cleaners fear dirt or germs, either for themselves or for others. For example, touching the taps may cause infection or disease, so they need to use something so as not to come into direct contact with it. They will obsessively wash, sometimes to the point of causing damage to their skin.

Symptoms of Obsessive Compulsive Disorder

OCD is split into two types of symptoms, obsessions and compulsions. Most people with OCD have both symptoms, although it is not unheard of for only one to be present.

Obsessions

Obsessions are excessive, unwanted, persistent thoughts or feelings that cause the person distress or anxiety. The person with OCD finds it difficult or impossible to control these thoughts. They believe the only way to deal with them is to carry out an action to subdue these thoughts (compulsions). The obsessive thoughts are not everyday worries about life. The person can usually recognise that the thoughts are irrational, but cannot simply dismiss them.

Compulsions

Compulsions are the acts or rituals that people are driven to follow in order to try to relieve the obsessive thoughts. They are often repetitive acts, and have to adhere to certain 'rules' in order for them to be effective. Compulsions in OCD do not bring pleasure to the person; the only purpose they serve is to bring relief. Some compulsions can lead to harm: for example people who hand wash excessively may wash their hands so much that they become inflamed and sore.

Some of the typical obsessions and related compulsions are:

Obsession	Relative compulsion
Fear of germs / contamination.	Excessive hand washing / cleaning.
Need for perfection.	Repetitive actions until things are just so.
Thoughts of someone being harmed.	Repetitive actions / words so as not to cause (imagined) harm to someone.
Doubt about religious or moral beliefs.	Counting, either physical objects or in their head.
Loosing control / aggressiveness.	Checking.
Sexual urges and thoughts.	Touching.

Diagnosis of Obsessive Compulsive Disorder

Under the DSM-IV, in order for a diagnosis of Obsessive Compulsive Disorder to be made, the following criteria need to be met:

- Either obsessions or compulsions: (Obsessions as defined by a – d) (Compulsions as defined by e&f)
    a) Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate, and that cause marked anxiety or distress.
    b) The thoughts, impulses, or images are not simply excessive worries about real-life problems.
    c) The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralise them with some other thought or action.
    d) The person recognises that the obsessional thoughts, impulses, or images are a product of his or her own mind.
    e) Repetitive behaviours (e.g. hand washing, ordering, checking), or mental acts (e.g. praying, counting, repeating words silently), that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
    f) The behaviours of mental acts are aimed at preventing or reducing distress, or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.
- At some point during the course of the disorder, the person has recognised that the obsessions or compulsions are excessive or unreasonable. Note: this does not apply to children.
- The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour per day), or significantly interfere with the person's normal routine, occupations functioning, or usual social activities or relationships.

- If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g. preoccupation with food in the presence of an Eating Disorder).
- The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

Causes of Obsessive Compulsive Disorder

There are three main theories as to why people develop OCD, but as yet there is no single known cause. The theories include genetics, physical changes in the brain, and infection. It is important that causes of OCD are realised, as treatment is more successful the earlier it is received. Many years ago it was believed that if a child suffered from this disorder, it was due to problems either growing up or in the family; this theory has since been discredited.

Genetic

OCD can run in families, but it is not definite that if a parent has OCD that the child will develop it. They will be in a higher risk group of developing the disorder. Children with OCD that have a parent with the disorder don't necessarily have the same rituals; for example the parent may wash their hands excessively, and the child may check things. Scientists have discovered a gene that plays an important role in the onset of OCD. It is hoped by studying this gene in more detail they will be able to assess who is at higher risk, and will be able to develop better therapies for people with OCD.

Physical

There is a marked physical change in the brain of someone with OCD. Serotonin, a chemical that carries signals to different parts of the brain (neurotransmitter), levels are usually low. In these cases SSRI (serotonin re-uptake inhibitors) antidepressants can help, as they increase the amount of serotonin the body produces, thus alleviating some of the symptoms. Scans have also shown there is a structural difference in certain parts of the brain.

Infection

OCD sometimes develops after certain types of infection, commonly streptococcal bacterial infections. Because of the nature of this infection, when the body immune system tries to fight it, it also attacks some of the adjoining cells in the brain causing swelling and the onset on OCD

The Facts

- Approximately 2.3% of people between the ages of 18 and 54 suffer from OCD.
- OCD is found all over the world in every culture.
- OCD is as common in men as it is in women.
- 1/3 to 1/2 of adults with OCD showed signs of it in childhood
- Only about 10% of OCD sufferers are in treatment.
- The earlier treatment for OCD starts, the better the prognosis.
- OCD can co-exist with other disorders, such as eating disorders, other anxiety disorders, and depression.
- Stress and illness can make the symptoms of OCD worse.
- It used to be believed that OCD was a rare illness.
- 1 in 200 adults have OCD.
- The earliest signs of OCD have shown in preschool aged children.
- Boys tend to develop OCD at an earlier age than girls (6-15 for boys 20-29 for girls).
- Most cases of OCD have become apparent by the age of 40.
- Early diagnosis and treatment improves the prognosis of recovery.

In this section:

Phobia

Psychosis

Phobia

Phobias are defined as a persistent, irrational fear of a certain object, situation, activity or person. When the client's fear becomes overwhelming (i.e. they feel out of control, or it affects their daily life), a diagnosis of an anxiety disorder may be given.

It is widely accepted that phobias are the result of a combination of internal predispositions and external events. They are generally broken down into three categories of:

- Social phobias.
- Specific phobias.
- Agoraphobia.

Social Phobias

Social phobias are fears involving other people or social situations. Clients with social phobias are often fearful of criticism or rejection, and as such, find it difficult to start / take part in conversations and make friends. Social phobias are one of the most common psychiatric disorders; they can be so intense that they provoke blushing, sweating, racing heart, stomach upset or panic attacks.

Specific Phobia

The anxiety associated with specific phobias occurs when a client is exposed to whatever they fear most. The most common specific phobias include the fear of certain animals, heights and thunderstorms; they are however, the most responsive to therapy.

Agoraphobia

Agoraphobia is the fear of fear itself. They fear a panic attack occurring in a situation where it would be difficult to gain help, and therefore try to avoid such a situation occurring by avoiding the situation they believe may cause such an attack. As a result of this, they may confine themselves to their homes. Furthermore, it is estimated that around 20% of people with agoraphobia attempt to commit suicide.

Psychosis

Psychosis is defined as a condition which affects the way a person thinks, feels and understands. This can include experiencing unusual or distressing perceptions, such as delusions or hallucinations, and may leave them with a reduced ability to cope with their normal day to day activities and routines. When such symptoms affect a person, they are described as having an 'episode of psychosis'.

Psychosis most commonly affects young adults who are in their twenties, and can affect both men and women from all walks of life. It is estimated that around 4 in every 100 people will experience a psychotic episode at some point in their lives, most of whom will make a full recovery.

There are a number of different types of psychosis which include:

- Organic Psychosis.
- Brief Reactive Psychosis.
- Drug-Induced Psychosis.

Organic Psychosis

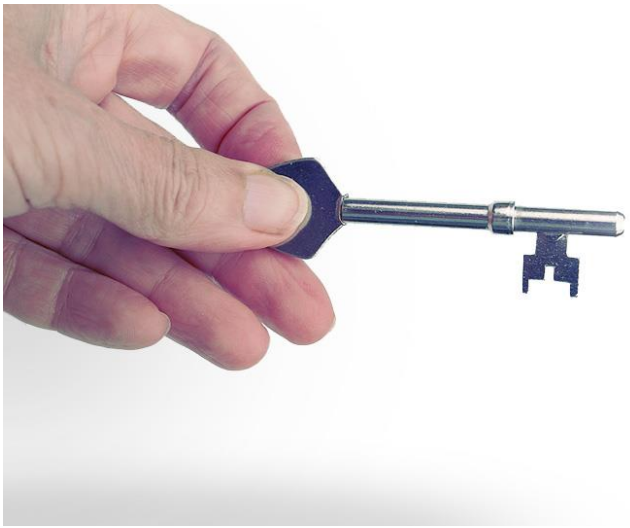
Organic Psychosis can be the result of a physical illness or head injury, which can disrupt brain functioning. Alongside this form of psychosis, other symptoms may also be present, including confusion or difficulties with memory.

Brief Reactive Psychosis

Brief Reactive Psychosis can be the result of major stress in the client's life (e.g. death of a loved-one, starting a new job, moving house). The symptoms of Brief Reactive Psychosis can be severe, but the client usually makes a rapid recovery.

Drug-Induced Psychosis

Drug-Induced Psychosis can be the result of withdrawal from alcohol and drugs. Often, the symptoms of Drug-Induced Psychosis wear off rapidly; however, for some the symptoms may last longer.



HOW TO HELP SOMEONE IN CRISIS

UNIT 9

In this section:

Self-harm

What to do if your Client has Self-harmed

Suicide

Eating Distress

Relationship Breakdown

Self-harm

The mental health charity ‘Mind’ define self-harm as “a way of expressing very deep distress. Often, people don't know why they self-harm. It's a means of communicating what can't be put into words or even into thoughts, and has been described as an inner scream. Afterwards, people feel better able to cope with life again, for a while.

“Self-harm is a broad term. People may injure or poison themselves by scratching, cutting or burning their skin, by hitting themselves against objects, taking a drug overdose, or swallowing or putting other things inside themselves. It may also take less obvious forms, including taking stupid risks, staying in an abusive relationship, developing an eating problem, such as anorexia or bulimia, being addicted to alcohol or drugs, or simply not looking after their own emotional or physical needs.” 16

Why do People Self-harm?

Self-harm affects roughly 1% of the population. A person self-harms for many reasons, but the underlying cause is usually to deal with painful emotions such as anger, loneliness, unhappiness, shame or guilt. These emotions may be related to abuse issues, such as flashbacks or self-hatred, resulting in a wish to punish themselves.

Many individuals that self-injure find it difficult to talk openly about their feelings, so harming themselves is a way of relieving their emotions and temporarily obtaining a sense of calm. For many people that self-mutilate, it is much easier for them to deal with physical pain than with emotional pain. Other people injure themselves because they feel numb, and pain is one way in which they can prove they are able to feel something, or that they are actually alive.

[16] Mind (2007) ‘Understanding Self Harm’

Self-harm can be seen as a way to prevent suicide or to help cope with suicidal or intense, unmanageable feelings. In this way it can be viewed as a survival mechanism, because the person feels that they have no other way of coping. Where self-injurious behaviour is used to prevent suicide, it is important to recognise that it has taken a great deal of effort for the person not to go to more extreme measures. It is also vital to understand that the severity of the injury is not indicative of the degree of emotional pain that the person is experiencing, or their risk of suicidal behaviour.

Methods of Preventing Self-harm

There are many ways to help prevent a client from self-harming, some of which will work better than others, as it will always depend on the individual concerned. While for some clients keeping busy can help, for others doing something relaxing or pampering is more beneficial. When working with a client who is prone to self-harm, it is important that they are aware of the following techniques which may help them to prevent or reduce the episodes of self-harm.

Clients could try:

- Keeping a diary.
- Phoning a friend to talk.
- Focusing on breathing and the movement of the abdomen and chest.
- Sucking lemon slices.
- Holding ice cubes or rubbing them on their skin.
- Listening to soft music.
- Watching a favourite comedy film.
- Calling a helpline.
- Eating comfort food.
- Listening to upbeat music and dance.
- Learning breathing exercises to aid relaxation.
- Treating self to a luxurious bath.
- Tearing up old newspapers.
- Putting on loud music and screaming.
- Playing a physical game like squash or tennis.

- If a client is angry or upset with a particular person, they could write them a letter and then tear it up or burn it.
- Cleaning the house or car.
- Eating a hot curry or other spicy food.
- Going for a walk or run.
- Going to the gym.
- Hitting a punch bag.
- Punching pillows.
- Writing about happy times in their life.
- Using a red marker pen and drawing on the area they want to cut.

What can Friends and Family do?

It can be very difficult for friends and family to understand self-injurious behaviour. However, it is important that they are encouraged not to make negative remarks towards your client, and that they accept that self-harm is how your client copes with difficult feelings. Furthermore, if your client feels that their friends and family are shocked, fearful, or rejecting of their self-harm, they will be unlikely to ask them for support again in the future if they believe it will cause their loved ones distress. However, if a client's friends and family are accepting of the self-injurious behaviour and understand that it is a coping mechanism, they can become a valuable source of support by giving your client the opportunity to talk about their feelings without fear of being judged.

In some cases, it is important that you as a therapist, as well as friends and family, realise that your client may not want help with their self-harm. When this is the case it is vital that their privacy is respected. When a client does seek help for self-harm, however, it is important that all those concerned in giving support to the client are clear on exactly what support the client wants from them. In some cases, just having someone around whom the client can talk to can be extremely beneficial to them, and help to reduce self-harm. This is for two reasons: firstly, because there is someone available to talk, should they need to, and secondly because self-harm most frequently occurs when a client is alone.

When working with a client who self-harms, you should not try to prevent the self-harm from occurring by trying to lay down rules. You should remember that no one wants to hurt themself, but this is the only way the client feels able to deal with the painful emotions they are experiencing. In some cases, if a client is forced to stop their self-harming behaviour and they do not have an alternative coping mechanism to fall back on, they may feel that the only option left to them is to take their own life.

What to do if your Client has Self-harmed

If your client has self-harmed and requires medical assistance, you should do one of the following:

If your client's injuries are life-threatening or require urgent medical attention, 999 should be contacted for an ambulance, or they should attend the nearest Accident and Emergency Department immediately.

If you are unsure of the severity of your client's self-harm, then:

Contact NHS Direct, who will assess whether or not your client will require medical attention or if they can self-care at home.

Unless urgent medical attention is required for your client, a local GP surgery or nurse could be contacted for an emergency appointment and necessary first aid.

If your client will only require home care, their local pharmacy will be able to advise them on the appropriate first aid.

Breaking the Pattern of Self-injury

The feeling and emotions that cause your client's self-harm do not just disappear, nor do they suddenly develop new healthy coping mechanisms from nowhere. Recovering from self-harm will mean that your client will be able to discuss it openly with you, so that you can work through the underlying issues for this behaviour together. The first step towards breaking the pattern of self-injury, however, is ensuring that you have a stable, trusting relationship with your client. Self-harm for some clients is the only coping mechanism they have, and should be recognised as such.

Suicide

Why do People Commit Suicide?

- To bring about change: suicide is a way for a client to change how they feel or what is happening in their present life.
- To make a choice: when a client feels that they do not have choices, or that important choices are being taken away from them, suicide may seem to be the only choice left to them.
- To exert control: an act of suicide is meant to stop the person's behaviour, to control events or to effect change in others.
- As a way to punish oneself: suicidal behaviour is a means of relieving guilt or punishing oneself for his / her actions.
- As a way to punish others: the act of suicide may be intended to inflict harm or punishment on others.

Talking to a Client who is Suicidal

When talking to a client who is suicidal, it is important as a therapist to remember:

- Not to act shocked, as this will put distance between you and your client.
- Not to be sworn to secrecy – seek support from your supervisor or other colleagues if necessary, including any agencies who deal in crisis intervention and suicide prevention.
- Offer your client hope that there are alternatives to suicide, but do not offer them glib reassurance.
- Ensure you take action which removes a means of suicide, such as stockpiled medications / drugs and poisons.
- If necessary seek help.
- Be direct with your client and speak openly and matter-of-factly about suicide.
- Be willing to listen to your client, ensuring that you allow them to express their feelings, and know that you are accepting of these.
- Do not debate with your client the 'rights' and 'wrongs' of suicide, or lecture them on the value of life.
- Show interest and support in your client; become available to them and be actively involved in helping them through their crisis.
- Do not dare your client to commit suicide.
- Use active listening skills and constructive questions.
- Be resourceful.
- Be practical.
- Get support / help for yourself as a therapist.
- Avoid being judgemental or shocked, minimising your client's fears, patronising them or using guilt, or agreeing confidentiality.

Suicide Management Plan

As a therapist you should:

- avoid labelling your client's suicidal feelings as the result of behaviour or being manipulative;
- ask the client questions about their future plans;
- assess / judge the hopelessness of your client;
- keep documentation of your decisions and rationale;
- identify where your client is on the continuum of suicidality (low – high risk);
- establish the client's present situation;
- determine client's accompanying psychopathology;
- ask yourself how realistic your client's plans of suicide are; and
- identify deterrents and protection.

Questions to Ask your Client about Suicide Ideation:

- Have you thought about harming yourself?
- What have you thought about it?
- When did you start thinking this way?
- Do you want to die?
- Have you told anyone you feel this way?
- Have you made a suicide plan?
- Have you made any preparations to commit suicide?
- Do you have the means to commit suicide (firearms etc.)?
- What has stopped you from committing suicide so far?
- What gives you hope?

Factors which Contribute to an Increased Risk of Suicide

- Alcohol and drugs.
- Anniversaries.
- Giving away possessions.
- Separation and divorce.
- Psychiatric history.
- Chronic illness.
- Feeling rejected.
- Impulsivity.
- Anxiety.
- Improvement in severe depression.
- Loss of standing / reputation.
- Inability to meet obligations.
- Explosive episodes.
- Depression.
- Recent change in behaviour.
- Isolation.
- A deep sense of loss.
- Unusual behaviour.
- Relative who has committed suicide.
- Loss of friend / relationship support.
- Efforts for help have been unsuccessful.

Known Critical Suicidal Feelings

- wishes they did not exist;
- thinking they would like to sleep and not wake up;
- dwelling on death;
- believing they would be better off dead;
- thinking about killing themselves
- making plans to kill themselves
- recent suicidal / harming behaviour
- The pervasiveness and incidence of the above.

Eating Distress

Clients with eating disorders need to seek support as soon as possible, before the condition becomes life-threatening. If a client is admitted into hospital for eating related disorders, counselling may be offered and the client given a fair amount of choice regarding food. If the condition is severe, however, some hospitals may use ECT, drugs, or force-feeding techniques. This is particularly the case if a client is admitted to hospital under the Mental Health Act.

It is important for therapists to remember that clients with eating disorders often use food as a way of taking some control of their lives. This in turn, however, often results in a loss of control as the disorder takes over their life. The client should be encouraged to talk about the underlying issues which are causing their eating distress (such as low self-esteem, lack of confidence). To ensure this, however, the client needs to feel that the therapeutic relationship is safe and confidential.

If you are concerned that your client requires urgent medical attention, they should be encouraged in the first instance to go to their nearest hospital immediately, or the emergency services should be contacted, in order for them to receive urgent treatment.

Relationship Breakdown

The breakdown of a relationship is an extremely difficult time for anyone, and therapists should encourage their clients to talk about their feelings regarding this openly. If the breakdown has come as a shock to the client, they may feel extremely hurt and betrayed. It is common for those going through a relationship breakdown to feel that they no longer have a reason for living. The therapist should therefore encourage their client to take the space and time they need to grieve from their loss.

The client may feel frightened of being alone, which in some cases can cause them to rush into another relationship which may not be ideal and cause further problems later. In other cases, a client may lose their confidence, and it may take them some

time to rebuild this confidence and self-esteem. As a therapist it is important that clients are aware that this process can take time, and that their thoughts and feelings will be listened to and acknowledged in sessions.

If a client is believed to be at high risk of suicide following a relationship breakdown, the guidelines set out earlier in this course should be followed to prevent this or any other damaging behaviours.

In this section:

Child Abuse
Munchausen by Proxy Syndrome
Sexual Abuse
Ritual Abuse
Domestic Abuse
Emotional Abuse
Physical Abuse
Sexual Assault
Verbal Abuse
Elder Abuse
Male Abuse
Staying Safe
Leaving an Abusive Environment
Abuse and the Law
Reporting Abuse
Life and Relationships after Abuse
Why do People Abuse

Abuse has been defined as “a general term for the misuse of a person or thing, causing harm to the person or thing, to the abuser, or to someone else. Abuse can be something as simple as damaging a piece of equipment through using it the wrong way, or as serious as severe maltreatment of a person. Abuse may be direct and overt, or may be disguised and covert.”
Source: Wikipedia

Abuse can take many forms and can occur across all cultures and social backgrounds.

Child Abuse

There are four main types of child abuse: physical, sexual, psychological, and emotional neglect. All forms of abuse are detrimental to the well-being of a child and can have a serious impact upon their development. Physical abuse, for example, can result in psychological damage, which can affect the child into adulthood.

Despite some people believing that sex with children should be encouraged, all forms of abuse are illegal. A child is incapable emotionally, intellectually, and does not possess the physical maturity to protect themselves from adults, and as such, is protected by law.

There are many problems facing adult survivors of abuse; one of the biggest of these problems is denial. In many cases a child often deals with the abuse by dissociating themselves from the situation, which results in them being in denial throughout the future. Others may turn to drug and alcohol abuse as a way of releasing the tension they feel, and at the same time divert attention away from the abuse they experienced as a child.

Those who have suffered child abuse may imagine themselves as young adults when they think back to what happened to them. They sometimes find it hard to realise that they were only a child and that what happened to them was the fault of the adult abuser, not their own.

In terms of abuse against a child, neglect is also regarded as emotional abuse, as it involves the failure of the primary caregivers to provide for the child's basic needs. This can include a lack of proper clothing, lack of shelter, or lack of medical care, and as a result the child's health, development and safety are threatened.

Abandonment and rejection by the caregivers also constitutes neglect. Neglect occurs when parents or caregivers choose not to provide adequately for the child.

Munchausen by Proxy Syndrome

Munchausen Syndrome is a psychological disorder in which a person induces or fakes an illness in order to gain attention, comfort and nurturing from family, friends and those who work in healthcare.

Munchausen by Proxy Syndrome, which is a related condition, is most commonly found in mothers who induce illness in their children in order to gain sympathy for looking after a sick child. The condition is a form of child abuse, due to the way they induce or feign physical illnesses in their child. In other cases however, it has been known for mothers to emotionally abuse their children in order to induce psychiatric illnesses. It is also one of the most dangerous forms of child abuse, as those affected (i.e. the child) can face fatal complications due to their induced symptoms – if a child is given treatment for an illness they do not have, the effect of any "treatment" medication they are given could actually make them ill. In other cases, it has been known for the caregiver to inject their victim with harmful bacteria or to poison them, in order for it to appear that they have the illness the abuser claims.

Munchausen by Proxy Syndrome is usually very difficult to detect, as the caregivers appear to pay the victim so much attention that people do not realise that they are actually abusing them. Signs of Munchausen by Proxy are usually evident when the victim's illness or symptoms seem to improve or reduce when the caregiver is not

present, or if the symptoms displayed by the victim are inconsistent with their apparent diagnosis, indicating that the “illness” may be fabricated.

The causes of Munchausen by Proxy Syndrome are dependent upon the history and motives of the sufferer. Some findings state that many of those who suffer from the condition were neglected or abused as children, which means they crave attention as adults, and lose basic parental instincts. It has also been stated that many of those with the condition may also suffer with other psychological illnesses including depression and anxiety.

When dealing with a case of child abuse where the abuser is suffering from Munchausen by Proxy Syndrome, it is important that the child is first removed from the abusive situation and receives any appropriate treatment for both physical and psychological problems caused as a result of the abuse. Secondly, it is also important that the abuser receives appropriate psychotherapy, which is most effective when the person who has committed the abuse can admit what they have done wrong, and are willing actively to take part in therapy in order to recover.

Sexual Abuse

The term sexual abuse refers to the forced involvement of a young person below the age of sixteen in sexual activity with an adult or significantly older child. The abuse is never the fault of the child, even if they appeared to welcome or encourage it – a person under the age of sixteen is not considered to fully understand the implications, and therefore is not capable of consent. Sexual abuse can also occur between two adults where one is in a much more powerful position, e.g. any sexual involvement between a doctor and patient. It can be an expression of power, compulsiveness, an act of vengeance, or a desire for control, which can often become dangerously masked as an act of love.

Sexual abuse can be a one-off or recurrent event, and can range from inappropriate touching to penetration. The abuser may be anyone: male or female, relative or stranger. Often the full impact of the abuse is not felt until the victim reaches adulthood, when they are more capable of fully understanding what happened.

There are numerous types of sexual activity which may take place, which include touching, manipulation of the genitals, anus, or breasts with fingers, lips, tongue, or with an object, kissing etc. Some children may not have been touched themselves, but instead may have been forced to perform sexual acts on an adult or older child. Additional forms of sexual abuse may not necessarily involve physical touching, instead “emotional incest”, which may for example include a child being told explicit sexual details of an adult’s life, can still have a damaging effect on the child’s development.

It is estimated that as many as 1 in 4 girls and 1 in 8 boys are sexually abused before they reach the age of 18. Further figures predict that this figure could rise to as much as 75% of children being sexually abused, for those who are in foster care.

Ritual Abuse

Ritual abuse is defined as a combination of severe emotional, physical, sexual and spiritual abuse, used with symbols, ceremonies and / or group activities that have a religious, supernatural or magical meaning. The abuse is recurrent, with the purpose of terrorising and silencing the victims. The abusers are usually a group which places value on abusing and harming children. Torture, drugs and pornography can also play a part in the abuse. Animals and other objects also play a role in creating the desired effect for the abusers to get what they want from the children.

It is very difficult to pin down an exact definition of ritual abuse, however, as all child abuse involves some form of ritual – either grooming, or for controlling purposes - and ritual seems to have some elements in common with the activities of paedophile rings (for example: secrecy; involvement of people with “respectable” professions;

excellent communication networks). However, there are enough distinguishing characteristics to treat ritual abuse as a category of abuse in its own right – and this obviously has implications for the support of survivors of ritual abuse.

Ritual abuse is highly organised abuse, which involves a group or groups of people, often in a pseudo-religious context. The rituals are not always satanic, although "evil" plays a big part in ceremonies and in the abuse. 'Rituals', 'ceremonies' and 'services' involve a great deal of planning and organising, and are often held in rural areas.

Ritual abuse is very sadistic; it is designed to cause a great deal of pain for the pleasure of the observers and those participating more directly in the abuse, and is very misogynistic (woman hating). In some cases infanticide (the murder of babies and children) is incorporated into the ceremonies, and animals may be included in the abuse and / or 'sacrificed' too. Such things are specifically designed to add to the level of terror experienced by survivors, and are particularly common images in the flashbacks they later suffer.

The general lack of belief in society that ritual abuse happens also has a great impact on survivors of such abuse.

Features Commonly Associated with Ritual Abuse

- Large church style candles.
- Stones / slabs.
- Altars of some description.
- Crucifixes.
- Knives / swords / daggers.
- Symbols.
- Chanting.
- Adult Abuse

Domestic Abuse

Domestic violence is defined as the physical, sexual, psychological or emotional abuse by one person in a relationship to control the other. In some cases it may also include financial abuse, in which one partner has control of all the money, as well as social isolation. The relationship may be a marriage or casual, and occurs in both heterosexual and gay relationships. Victims are often women, but it can still happen to men. Anyone can suffer domestic violence, regardless of their lifestyle, sexuality, class, race, age or social group. In London alone, there were over 110,000 cases of domestic violence in 200617. It can happen at any stage in a relationship (in new relationships, or after being together for a number of years). It is not only adults who are affected by domestic violence; witnessing such abuse also has an impact on children.

The violence and abuse suffered may involve actual harm, or being threatened with harm if they do not comply with what the abuser wants. Such abuse may happen on a regular basis, or every so often.

Any form of abuse comes from an abuser's desire for power and control over another person.

Although domestic violence is chronically under reported, research estimates that it:

- Accounts for 16% of all violent crime.
- Has more repeat victims than any other crime (on average there will have been 35 assaults before a victim calls the police).
- Costs in excess of £23bn. a year.
- Claims the lives of two women each week and thirty men per year.
- Is the largest cause of morbidity worldwide in women aged 19 – 44, greater than war, cancer or motor vehicle accidents.
- Will affect 1 in 4 women and 1 in 6 men in their lifetime.

Source: Home Office – Domestic Violence

[17] Metropolitan Police Service – Domestic Violence Advertising Campaign

Further research has found:

- Approximately three-quarters of a million women (754,000) have been raped on at least one occasion since age 16.
- One incident of domestic violence is reported to the police every minute.
- In a study by Shelter, 40% of all homeless women stated that domestic violence was a contributor to their homelessness. Domestic violence was found to be "the single most quoted reason for becoming homeless". (Shelter, 2002)18

Source: TSSA.org

It is important that victims of domestic violence realise that the abuse that has been inflicted upon them is never their fault, as no one has the right to treat another person in that way. Despite the way an abuser may make their victim believe that they should feel guilty and responsible for what has happened, the problem will always lie with the abuser themselves.

A large number of people who are in abusive situations often find it difficult to leave, as they may fear that the person abusing them might find out that they are trying to leave, and therefore become more violent. In some cases, people also worry about trying to leave the abusive situation when there are children involved, as they worry that they may lose access to them in the future. Others however, may try to stay focused on the 'good' times, in which their partner has not been abusive, and live in the hope that the abuse will not become a regular occurrence.

[18] TSSA.org – Domestic Violence: An Introduction – UK Statistics

Emotional Abuse

Emotional abuse is a series of destructive behaviour and / or verbal attacks which results in the victim's self-esteem being severely damaged. Emotional abuse may not be as obvious as physical abuse, but it can still have devastating consequences, the psychological effects are still significant and long-lasting.

It is hard to define emotional abuse as it is so broad. It can include threatening behaviour, being made to feel ashamed of self, humiliation, name calling, witnessing abuse against someone else, belittling, rejection and isolation.

Signs of emotional abuse include your partner:

- isolating you from friends and family;
- dominating or controlling you;
- being jealous and possessive;
- controlling your money;
- humiliating or insulting you;
- being verbally abusive;
- claiming you could not cope without them;
- constantly criticising you;
- threatening to harm you or people close to you;
- threatening to kidnap or gain custody of your children if you leave;
- locking you out of the house during an argument;
- telling you what to wear etc.;
- being charming one moment then abusive the next; and
- having sudden mood changes which affect and dominate the whole household.

You may be:

- fearful of your partner; or
- unsure of your own judgements.

Physical Abuse

Physical abuse is generally the most recognisable form of abuse. It can be wide ranging, from being slapped, having your hair pulled, and in extreme cases, death. It does not, however, always leave visible marks; having something thrown at you is also regarded as physical violence. In many cases, things can get worse over a period of time.

It has been stated that:

"*Many forms of violence are suffered uniquely by women, such as forced pregnancies, forced abortion, bride-burning and dowry-related abuses. Other forms of violence such as domestic violence, rape and sexual violence are suffered disproportionately by women. Statistics show that globally, one in three women will be beaten, forced into sex or otherwise abused in her lifetime.*

It would be futile to deny that men can also be victims of gender-based violence, and also futile to deny that some women can perpetrate violence against men. However, the raw statistics prove that women are disproportionately affected by gender-based violence, and in a majority of circumstances, the effects of this violence are much more severe.

In many instances where women have been arrested and / or charged with perpetrating violence against a man (specifically within the context of domestic violence), it has been found that the woman has been a victim of domestic violence in the lead-up to her act of violence."19

Source: TSSA.org

Physical abuse is generally defined as any form of corporal punishment which leaves marks or could be potentially dangerous. A problem which arises out of this however, is the fact that the law does not define the emotional abuse which can result from this physical abuse.

[19] Tssa.org.uk – Domestic Violence: An Introduction

Sexual Assault

Sexual assault is an extremely distressing experience for the victim and can have a number of long-lasting effects. The way a person is affected varies from person to person, as everyone deals with things in their own way. Despite these differences, however, it is likely that victims will often feel very intense emotions, and may find it difficult to concentrate, eat, sleep, or may begin to withdraw from other people.

It is important that people who have been sexually assaulted are given the opportunity to talk about their feelings in a safe and confidential environment, in which they are given support and are understood.

If a person who has been sexually assaulted is concerned about the risk of pregnancy or sexually transmitted diseases, they should be put in touch with the appropriate source of help, whether they are specialist clinics, or GP's. The victim should also be assured that these clinics or GP's will not pass on any information to the police if they do not want them to, and that anything they do say will be confidential.

Police Action

The Metropolitan Police have set up 'Project Sapphire', which is a unit set up in each borough, specialising in investigating rape and sexual assault cases. They aim to provide information and support to victims of sexual offences and put them in touch with any partner agencies that can help, as well as ensure that victims are kept up-to-date with any developments in their case.

Verbal Abuse

Verbal abuse involves the use of words to hurt rather than using physical harm. An abuser will use words to attack, control and inflict harm on their partner; they inflict psychological violence on another person by attacking the very nature of their being, destroying their self-esteem. Verbal abuse can affect people of all ages and in any type of relationship; it has been found, however, to be more prevalent in marital relationships.

Verbal abuse can include name-calling, angry outbursts and screaming rages. It is an extremely manipulative form of abuse, as many insults are disguised as caring comments. Hurtful comments may also be masked as jokes, so when the victim voices their hurt, they are told that they are being over-sensitive. The abuse can be overt or covert, but for the abuser it is always about controlling and manipulating the victim. In many cases, verbal abuse later develops into physical abuse as well.

It is common for verbal abusers to tell their partners what to think and how they should feel. They generally seem unable or unwilling to understand their victim's point of view. They refuse to accept their partner's opinions or desires, and attempt to keep their partner in a state of confusion by distorting or constantly changing issues.

Another issue surrounding verbal abuse is the way in which abusers isolate their partners from family or friends, by cutting or blocking contact with them. This may be done by convincing the victim that the abuser is the only person who cares about them. In some cases the abuser may admit to their behaviour and state that they will change and become a better person. While this may be the case in the short-term, their behaviour usually reverts back to being abusive within a short period of time.

As the victim's self-esteem is worn down, they begin to believe that he or she is the cause of problems within the relationship. After a while they may not notice the abuse, and after becoming worn down they may not be able to put up a defence mechanism against it. The victim may try to change their behaviour in the hope that

it will make the abuser happier, but it is rare that it will be enough. The problem is not the victim themselves, and so the abuser will continue verbally abusing their partner, regardless of what they do.

Elder Abuse

'Action on Elder Abuse', define elder abuse as: "A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person".

Elder abuse can include sexual, physical and financial abuse, over-medication and neglect. It has been found that a large percentage of elderly people who are abused suffer this abuse within their own homes, although it can also occur in nursing homes, hospitals and residential care.

Elderly people are like children in the way that they are often very vulnerable, and medical conditions can cause them to become incapable of caring for themselves. The majority of elderly people who are abused, however, have stated that they feel that they are unable to report the abuse as they feel embarrassed, or unable to due to fear. In some cases, the reduction of general health and medical faculties can cause abusers to continue their abuse, as they believe that these factors will mean they will not get caught.

Elder abuse can happen for a number of reasons, the main of which is the emotional state of caregivers. When dementia occurs in elderly people, it can sometimes be frustrating for those who look after them, causing them to lash out. Impatience, resentment and depression, for example, can have a large impact on the quality of care that caregivers are able to provide to elderly people.

These same factors can also affect the quality of care elderly people receive in nursing and residential settings. Alongside this, poor management, unqualified staff and overcrowding can also have a negative impact on the quality of care people receive.

Physical abuse in elderly people is usually evident through unexplained bruises or bedsores, a lack of basic hygiene, and any injuries or ailments which cannot be explained medically. Other signs, which are less obvious, may include depression, becoming increasingly isolated, and being belittled by caregivers.

Male Abuse

Males who have been abused may experience additional problems due to the pressures of our society. They can still suffer the same abuse as women, including physical, mental and sexual violence or abuse. It is generally regarded by the population that men do not fit the role of a “victim”, instead when they are hurt it is common for them to be told to “act like a man” or to “get over it”. Such views can be extremely damaging, as they may result in them feeling that they are unable to speak out about the abuse which has happened or is happening to them. Further problems facing men can also include their reluctance to leave the family home despite the abuse, as they may be concerned that they will later be denied access to see their children.

Such pressures can sometimes increase the risk of males taking on the role of an abuser as a way of understanding their own experiences. However, it is not only men that abuse, women can also be responsible for abuse, although the figures are generally lower.

Staying Safe

For those in abusive situations, it is important that they are aware of how they can keep themselves safe and develop an escape plan, should the need arise. Possible ideas include:

- Keeping a mobile phone to hand at all times.
- Keeping a record of any abusive situations that occur.
- Keeping letters, messages or anything which may contain frightening or abusive messages so that they can be used as evidence against the abuser if necessary. If they are in electronic format (such as emails or text messages), ensuring that the original message, as well as a hardcopy, is kept.
- Keeping a diary soon after an event occurs, including as much detail as possible.
- Keeping a tape recording of telephone conversations, if possible.
- Confiding in a friend, colleague or other member of the family.
- Keeping photographic evidence of any injuries.
- Planning how to respond to crisis situations.
- Keeping any important and emergency telephone numbers to hand (i.e. National Domestic Violence Helpline).
- Ensuring children understand that they need to call 999 in an emergency and provide the operator with their name, address and telephone number, so they know how to react in an emergency situation.
- Finding a safe place to go in an emergency – avoiding mutual friends or family where possible.
- If there are trusted neighbours, confiding in them what is happening and asking them to phone the police if they can hear a violent attack.
- Keeping an emergency bag packed for self and any children – keeping it hidden so that it is ready should the need to leave quickly occur.
- Being aware of where the nearest phone is if a mobile is not owned.
- Keeping a small amount of money at all times so that you have enough for bus fare or a pay phone.

- If an attack seems imminent, trying to avoid areas of the house where it is possible to be easily trapped, or where there are objects which could be used as weapons.

Leaving an Abusive Environment

When the only option is to leave an abusive environment, it is important that precautions are taken to ensure that the victim can stay safe. In some cases, abusive partners can become more violent if they are aware of their partner's plan to leave them. Although leaving the abusive situation may seem like the solution, the abuse may not necessarily end there; an abusive partner may attempt to continue abusing his or her partner even after they have left.

It may be beneficial for those planning to leave an abusive environment to do so when their partner is not in the house (when they are at work, for example). When this is the case, it is important that the victim takes any important documents they may need at the present time or in the future, such as passports and birth certificates. It would also be beneficial for the victim to take their children with them immediately, as it may be more difficult to collect them at a later stage. Where children are concerned it is important that any nurseries and schools are informed of the situation, so they will be aware of the reason that the children may be absent for some period of time.

If a victim has an emergency bag already packed for themselves and their children, it would be beneficial for them to ensure that they include any forms of identification they may have, credit and debit cards (and any other bank documents), car keys, medications, an address book, clothes and any favourite children's toys.

After a person has left an abusive situation they may be reluctant to tell others the reason they have left their partner. It is the decision of the victim whether or not to disclose to others their reason for leaving, but they may find it helpful to tell a trusted friend or family member why, so that they are aware of the situation and can offer support.

There are further steps which can help to protect a victim of abuse, such as joining the electoral role anonymously so that they do not lose the right to vote, but at the same time they will be untraceable. In order to do this however, evidence must be provided (i.e. an order under the Protection from Harassment Act 1997). If anonymity under the electoral role is granted, the only details to appear on the register will be the person's electoral number and the letter 'N'. Further steps, such as using the code 141 before dialling a telephone number also ensures that, should a victim need to contact their partner for any reason, the number they use cannot be traced, and making any phone numbers ex-directory. The use of any bank or credit cards which can be traced by an abusive partner should be avoided, so that they cannot see where transactions have been made, and the amount.

If even after leaving the abusive situation, a partner continues to threaten or harass, it is important that detailed records are kept of any incidents that occur, including the date and time, as well as any injuries which occur as a result of the abuse.

Abuse and the Law

Domestic violence is dealt with under both criminal and civil law. In civil law, the main aim is the protection of the victim of domestic violence, as well as any application made for an injunction against an abusive partner. Alongside this, family proceedings such as child contact will also take place in a County Court.

In criminal law, the main aim is punishing the offender. This process is initiated by both the police and the Crown Prosecution Service. Such cases are heard in either a Magistrates' Court or the Crown Court, dependent on the severity of the charge.

There are now a number of laws protecting people from domestic violence and sexual assault. These include the Sexual Offences Act 2003, and the Domestic Violence, Crime and Victims Bill 2003.

Sexual Offences Act 2003

The Sexual Offences Act is "an Act to make new provision about sexual offences, their prevention and the protection of children from harm from other sexual acts, and for connected purposes"20. The Act is divided into three parts. The first covers the "non-consensual offences of rape, assault by penetration, sexual assault and causing a person to engage in sexual activity without consent"21. This Act also covers sex offences against children, who are defined under the Protection of Children Act 1978 as anyone under the age of 18 years old. Further provisions are made for anyone over the age of 16 where the defendant is the victim's partner. The first part of the Act continues by covering offences which relate to child pornography, trafficking and prostitution, as well as the administration of a substance with the intent to commit a sexual offence.

The second part of the Act "contains measures for protecting the public from sexual harm"22. Amendments have been made to the Sex Offenders Act 1997, as well as a range of orders which have been created specifically to protect children from sexual harm. The Act also includes travel orders in which convicted sex offenders are prevented from travelling abroad when they are at risk of abusing other children.

The third part of the Act "contains general provisions relating to the Act, including minor and consequential amendments and commencement provisions"23.

[20] Office of Public Sector Information – Sexual Offences Act 2003

[21] Office of Public Sector Information – Sexual Offences Act 2003 Explanatory Notes: Summary

[22] Office of Public Sector Information – Sexual Offences Act 2003 Explanatory Notes: Summary

[23] Office of Public Sector Information – Sexual Offences Act 2003 Explanatory Notes: Summary

Domestic Violence, Crime and Victims Bill 2003

The Domestic Violence, Crime and Victims Bill 2003 is divided into three parts. Within the first section, clauses 1 to 3 are amendments to the Family Law Act 1996. Under these sections a "breach of a non-molestation order will become a criminal offence"24. This will also include same-sex cohabiting couples and those who are in intimate personal relationships for a significant period of time, but have never lived together or been married.

Within clauses 4 and 5 of the Bill, a new offence has been included of causing or allowing the death of a child or vulnerable adult. "The offence will apply where a child or vulnerable person dies as a result of unlawful conduct; a member of the household caused the death; the death occurred in anticipated circumstances; and the defendant was or should have been aware that the victim was at risk, but either caused the death or did not take all reasonable steps to prevent the death". Under these clauses, subject to age restrictions and mental capacity, all members of the household will be liable for this offence. Under this offence, the maximum penalty is imprisonment for up to 14 years.

Within clause 6, arrangements are set out "for the establishment and conduct of domestic homicide reviews"25.

Within Part 2 of the Bill, criminal procedure is set out, in which common assault is an arrestable offence, and the availability of restraining orders specified under the Protection from Harassment Act 1997, are extended.

Part 3 of the Domestic Violence, Crime and Victims Bill "makes provision about victims and witnesses of crime". Within this section, the Secretary of State is permitted to pay grants to "bodies which assist victims and witnesses, giving a statutory basis for existing financial arrangements".

---

[24] Parliament UK – House of Lords – Domestic Violence, Crime and Victims Bill – Explanatory Notes

[25] Parliament UK – House of Lords – Domestic Violence, Crime and Victims Bill – Explanatory Notes

Rights of Victims

All victims of abuse have the right to receive information about the progress of their case, and any explanation they need should be provided. They have the right to receive compensation and to be protected in any way necessary. It should be the responsibility of the state to decide what should happen to an offender, and the victim should be entitled to receive support and respect for any decisions they make.

Injunctions

Victims of domestic violence can gain some protection from their abuser by applying for a protection order or civil injunction. Under the Family Law Act 1996 there are two types of injunctions available: a 'non-molestation order', or an 'occupation order'.

A non-molestation order is defined as an order which is aimed at preventing an abusive partner threatening or using violence against their partner or any children. Under this order they are also unable to intimidate, harass or pester their partner.

Under an occupation order it is regulated who is allowed to live in the family home, as well as restricting an abuser from entering the house or area surrounding it.

It is a criminal offence to breach a non-molestation order, and should a victim of domestic violence wish to, they can take their abuser back to civil court for breaking the order. If a victim of domestic violence has an injunction with a power of arrest attached to it, this can also be attached to an occupation order. Victims should be aware however, that while in some cases a court order can provide a certain level of protection, it may also be counter-productive.

Applying for an Injunction

In order for a person to apply for an injunction the following conditions apply to the two parties:

- They are, or have been, married to each other.
- They are, or have been, in a civil partnership.
- They are relatives.
- They are living, or have lived, in the same household.
- They have formally agreed to marry each other, even if this agreement has now ended.
- They have a child together.

If they are not living together, they have been in an "intimate relationship of significant duration".

The Domestic Violence Crime and Victims Act, 2004 amends the Family Law Act so that couples who do not live together, or do not have children together, can apply for non-molestation orders, as well as same-sex couples being able to apply for occupation orders.

If under the terms given above, a person is not eligible to apply for an order under the Family Law Act, or they are being threatened and harassed constantly after a relationship has ended, they can apply for a civil injunction under the Protection from Harassment Act 1997. A restraining order can also be used to provide the same protection as an injunction under civil law, and may be more effective in the long run as it carries stronger penalties for breaking its terms.

An injunction is usually set for a specific period of time but can, if necessary, be renewed. There is not a time limit on the period of time in which a non-molestation order can be extended, whereas an occupation order can only be extended beyond 12 months if they have the right to stay in the home legally.

If the victim of abuse needs an injunction application to be made immediately, due to them being in immediate danger, an application can be made to the court on the same day without the need for the abuser to be present. In this situation, the court will consider whether or not the victim is at risk of significant harm, and whether or not they will be deterred or prevented from applying if they are made to wait. If the court decide to grant a 'without notice' order, the victim will be required to attend a full court hearing once the person accused of abuse has been served with this notice.

Evidence Required

In order for proceedings to take place, the victim will need to make a sworn statement to the court in which precise details about the emotional and physical abuse the person has suffered will be given. This will also need to include dates and times in which the incidents occurred if possible, and the effects this had on the victim themselves, as well as their children. Police reports and medical records may also be given as evidence if necessary.

Before the court will make a decision on an injunction they will consider a range of factors, such as the health and well-being of both parties, housing and financial arrangements, and general needs.

If an injunction is regarded as unsuitable, the court may instead ask the abuser to make an undertaking stating that they will not harass or threaten the victim further. In breaking this, however, there are no powers of arrest, so while doing so would be contempt of court, it is generally much harder to enforce.

Breaking a Court Order

If a court order is broken it should be treated as a criminal offence, as stated under the Domestic Violence, Crime and Victims Act 2004. When the abuser is arrested they will then be required to attend a Magistrates' Court, as this will strengthen the power of any court orders made. If a non-molestation order which has been made after 1st July 2007 exists, or if there is a power of arrest attached to the order, the police are required to arrest the abuser and bring him back to court within 24 hours.

Reporting Abuse

It is important that abuse is reported so that an abuser cannot go on to abuse other people. However, for those affected by the abuse, reporting what has happened to them can be extremely daunting. If they are reporting the abuse a long time after it occurred, they may feel that the police, or others, will not believe them. Others may feel that they were responsible for the abuse and they will therefore not be helped.

As a therapist, it is vital that you do not ask the client inappropriate or leading questions about the abuse they have suffered, or cause them undue pressure in discussing what happened. You must be aware of any organisational or legal procedures related to your work, as these actions can have an adverse effect on the use of evidence in future investigations.

The use of the client's language is particularly important when discussing the reporting of abuse, especially with children. The use of their preferred language and their method of communicating (such as the use of pictures, objects and other non-verbal forms of communication) allows the client to express what has happened, and their thoughts and feelings about the abuse in a way that is more comfortable for them.

As a therapist, you should also be aware of the risks to the client when reporting abuse. People react in different ways – some may display reckless behaviour, others may self-harm to deal with the painful emotions reporting their abuse raises, whilst others may damage the environment around them. Therefore you should be aware, not only of the risks to your client, but also yourself.

There are a variety of ways in which abuse can be reported. If in the case of domestic violence, for example, a partner is being abusive at that particular moment, the emergency services should be contacted directly. Otherwise, the victim's local police station should be contacted directly rather than the emergency services. It is also possible for victims to walk into their local police station to report abuse, regardless of when it occurred. In addition to this, abuse can also be reported to independent organisations, i.e. 'Rape Crisis', in which the abuse can be reported

anonymously and the necessary information passed on to the police by the organisation.

There are a number of organisations which can help to support an abused person if they do not want to go to the police to report what has happened to them. 'Victim Support', for example, operates a confidential service in which they offer support and reassurance, as well as allowing victims to voice any concerns they may have. There are further services available for those who take their abuser to court, in which they will be guided through the criminal justice system.

Police Action

After a person has reported the abuse to the police, they may be given a 'Victims of Crime' booklet (see resources), which will explain the process of what will happen next. The victim may also be put in touch with a support agency, such as 'Victim Support' who will be able to provide emotional support during the time which follows.

The time following the report of the abuse may be difficult for the victim as the police will need to gather evidence. In some cases, if the abuse has happened fairly recently, the victim may be asked if they would undertake a medical examination in order to help the police further with their investigation. In addition to this, a statement will also need to be made which, once written, the victim will be asked to check for any errors and then sign to confirm its accuracy. Being interviewed in order to give this statement can be extremely distressing, as it requires the victim to recount everything that has happened to them. It is therefore perfectly acceptable for them to request a break during the interview if they feel the need.

After undertaking interviews and medical examinations (if necessary), police will carry out an in-depth investigation, which can sometimes take a significant amount of time. At all stages, however, the victim will have the contact details of the person dealing with their case, who will keep them updated of any significant progress they make.

If the Crown Prosecution Service believes there is significant evidence, and that it is in the public interest to prosecute the abuser, the case will go to court. The CPS, however, will take into consideration the effect going to court will have on the victim, and any views they or their family may have expressed prior to this.

The victim, however, will not need to attend court if the defendant (the abuser) pleads guilty to the offence(s) they are charged with. If however, they deny an important aspect of the offence, or plead 'not guilty', the victim will more than likely be asked to give evidence at the trial.

Before Court

If the victim has been asked to give evidence in court, the police will probably provide them with a 'Witness in Court' leaflet (see resources) which will explain what will happen. The majority of cases are usually heard in a Magistrates' Court; however, more serious cases are required to be sent to the Crown Court, in which the trial will be heard by a jury. If the victim feels that it would be beneficial, they can request to see the court prior to the trial, as some may find that this will make things slightly less daunting when the court date arrives.

Court

It is perfectly normal for the victim to find going to court a bewildering experience, particularly if they have not been to a court before and are therefore unfamiliar with what to expect. Many people also find giving evidence particularly difficult, as they once again have to talk about difficult aspects of the abuse they faced, in front of a number of people. Actually having to stand and accuse the person of abuse can also be particularly difficult. Cross-examination can seem to be a critical and humiliating process, and it is therefore vital that victims are aware of the support available to them should they need it, as well as the services available to their family and friends.

After Court

After court there are a number of sentences which can be given, which include community sentences, prison and fines. The type of punishment received is dependent on a wide range of factors, including the offenders age, criminal history, whether they pleaded ‘guilty’ or ‘not guilty’ in the case, and whether they have shown any remorse for what they have done.

Prison

The majority of prisoners do not serve the whole of their sentence in prison, and their release is dependent on the length of the sentence they were given, the amount of time they spent in prison before their sentencing, and if they have passed a risk assessment allowing them to be released on licence or Home Detention Curfew.

If a victim is worried that their abuser will try to contact them by either letter or telephone whilst they are in prison, it is important that they contact the Prison Service Victim Helpline to voice their concerns. Further concerns which should be raised with this service include what will happen if the abuser is released on a temporary licence or allowed home leave.

Probation Contact

If the abuser has been given a sentence of one year or more due to committing a violent or sexual crime, the victim will be asked by the probation service whether or not they wish to be kept informed about the release of the offender and any other arrangements, including the conditions of their release. If the victim is concerned that the offender may try to contact or come near them after their release, they can request an injunction from the civil courts preventing this.

Restorative Justice

Restorative Justice is an approach in which the harm caused by the crime committed is dealt with in order to help the victim, general community, and to help the offender fit back into society.

This also provides the victim with the opportunity to tell the offender how what they have done has affected them and made them feel, as well as asking them any

questions they may have. This does not necessarily have to be done on a face-to-face basis, and mediators can be used if this is preferred. It also provides the opportunity for the offender to admit to the effect of what they have done, and to try find ways in which they can change their behaviour for the better.

It is however, completely the choice of the victim whether or not they wish to take part in the Restorative Justice

Life and Relationships after Abuse

Even after a person has left an abusive situation and has found somewhere new to live where they are no longer harassed, they will not necessarily feel like everything is finally 'sorted' in their life. Recovering from abuse can be a long and difficult process, and one in which they may require support from others.

It is normal for survivors of abuse to feel a sense of deep loss, grief and pain, due to the betrayal of trust they have experienced. A lack of confidence and lowered self-esteem are also common feelings associated with surviving abusive relationships. It is therefore important that the survivor takes time in healing from their abusive past, and does not try to rush into things. The healing process can take time, and while some people may want to make drastic life changes immediately, others may want to take more time. Both are completely acceptable and it is important that friends and family are supportive in the persons' decision. Helping a survivor to set small, realistic goals which they can work to achieve at their own pace may help them to gradually work through the issues raised from their abusive past.

After leaving an abusive environment, some people may feel isolated and alone when they return to an empty house each day. It is at times like this when people may begin to think that they were better in the abusive relationship, rather than coming home to no one at all. In some abusive relationships the victim may have been cut off from their usual support network of friends and family, so that, when they are away from the abusive situation, they may feel that they have no one they

can talk to or spend time with. In this situation it is important to remember that it may not be too late to repair relationships with friends and family, as the abuse was not the victim's fault. They could also be encouraged to try new activities in order to meet new people.

After being in an abusive relationship it may take time for the survivor to gain confidence in themselves and their abilities. In their previous relationship, their partner may have had control over all the household finances and any decisions, no matter how minor they may be. This can result in the survivor finding it extremely difficult to make what, to others, would seem simple decisions. Survivors of abuse should be made aware of how brave their decision to leave the abusive situation was, and that this deserves a huge amount of credit. This, along with any other achievements the survivor has made throughout their life, should be built up in order to help them 'get through' the 'low' times they may experience.

Some people may also find it beneficial to talk to other survivors of abusive relationships in order for them to talk about and share their experiences. Groups specialising in this area can help survivors discuss ways they have worked through the difficult times in their lives, to share coping techniques and learn new skills. Further ways which can help survivors move on from their abusive pasts are to try new activities which they may have previously been prohibited from doing by their partner, such as joining an evening class or joining a social group.

If there are children involved, it is important that they too are given the support they need to adjust to the changes leaving the abusive situation will have brought. If the survivor has moved to a new area, for example, the children will have to adjust to not only a new living environment, but also a new school and making new friends. The abuse they may have witnessed can also have a large impact on their well-being, and it is therefore vital that they receive the appropriate counselling or support as necessary. The development of a 'normal' routine, which is established as quickly as possible, may help them to settle into the new situation quicker. Listening to children is also important, and making sure that their feelings and concerns are understood and valued. Telling children that they are loved and making them feel

safe and secure in their new environment will also help them to adjust to the drastic changes they are facing.

Although children may be glad to have left an abusive situation, it is only normal for them to miss their parent whom they have just left. There may be times in which they blame their abused parent for taking them away from the other, and want to visit them. If this is the case, it is important that the survivor feels that it is safe for themselves and their children to visit, and that, if necessary, they take another person with them on visits for support.

The following is an article on relationships after abuse:

Many people have done the tough work of recovery from sexual abuse, whether with help in therapy or on one's own. It challenges us to the core, but it also frees us, and gives life and possibility where we once felt that we might never get through it.

For some, getting into a relationship, or continuing with one we've been in, after abuse recovery is a fairly smooth process. For others, the challenge holds a range of feelings, such as the longing to be loved, mixed with uncertainty, anxiety and fear, even panic. It often comes with a deep sense of undeserving, or the belief, "I am unlovable." Some people will go through a long period of celibacy, even after sexual abuse counselling. Others might try dating, but find themselves repeating patterns that occurred in abusive relationships, with their new partners. Sometimes abuse survivors find it very difficult to be intimate, either sexually or emotionally, or both. Or they might tend to feel more like a sex object, and not be recognised for who they are as a person.

"Healthy relationships are not only a source of fulfilment; they are where the final healing takes place."

But we can love and be loved, trust, and be trusted, again. I have a number of clients who have sexual abuse history, and do the work of recovery, only to discover that they feel handicapped when it comes time to be in a healthy relationship. Yet healthy

relationships are not only a source of fulfilment, they are where the final healing of sexual abuse issues takes place. I have seen many women and men overcome their fears, and build healthy and loving relationships.

While everyone is different, there are a few common themes that surface for those with a history of abuse. For instance, it's unlikely that one who suffered abuse was taught much about boundaries. Yet good boundaries are inherent in any healthy relationship. This comes up in a variety of ways. For example, many couples have learned to be very careful not to say hurtful things to their partner during a fight; they've learned not to be flirtatious with others if they are in an exclusive relationship. These may seem like small concerns, but they actively maintain safety and respect, both for each other and for the integrity of the relationship.

People without abuse history typically recognise when another person (man or woman) is "coming onto" them inappropriately, and they have no trouble telling the "intruder," so to speak, to back off. With abuse history, especially if the abuse was chronic, we don't even recognise inappropriate behaviour, because such behaviour was "normalised" during one's childhood. ("I thought that was normal!") The abuse survivor then is less likely to take steps to protect themself, and is left with an array of feelings, including frustration, disappointment, confusion ("How come this keeps happening for me?"), anger, and resignation ("All men / women are like this, they just want me for sex.") How different it becomes when the survivor learns to recognise inappropriate behaviour for what it is, to use appropriate boundaries, move on, and then be able to open to what we do want: a person who is respectful, loving, honest, and so on.

"As children, when our parents directly contradict our inner voice, our intuitive knowing, we'll trust them and discount our own truth. As adults, we have to learn to trust our intuition all over again."

Another unfortunate, but repairable, side-effect of sexual abuse is that we have often lost trust in our intuition. If our intuition told us that something that happened wasn't right, but all the adults in our family said, "I don't see any problem here," or "You're

lying! Shame on you!", we get confused. As children we need to trust our parents for our basic survival. When our parents say and do things that directly contradict our inner voice, our intuitive knowing, we'll trust mom or dad, and discount ourselves. For children, it's safer this way. But as adults, it takes retraining to trust our intuition again. This is a gradual process, but it can be done. Once we trust our inner knowing more fully, we become confident, more empowered, and more able to receive what is beneficial to us.

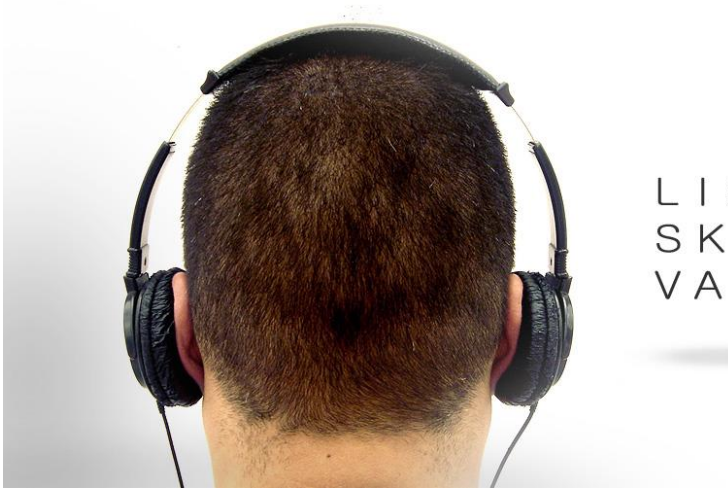
Love, trust, intimacy, and ease are not only possible; they are our birthright. We mustn't allow someone else's violation of us to impede our right to love and be loved. Thankfully, we don't have to.

Source: http://www.articlemotron.com/Article/After-Abuse--The-Challenging-Work-of-Forging-Healthy-Relationships/69641

Why do People Abuse?

The reasons why people abuse have multiple answers and can vary from person to person. Some people abuse others as they have learned it from their own childhood, from witnessing a parent being abused by another, or from being abused themselves. Others begin to abuse due to stress, social isolation, lack of appropriate resources being available to them, inappropriate expectations of others around them, or poor parenting skills.

For those who have witnessed abuse from a young age, they may find having an ‘abuser’ and ‘victim’ role to be a normal relationship dynamic. They are familiar with, and understand the terror associated with being a helpless victim from their own experiences. In some cases, rather than being the helpless victim in later life, they themselves take on the role of the abuser. This does not, however, mean that everyone who has been abused will later go on to abuse other people.



LISTENING SKILLS AND VALIDATION

UNIT 11

In this section:

Stages of Listening

Types of Listening

Common Problems

Types of Validation

Stages of Listening

As a therapist, good listening skills are a vital part of your job. Listening, which is an active process, has three steps:

Hearing - Simply hearing what has been said.

Understanding- Taking what you have heard and understanding it in your own way.

Judging - After hearing and understanding what has been said, you need to think about if you believe what you have been told.

To be a good listener as a therapist you should:

- Ensure you are completely focused on what your client is saying, giving them your full attention.
- Allow your client to finish speaking before you begin to talk; you should not interrupt them.
- Listen for the main points of what your client is saying.
- If you are unsure about anything your client has said, ask questions for clarification.
- Give your client feedback on what they have said, to show you have understood – verbally, facial expression etc.

Types of Listening

There are a number of types of listening which it is important to be aware of when listening to a client. These include:

Comprehensive Listening

This involves concentrating on the message the client is putting across and not making any critical judgement about what they are saying.

Empathic Listening

This is the process of listening in order to help, support and empathise with the client.

Reflective Listening

Although it is one of the most complex types of listening, it is important for counsellors to be able to effectively use reflective listening, as it involves the process of actively listening, interpreting what the client is saying, and observing how the client is saying it. It is important to reflect on what the client has said after they have finished speaking, to show that you have listened to what they have said and understood it.

Common Problems

As a counsellor or therapist, it is vital that you are also aware of bad listening habits which can be damaging to the client–therapist relationship:

- Jumping to conclusions.
- Becoming distracted.
- Faking attention.
- Pre-judging the speaker.
- Listening too hard.

Tips for Good Listening

- Allow your client to finish speaking.
- Find value in everything your client says.
- Take notes if this will be beneficial to you in reflecting.
- Show interest.

Types of Validation

Validation is an important part of therapy and consists of:

- Mindful listening.
- Reflecting and acknowledging.
- Clarifying and summarising.
- Putting problem behaviour in a larger context.
- Normalising.

The first part of validation, 'mindful listening', requires the therapist to give their total, undivided attention to what the client is saying. Within this, they should make the client aware that they are listening, by not appearing distracted by other things in the room and giving a series of verbal and non-verbal cues (i.e. facial expression) that show the client that they are listening and interested in what they have to say.

In the second part of validation, 'reflecting and acknowledging', the therapist should acknowledge what the client has said and demonstrate they have listened by reflecting on it. In doing this, the therapist should not repeat what the client has said word for word, but instead convey the essence of what the client has discussed.

In 'clarifying and summarising', the therapist may ask the client questions for clarification on any areas they did not understand fully. In summarising what has been said, the client can correct the therapist on anything which they have misunderstood.

By 'putting problem behaviour into a larger context', the therapist does not ignore the client's problematic behaviour, but avoids more negative behaviour following. If a client, for example, describes a time in which he / she had an argument with their partner and said something nasty, they may feel that they themselves are entirely to blame for what happened. If however, the client's partner also said something nasty, this could be validated by saying, "Yes you

said something nasty, but your partner also did the same. Rather than storming out of the house, you stayed and calmed yourself down".

'Normalising' requires the therapist to explain to the client that their feelings and reactions can be perfectly legitimate. If the client has said that he / she was upset because they had arranged a family outing and no one came, the therapist could say, "I understand you are upset that no one came, anyone would feel the same in that situation".

Unit twelve

Research

Article discussing BPD and eating disorders:

Borderline Personality and Eating Disorders

RANDY A. SANSONE
Wright State University, School of Medicine, Dayton, Ohio, USA and Kettering Medical Center, Kettering, Ohio, USA

JOHN L. LEVITT
Alexian Brothers Behavioural Health Hospital, Hoffman Estates, Illinois, USA and clinical practice, Rolling Meadows, Illinois, USA

Borderline Personality Disorder (BPD) is an Axis II disorder that is characterized by an intact façade, longstanding self-regulation difficulties and self-harm behaviour, and unstable interpersonal relationships and mood. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994), the prevalence of BPD in the general population is around 2%. The symptoms of the disorder appear to be influenced by gender. Despite defined diagnostic criteria, BPD tends to have polymorphic clinical presentations with both multiple psychological and somatic symptoms. The etiology of BPD appears to be related to genetic predisposition, early developmental trauma, and biparental failure, although other contributory factors may be involved. We discuss, through the use of several models, the possible relationships between BPD and eating disorders.

Borderline personality disorder (BPD) is a complex Axis II phenomenon in which affected individuals sustain a superficially intact (albeit transient) social façade, in conjunction with longstanding self-regulation difficulties and self-harm behaviour (SHB), chaotic interpersonal relationships, and chronic dysphoria. This polar combination of features (intact façade, underlying impulsive chaos) has been the inspiration for several intriguing movies including Play Misty for Me, Fatal Attraction, Misery, Looking for Mr. Goodbar, The Crush, and Single White Female.

THE EPIDEMIOLOGY OF BPD

Prevalence Rates in the United States

The overall prevalence of personality disorders in the general population is around 5–10% (Ellison & Shader, 2003). The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association [APA], 1994) indicates that the prevalence of BPD in the general population is around 2%. According to Stone (1986), however, the prevalence rate for BPD may be as high as 10%, indicating that it may be the most common Axis II disorder in the general population.

Although more recent data are limited, the prevalence of BPD in inpatient and outpatient psychiatric settings is reported as 15% and 27%, respectively (Widiger & Rogers, 1989). Among inpatients with personality disorders, up to 50% suffer from BPD (Widiger & Weissman, 1991). In an inpatient psychiatric sample of convenience, we found the prevalence of BPD to be nearly 47% on clinical interview and nearly 55% on assessment with a DSM-IV criteria checklist (Sansone, Songer, & Gaither, 2001). In a retrospective review of medical records in a university-based outpatient psychotherapy clinic, we found the prevalence of BPD traits or disorder to be nearly 22% (Sansone, Rytwinski, & Gaither, 2003). Changes in the management of mental health services (e.g. increasingly strict criteria for inpatient admission), may account for the differing prevalence rates observed at different times in various treatment settings.

Gender Distribution

The DSM-IV (APA, 1994) indicates that more women than men suffer from BPD. However, there appear to be distinct gender patterns in symptom presentation. In clinical settings, women with BPD tend to demonstrate more histrionic features, self-directed self-harm behaviour, Axis I diagnoses of eating disorders (ED), and post-traumatic stress disorder (Johnson et al., 2003). In contrast, men tend to demonstrate more antisocial features (Johnson et al.), externally directed self-harm behaviour (i.e. fights), and Axis I diagnoses of substance abuse (Johnson et al.). These gender differences may relate to cultural, genetic, and neurohormonal factors. As a result of symptom differences, women with BPD tend to congregate in mental health settings, while men with BPD emerge in prison settings. Therefore, investigator bias as well as study setting may contribute to the impression of female predominance in BPD (Skodol & Bender, 2003).

Racial and Cultural Differences

Few empirical studies have explored racial or cultural patterns, but Chavira et al. (2003) found that, compared with Whites and Blacks, Hispanics evidenced higher rates of BPD. In a Norwegian community sample, investigators (Torgersen, Kringlen, & Cramer, 2001) found BPD to be relatively infrequent, particularly when compared with other personality disorders. Chabrol, Montovany, Chouicha, Callahan, and Mullet (2001) found, among French high school students, a prevalence rate for BPD between 10% and 18%.

From a broader perspective, Paris (1996) indicates that BPD is more likely to be encountered in Western cultures. If so, then non Western cultures may have some tempering factors with respect to the suspected causative factors of genetics, early developmental trauma, and/or parental disengagement. On the other hand, if the proposed etiological variables are consistent worldwide, local culture may temper the expression of self-harm behaviour (e.g., in non-Western cultures, symptoms might manifest as somatic preoccupation or

medically self-defeating behaviours); therefore, BPD patients in particular cultures may go under-detected.

The Prevalence of BPD Among Eating Disorders

Among those with an ED, the explicit prevalence of BPD remains unknown. However, Sansone, Levitt, and Sansone (2005) reviewed the majority of available studies and found BPD prevalence rates of 10% in restricting anorexia nervosa, 25% in binge-eating / purging anorexia nervosa, and 28% in bulimia nervosa. The prevalence of BPD among those with binge eating disorder appears to be around 12% (Sansone et al., 2005). Therefore, the clinical intersection of ED and BPD is not uncommon.

THE DIAGNOSIS OF BPD

The DSM-IV Criteria

The DSM-IV (APA, 1994) is the current benchmark for psychiatric diagnosis. The DSM lists nine criteria for BPD; five are required for diagnostic confirmation (see Table 1).

Self-report BPD Assessment Tools

In addition to the DSM-IV, there are other available assessment tools for BPD. Those that are self-report in nature are particularly well adapted for use in the clinical setting. Examples include the borderline personality subscale of the Personality Diagnostic Questionnaire-4 (PDQ-4; Hyler, 1994), the Self-Harm Inventory (SHI; Sansone, Wiederman, & Sansone, 1998), and the McLean Screening Instrument for Borderline Personality Disorder (MBIBPD;
Zanarini et al., 2003). Each of these measures is brief in length (i.e. one page), easily scored, and available for clinician use without charge. In addition to diagnosing BPD, the SHI also elicits the respondent's history of SHB, which may help to focus the therapist's initial intervention strategies. A potential

limitation of these measures is their tendency to be diagnostically over-inclusive. As with all assessment tools, each requires clinical substantiation in order to confirm the diagnosis.

Semi-Structured Interviews

Several semi-structured interviews are available for the diagnosis of BPD. These are more commonly utilized in research settings because of cost, administration time, and required training for use. Examples include the Diagnostic Interview for Borderlines (Kolb & Gunderson, 1980), the Personality Disorder Examination (Loranger, 1988), the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II; Spitzer, Williams, Gibbon, & First, 1990), and the Diagnostic Interview for Personality Disorders (DIPD; Zanarini, 1983).

Difficulties in BPD Diagnosis

While the diagnostic criteria in DSM-IV are relatively clear, BPD can be difficult to diagnose in the clinical setting. First, there is the elusive, intact social façade that momentarily obscures the dramatic underlying symptomatology of BPD.

Second, BPD is known to be a polysymptomatic disorder. In this regard, studies in psychiatric settings indicate that BPD is associated with both multiple Axis I and II diagnoses (Sansone et al., 2003; Zanarini et al., 1998; Zimmerman & Mattia, 1999). As a result, comorbid Axis I diagnoses may distract the clinician from exploring or considering a diagnosis of BPD, particularly when the Axis I disorder is a life-threatening ED.

Third, BPD may be particularly difficult to diagnose in medical settings. As in mental health settings, there may be a profusion of diagnoses, but these may be somatically based and include somatic preoccupation involving multiple body areas (Sansone & Sansone, 2003), chronic pain syndromes (Sansone, Whitecar, Meier, & Murry, 2001), and bona fide somatisation disorder (Hudziak, Boffeli, Kreisman, & Battaglia, 1996). (Note that physical symptoms are not even alluded to as diagnostic criteria in the DSM.) In addition, in medical settings, the characteristic self-harm behaviour associated with BPD

in mental-health settings may manifest in more medicalised modes, such as sabotaging one's medical care. Examples of this are medication non-compliance, interference with wound healing, and getting into altercations with healthcare providers to intentionally precipitate one's dismissal from a practice (Sansone, Wiederman, & Sansone, 2000; Sansone,
Wiederman, Sansone, & Mehnert-Kay, 1997).

Finally, BPD exists along a functional continuum, from high to low. In contrast to BPD patients in state hospitals and community mental health centers, higher functioning patients tend to experience fewer quasi-psychotic episodes, engage in more socially discreet SHB (i.e. no visible self-mutilation), maintain a more durable social façade, sustain more stable interpersonal relationships (e.g. longstanding marriages), and demonstrate less lability in affect. In our experience, ED patients, in general, tend to reside in the higher range of this continuum of functionality, compared with other types of BPD patients. This latter observation may support Stone's (1990) finding of a better long-term prognosis for the BPD eating-disorder subgroup, compared with other subgroups of patients with borderline personality.

ETIOLOGICAL FACTORS

The etiology of BPD appears to be related to the intersection of several contributory variables. First, although earlier research discounted a genetic contribution (Torgersen, 1994), more recent studies indicate that, as in many of the personality disorders, there may be a non-specific genetic predisposition to BPD (Skodol et al., 2002). Second, the majority of empirical studies confirm the presence of some form of repetitive early developmental trauma, which may include sexual, physical, and emotional abuse, as well as the witnessing of violence (Sansone & Sansone, 2000). Because of genetic predisposition and the trans-generational nature of trauma and maltreatment, BPD tends to run in families. Finally, Zanarini et al. (2000) describe the contributory role of biparental failure, or the absence of sufficient and

consistent support from both parents. These etiological factors do not exclude the possibility of other causes.

THE RELATIONSHIP OF BPD TO EATING DISORDERS

Why comorbid ED pathology emerges among some individuals with BPD remains unknown. In the following section, we examine a variety of possible relationships between BPD and ED. Although these are speculative in nature, they may provide the basis for further clinical discussion and research.

Differences and Similarities in Diagnostic Criteria and Areas of Functioning

The ED diagnoses represent syndromes or constellations of related behaviours that, at particular thresholds, result in a specific diagnosis. That is, when a certain number of relevant behaviours (e.g. purging, restricting) present together over a specified period of time, an ED diagnosis is indicated and confirmed. Broader aspects of individual functioning are not diagnostically required for ED diagnoses. On the other hand, the criteria for BPD (see Table 1) appear globally broader and cover a greater number of functional areas than the ED diagnoses. This is, in part, related to the fact that the BPD diagnosis represents a trait condition—that is, an ongoing, integral facet of the individual's general functioning—whereas an ED diagnosis represents a state condition—that is, a hypothetically acute or transient condition. From this perspective, we would expect that the personality disorder is more fixed, longstanding, and resistant to change, while the ED would be somewhat more susceptible to change. Yet, some ED patients demonstrate remarkable resistance to change with resulting symptom longevity that is similar in many ways to personality disorders. Do these resistant cases of ED actually represent personality disorders that have aggregated around particular symptoms? Or, is our view of ED as an acute phenomenon too narrow? Or both?

Table 2 compares the ED and BPD diagnostic criteria according to functional dimensions. Note that the BPD diagnosis covers relational, behavioural,

cognitive, and affective processes or areas of functioning. In contrast, the ED diagnoses generally emphasize behavioural and cognitive processes, with relatively little emphasis on relational (i.e. none) or affective processes (i.e. minimal).

TABLE 2. Borderline Personality Disorder versus Eating Disorder Diagnoses: Criteria Comparison According to the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (American Psychiatric Association, 1994)

	Borderline Personality Disorder	Anorexia Nervosa	Bulimia Nervosa
Relational processes	2 criteria		
Behavioural processes	2 criteria	1 criterion	3 criteria
Cognitive processes	2 criteria	2 criteria	2 criteria
Affective processes	3 criteria	1 criterion	—

Despite these seeming differences, the affected areas of functioning in ED may be quite similar to BPD. For example, the role of impaired affective functioning in ED may be understated in the DSM. In this regard, the work of Garner (1997) underscores the concept that starvation predisposes an individual towards affective instability (i.e. emotional distress, mood changes, irritability, outbursts of anger). Likewise, the social isolation encountered in ED patients certainly represents the relational effects of the disorder.

Goodsitt's (1997) description of anorexia nervosa and bulimia nervosa seem very compatible with BPD, particularly with regard to self-regulation and affective difficulties. Goodsitt (1997) describes the world of the anorexic as:
Lacking reliable self-soothing, tension regulation, and mood regulation, and feeling restlessly bored, empty, and aimless, the anorexic is driven to constant activity and strenuous physical exertion to drown out these painful internal conditions. By focusing on food and weight, by rigidly counting calories and regulating ingestion, by turning off her needs for others and turning inward to herself, and by filling up her life with rituals that help her feel a sense of predictability and control, she narrows down her world to something she feels she can manage (pp. 209–210).

Likewise, Goodsitt (1997) describes the early world of the young bulimic: "prior to the onset of bulimia is a child who is more tension-ridden, conflicted, and impulsive than the anorexic child. Her self-esteem is unstable... The bulimic enters puberty and adolescence poorly equipped to regulate her moods, tensions, self-esteem, and cohesion (p. 209)."

Finally, Levitt and Sansone indicate that impulsivity (e.g. self-harm behaviour and suicide attempts) and dissociation are common phenomena in ED patients, particularly among bulimics (Levitt & Sansone, 2002; Sansone, & Levitt, 2002). Given that ED patients often appear to have difficulty modulating moods and behaviour, maintaining self-esteem, sustaining successful relationships, and constructing an identity, there appear to be fewer genuine differences with BPD in areas of functioning than indicated by the DSM-IV (APA, 1994).

Possible Relationships Between ED and BPD

ED and BPD are frequently encountered in the same patients. The notion of co-occurrence simply states that the two disorders exist in the same individual, but does not clarify the relationship.

Dolan-Sewell, Krueger, and Shea (2001) provide a useful framework for organizing different theoretical models that explore how Axis I and II disorders might co-occur. The following briefly reviews these models as they apply to BPD and ED. We limit our focus to two broad categories for examining the relationship between ED and BPD: etiology (i.e. origin or cause) and mechanisms of action (i.e. the ways that disease processes affect the patient). A summary and comparison of these models, in terms of etiology and mechanisms of action, are found in Table 3.

TABLE 3. Comparison of Theoretical Models that Might Explain the Co-Occurrence of Borderline Personality Disorder and Eating Disorders*

Models	Shared etiology	Shared mechanism of action
Independence	No	No
Common cause	Yes	No
Spectrum / Sub-clinical	Yes	Yes
Predisposition / Vulnerability	No	Yes
Complication / Scar	No	Yes
Pathoplasty / Exacerbation	No	Yes
Psychobiological	Maybe	Yes

*Based on Dolan-Sewell, Krueger, and Shea (2001).

INDEPENDENCE MODEL

The Independence Model assumes that BPD and ED have no actual relationship to one another except co-occurrence. This approach assumes that the co-occurrence is primarily due to chance and that the disorders do not share “etiology, disease process, or symptom presentation” (Dolan-Sewell et al., 2001, p. 86).

COMMON CAUSE MODEL

The Common Cause Model assumes that ED and BPD share a common etiology (i.e. the same cause) but have different presentations and disease processes. Thus, from this perspective, ED and BPD originate from the same cause, but later may become very different diseases with different mechanisms of action (i.e. affect the patient in quite varied ways).

SPECTRUM / SUBCLINICAL MODEL

This model assumes that ED and BPD share both similar etiologies and mechanisms of action. Consequently, from this perspective the two disorders are not really distinct from one another, but one is actually a milder version of the other. In this case, the ED would likely represent a sub-clinical variant, or an attenuated form, of BPD. This would appear more likely than BPD representing a variant of an ED.

PREDISPOSITION / VULNERABILITY MODEL

This model assumes that one of the disorders occurs before the other disorder and increases the likelihood, or risk, that the second disorder will occur. For this approach, etiologies are generally quite distinct but the mechanism of action, or disease processes, of one of the disorders increases the risk of the second. Additionally, the second disorder (in this case, ED) is not necessarily dependent upon the presence of the first (i.e. BPD). To

summarize, the disease processes associated with BPD may increase the vulnerability of a patient to develop an ED.

COMPLICATION / SCAR MODELS

These models assume that the two disorders are distinct entities. The second disorder develops in the environment caused by the first condition, but then the second disorder continues after the first disorder remits. Thus, the second disorder could be construed as a "scar," or even a remnant, of the first disease condition. This model suggests that BPD and ED have distinct etiologies but their disease processes are related. This model posits that ED occurs in the environment caused by BPD, but continues as an after-effect or scar of BPD as some, many, or all, of the symptoms dissipate.

PATHOPLASTY / EXACERBATION MODEL

Dolan-Sewell et al. (2001) suggest that the central assumptions of this model are that two disorders occur randomly (i.e. their etiologies are independent) but one of the disorders affects the presence and disease course of the other, either additively (i.e. pathoplasty) or synergistically (i.e. exacerbation). This model suggests that the presence of an ED affects the course of BPD and/or the presence of BPD affects the course of an ED. Thus, the presence of both BPD and ED together can have quite severe interactive effects on a patient's disease processes. Whether the effects of the disorders are additive or synergistic is an empirical question and requires further exploration.

PSYCHOBIOLOGICAL MODELS

Psychobiological models focus on biology and genetics and assume that these have a significant role in the development and interaction between disorders. In this case, BPD and ED are, "manifestations (or indicators of activity in) these underlying biological systems" (Dolan-Sewell et al., 2001, p. 87). The notion of etiology is relatively unclear in this approach because rather

than viewing ED and BPD as being generated from the same cause, these disorders are seen as representations of biological or genetic predispositions. Their disease processes, however, are shared as a result of biological and genetic factors.

From an intuitive perspective, it would seem that a personality disorder such as BPD would tend to predispose an individual to, or precipitate, an Axis I disorder such as an ED, based upon some variation of one of the following models: Spectrum, Predisposition/Vulnerability, Complication/Scar, Exacerbation, or Psychobiological. As an example, in the Psychobiological Model, it might be possible that BPD is genetically programmed and that the ED actually exacerbates the BPD potential (i.e. the BPD potential would actually be present but lying relatively dormant). In this example, as the ED symptoms become more pronounced, various BPD symptoms also become stimulated, as in a cascade effect, with the BPD symptoms evolving to diagnostic proportions.

As a second example, in the Predisposition/Vulnerability Model, the
BPD symptoms could be already present within the individual but, again, not evident. As the patient begins to manifest the ED symptoms, adjunctive symptoms associated with BPD might be stimulated. Using a pragmatic example, a patient who had been abused and who was having difficulty with repetitive relationship failures might turn to employing ED symptoms. As the ED symptoms increase in intensity, other symptoms associated with BPD might become activated such as depersonalization, anger, fears of abandonment, and so forth.

CONCLUSION

BPD is a relatively common Axis II disorder that appears to be multi-determined. This complex disorder co-occurs with some frequency among those with ED. The precise relationship between the two disorders remains unknown. Through models, we have presented some of the possible

relationships between BPD and ED. In a number of these models, ED and BPD have a variety of potential effects on one another. However, the genuine relationships between the two disorders remain unknown. From a clinical perspective, both disorders appear to complicate the treatment of the other.

We have generated perhaps more questions than we have answered. Only further research will clarify the various complex relationships between these two challenging disorders. By understanding their relationship to one another, we may be able to develop more effective treatment strategies.[26]

[26] Sansone, R. A. and Levitt, J. L. , 'Borderline Personality and Eating Disorders', Eating Disorders, 13:1, 71 - 83

Unit thirteen

Resources

In this section:

Depression questionnaire

Anorexia nervosa – accept, heal and reclaim your life

Diary card

Chain analysis of problem behaviour

Depression Questionnaire

The following is a set of sixteen questions which may help to identify some of the symptoms of depression. However, this does not provide an actual diagnosis and the results should be discussed with a GP or other mental health professional.

Tick the options which best describe you over the last seven days.

1. Falling asleep:

- I am always asleep within 30 minutes.
- It takes 30 minutes to fall asleep less than half the time.
- It takes 30 minutes to fall asleep more than half the time.
- It takes more than an hour to fall asleep more than half the time.

2. Sleep during the night:

- I never wake up at night.
- I sleep lightly and wake up briefly during the night.
- I wake up at least once a night but am able to go back to sleep easily.
- I wake up more than once during the night, for at least 20 minutes, more than half the time.

3. Waking up too early:

- Most of the time I do not wake up more than 30 minutes before I need to get up.
- More than half the time I wake up more than 30 minutes before I need to get up.
- I nearly always wake up more than an hour before I need to get up, but I am able to go back to sleep eventually.
- I wake up at least an hour before I need to and cannot go back to sleep.

4. Sleeping too much:

- I do not sleep for more than 7 – 8 hours and do not nap during the day.
- I do not sleep for more than 10 hours, including naps during the day.
- I do not sleep for longer than 12 hours, including naps during the day.
- I sleep for longer than 12 hours, including naps during the day.

5. Feeling sad:

- I do not feel sad.
- I feel sad less than half the time.
- I feel sad more than half the time.
- I feel sad nearly all the time.

6. Decreased appetite:

- No change in usual appetite.
- I eat somewhat less than usual.
- I eat far less than usual and only with personal effort.
- I rarely eat within a 24-hour period and only with extreme personal effort, or when others persuade me to eat.

7. Increased appetite:

- No change in usual appetite.
- I feel a need to eat more frequently than usual.
- I regularly eat more frequently, or greater amounts than usual.
- I feel driven to overeat at mealtimes and in between meals.

8. Decreased weight (within the last two weeks):

- No change in weight.
- I have lost a small amount of weight.
- I have lost 2 pounds or more.
- I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):

- No change in weight.
- I have gained a small amount of weight.
- I have gained 2 pounds or more.
- I have gained 5 pounds or more

10. Concentration / decision making:

- No change in ability to concentrate or make decisions.
- I sometimes feel indecisive or find it difficult to concentrate.
- I struggle to concentrate and make decisions most of the time.
- I cannot concentrate enough to read and cannot make minor decisions.

11. View of myself:

- I see myself as equally worthwhile and deserving as other people.
- I am more self-blaming than usual.
- I largely believe I cause problems for others.
- I think almost constantly about major and minor defects in myself.

12. Thoughts of death or suicide:

- I do not think of death or suicide.
- I feel that life is empty or wonder if it is worth living.
- I think of suicide or death several times a week for several minutes.
- I think of suicide or death several times a day in some detail, or I have made specific plans for suicide, or have actually tried to take my life.

13. General interest:

- There is no change in my usual interest in other people or activities.
- I am less interested than usual in other people or activities.
- I only have interest in one or two activities that I enjoy
- I have no interest in any of the activities I usually enjoy.

14. Energy level:

- No change in energy levels.
- I get tired quicker than usual.
- I have to make a big effort to start or finish usual daily activities.
- I cannot carry out most of my usual daily activities due to a lack of energy.

15. Feeling slowed down:

- I think, speak and move at my usual speed.
- My thinking is slower than usual or my voice sounds flat or dull.
- It takes several seconds to be able to respond to a question and I think my thinking has slowed down.
- I am often unable to respond to most questions without extreme effort.

16. Feeling restless:

- I do not feel restless.
- I am often fidgety, or need to shift my sitting position.
- I have impulses to move around and I am often restless.
- At times I am unable to sit still and need to pace around.

ANOREXIA NERVOSA

Accept, Heal and Reclaim Your Life.

Do you have an intense fear of weight gain? Do you have an overwhelming need to be thin? Do you think you are fat, even though others say you aren't? Have you missed at least 3 consecutive menstrual cycles, or is your BMI score less than 18? If your answer is yes to most of these, red lights should be flickering.

Let's start by calculating your BMI (Body Mass Index). A BMI count is the way to show your weight in relation to your height. A healthy BMI range is between 20-25

CALCULATING YOUR BMI

Height in inches:_____

(feet x 12 + inches) e.g. 5 feet, 3 inches is 63

(5 x 12 = 60; 60 + 3 = 63)

Weight in pounds: _____

Formula:

[Weight ÷ Height ÷ Height] x 703 = _____

REASONS FOR DIETING

What does dieting do for you? How do you feel if you don't diet?

PHYSICAL EFFECTS OF DIETING

Tick the box if you experience any of the following symptoms:

Absent periods	
Facial hair growth	
Hair loss	
Tiredness	
Dizziness	
Irregular heartbeats	
Dry skin	
Frequent constipation	
Water retention	
Cold hands / feet	

Taking Control

One of the causes of anorexia is to be able to be in control. Write down 5 important things in your life that you have little or no control over.

1.

2.

3.

4.

5.

Goals in Your life

It is important to set yourself goals in life; things you want to reach, things that can improve your life, things that are enabling. What goals have you set in your life, and what is the value behind these goals?

Goals you've set	Why are you doing this?
e.g. I want to have children someday	To nurture children and watch them grow.
1.	
2.	
3.	
4.	
5	

YOUR LIFE TIMELINE

When we think about life, there are three areas which we need to think about. Our past, present and future.
Starting with your birth, include all the events in your life that define you.

__ _____

Have you listed any weight-related achievements? E.g. fit in a size 6 jeans. People don't usually mention these achievements.
Now look back on your timeline. This will show you what is most important to you.

Diary Card

This diary sheet can be used to monitor your client's feelings and how they coped with them. The way to use this sheet is to put a number between 0-5 in each box. Some of these boxes are pre- made but can be adjusted to each individual client. 0 would be the lowest level of emotion, whereas 5 would be extremely intense. It could be accepted that 3 and below is a normal response for someone with a personality disorder.

On the back of the diary sheet, add a list of skills that either your client has or you can teach them. In the box marked as ‘Used Skill’ you could number the skills on the back of the worksheet and then add in which number skill was used in coping with the problem experienced.

This worksheet is useful for those who dislike talking about emotions or find it difficult describing them. Any days that are particularly distressing, or when there has been an episode of harm, may be worth exploring. This is also a useful way to monitor patterns and changes in the work you do with your client.

DIARY CARD														
NAME:														
	What I Felt						How Much I wanted To:			What I did		What Happened		Used Skill
	Sad	Ashamed	Angry	Afraid	Happy	Anxious/ Other	Hurt Myself	Kill Myself	Other	Hurt myself	Tried to kill myself	Went to hospital	Stayed in hospital	
Day and date	(0-5)	(0-5)	(0-5)	(0-5)	(0-5)	(0-5)	(0-5)	(0-5)	(0-5)	Y/ N	Y/N	Y/N	Y/N	Y/N
Mon														
Tues														
Weds														
Thurs														
Fri														
Sat														
Sun														

Chain Analysis of Problem Behaviour

It is advisable to ask your client to complete this sheet after any negative or self-damaging behaviour. This will allow them to reflect on their ways of coping, and help them to challenge their own ways of reacting to various situations. It may not be something your client enjoys, but they will start to realise it is a consequence of their actions and a very useful tool.

Chain Analysis of Problem Behaviour

Name:

Date of problem behaviour:_____

1. What exactly is the problem behaviour? (Be specific.)_____

_____

_____

2. What was the trigger / prompting event in the environment
that started the chain?_____

3. When did I know I was going to do it?_____

4. What links form a chain between the problem behaviour and the prompting event? (Start with the prompting event. Include the thoughts, feelings, behaviours, sensations and events. It might be helpful to imagine you are the director of a play, instructing an actor to play your part) the more details the better.

a. Prompting event: _____

_____

b.

c.

d.

e.

f.

g.

h.

i.

j.

k. Problem Behaviour_____

Chain Analysis of Problem Behaviour: Part 2

5. What were the consequences of my problem behaviour for:

Me:

Others:

6. Do I need to make any repairs, and if so, what?_____

7. What other links could have been in the chain that were more skilful, and might not have led to the problem behaviour? What could I have done differently?

a.

b.

c.

d.

e.

f.

g.

h.

i.

j.

K: Alternative better outcome:_____

_____

How can I reduce my vulnerability in the future?_____

Is there anything else I would like to share?_____

Useful Websites

BBC Health

http://www.bbc.co.uk/health/conditions/mental_health/disorders_eating.shtml

Beat: Beating Eating Disorders

http://www.b-eat.co.uk

BPD World

http://www.bpdworld.org.uk

Depression World

http://www.depression-world.org.uk

Dissociation World

http://www.dissociation-world.org.uk/

Eating Disorders Association

http://www.edauk.com

OCD WORLD

http://www.ocd-world.org.uk

Royal College of Psychiatrists

http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/eatingdisorders.aspx

Schizophrenia World

http://www.schizophrenia-world.org.uk

Self-Harm: Fighting Pain With Pain

http://www.fpwp.org.uk

Taking Control

http://www.takingcontrol.org.uk

References

False Allegations (2006) ‘Depression According to DSM-IV’
http://www.falseallegations.com/dsm-dprj.htm#mixed
[05/2007]

NHS Direct (2007) ‘Health Encyclopaedia’ Depression
http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=127
[05/2007]

Psychology Information Online (2003) ‘Depression’ Information and Treatment
http://www.psychologyinfo.com/depression/
[05/2007]

BBC News - Health (1999) ‘Genetic Clues to Eating Disorders’
http://news.bbc.co.uk/1/hi/health/259226.stm
[05/2007]

B-eat – Beating Eating Disorders (2007) Some Statistics
http://www.b-eat.co.uk/ProfessionalStudentResources/Sudentinformation-1/SomeStatistics
[05/2007]

Bell, L. (2003). What can we learn from consumer studies and qualitative research in the treatment of eating disorders? Eating & Weight Disorders, 8, 181–187.

Beresin, E. V., Gordon, C., & Herzog, D. B. (1989). The process of recovering from Anorexia Nervosa. Journal of American Academy of Psychoanalysis, 17, 103–130

Blumer, H. (1969). Symbolic Interactionism: Perspectives and Method. (New Jersey: Prentice-Hall Inc.)

Bordo, S. (1993). Unbearable weight. (London: University of California Press).

Brown, C. (1990). The control paradox. In N.E.D.I. Centre (Ed.), Bulletin. (Toronto: Ontario Ministry of Health).

Bruch, H. (1978). The golden cage: The enigma of anorexia nervosa. (Cambridge, MA: Harvard University Press).

Bryant-Waugh, R. (1993). Prognosis and outcome. In B. Lask, & R. Bryant-Waugh (Eds.), Childhood onset anorexia nervosa and related eating disorders (pp. 91–108). (Sussex: Psychology Press).

Bryant-Waugh, R., Hankins, M., Shafran, R., Lask, B., & et al. (1996). A prospective follow-up of children with anorexia nervosa. Journal of Youth and Adolescence, 25, 431–437.

Butzlaff, R., & Hooley, J. (1998). Expressed emotion and psychiatric relapse. Archives of General Psychiatry, 55, 547–552.

Chesla, C. A. (1989). Parents' illness models of schizophrenia. Archives of Psychiatric Nursing, 3, 218–225.

Claude-Pierre, P. (1997). The secret language of eating disorders. (Moorebank, Australia: Bantam).

Colahan, M., & Senior, R. (1995). Family patterns in eating disorders: Going round in circles, getting nowhere fasting. In G. I. Szmukler, C. Dare, & J. Treasure (Eds.), Handbook of eating disorders: Theory, treatment and research (pp. 243–257). (Chichester, UK: John Wiley).

Crisp, A.H., McClelland (1996) 'Anorexia Nervosa' Guidelines for Assessment and Treatment in Primary and Secondary Care. (Psychology Press: East Sussex)

Crisp, A.H. (1995) 'Anorexia Nervosa' Patient's Log Book. (LEA Ltd: East Sussex).

Crisp, A.H., Joughin, N., Halek, C., and Bowyer, C. (1996) 'Anorexia Nervosa' The Wish to Change. (Psychology Press: East Sussex).

Disordered Eating (2007) 'Eating Disorders Statistics (UK)' http://www.disordered-eating.co.uk/eating-disorders-statistics/eating [05/2007]

Eisler, I., le Grange, D., & Asen, E. (2003). Family interventions. In J. Treasure, U. Schmidt, & E. van Furth (Eds.), Handbook of eating disorders (2nd ed., pp. 291–310). (Chichester, UK: John Wiley).

Eliot, A. O., & Baker, C. W. (2000). Maternal stressors and eating-disordered adolescent girls. Family Therapy, 27, 165–178.

Fairburn, C. G., Cooper, Z., Doll, H. A., & Welch, S. L. (1999). Risk factors for anorexia nervosa. Three integrated case-control comparisons. Archives of General Psychiatry, 56, 468–476

Gilbert, A. A., Shaw, S. M., & Notar, M. K. (2000). The impact of eating disorders on family relationships. Eating Disorders: The Journal of Treatment and Prevention, 8, 331–345.

Glaser, B. (1998). Doing grounded theory: Issues and discussions. (Mill Valley, CA: Sociology Press).

Glaser, B., & Holton, J. (2004). Remodelling grounded theory... Forum: Qualitative Social Research, 5(2). Available: www.qualitative-research.net/Fqs-texte/2-04/ 2-04glaser-ehtm.

Herzog, W., Kronmueller, K. T., Hartmann, M., Bergmann, G., & Kroeger, F. (2000). Family perception of interpersonal behaviour as a predictor in eating disorders: A prospective six-year follow-up study. Family Process, 39, 359–374.

Highet, N., Thompson, M., and King, R.M., The Experience of Living with a Person with an Eating Disorder: The Impact on the Carers, Eating Disorders, 13:4, 327 – 344

Honey, A., and Halse, C., Parents Dealing with Anorexia Nervosa: Actions and Meanings, Eating Disorders, 13:4, 353 - 367

Hoskins, M. L., & Lam, E. (2001). The impact of daughters' eating disorders in mothers' sense of self: Contextualizing mothering experiences. Canadian Journal of Counselling, 35, 157–175.

Hsu, L. K. G. (1996). Outcome of early onset anorexia nervosa: What do we know? Journal of Youth and Adolescence, 25, 563–568.

le Grange, D. (1999). Family therapy for adolescent anorexia nervosa. Journal of Clinical Psychology, 55, 727–739.

Lemmon, C. R., & Josephson, A. M. (2001). Family therapy for eating disorders. Child and Adolescent Psychiatric Clinics of North America, 10, 519–542.

Lobban, F., Barrowclough, C., & Jones, S. (2003). A review of the role of illness models in severe mental illness. Clinical Psychology Review, 23, 171–196.

Lock, J., le Grange, D., Agras, W.S., & Dare, C. (2001). Treatment manual for anorexia nervosa: A family based approach. (New York: Guilford).

Malson, H. (1998). The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa. (London: Routledge).

McMaster, R., Beale, B., Hillege, S., & Nagy, S. (2004). The parent experience of eating disorders: Interactions with health professionals. International Journal of Mental Health Nursing, 13, 67–73.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). In-depth interviewing: Researching people. (Melbourne: Longman Cheshire).

Moss-Morris, R., Weinman, J., Petrie, K., Horne, R., Cameron, L., & Buick, D. (2002). The revised illness perception questionnaire (IPQ-R). Psychology and Health, 17, 1–16.

Nielsen, S., & Bara-Carril, N. (2003). Family, burden of care and social consequences. In J. Treasure, U. Schmidt, & E. van Furth (Eds.), Handbook of eating disorders (2nd ed., pp. 191–206). (Chichester, UK: John Wiley).

Nilsson, K., Abrahamsson, E., Torbiornsson, A., and Hägglöf, B. (2005) 'Causes of Adolescent Onset Anorexia Nervosa: Patient Perspectives', Eating Disorders, 15:2, 125 – 133

Perednia, C., & Vandereycken, W. (1989). An explorative study on parenting in eating disorder families. In W. Vandereycken, E. Kog, & J. Vanderlinden (Eds.), The family approach to eating disorders: Assessment and treatment of anorexia nervosa and bulimia (pp. 119–146). New York-London: PMA. Qualitative Solutions and Research Pty Ltd. (1999). QSR NVivo (Version 2.0). Melbourne: Qualitative Solutions and Research Pty Ltd.

Rethink (2006) ‘Eating Disorders’
http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/eating_disorders/index.html
[05/2007]

Ross, K., & Handy, J. A. (1997). Family perceptions of anorexia nervosa: A qualitative study of two families' histories. In G. M. Habermann (Ed.), Looking back and moving forward: 50 years of New Zealand psychology (pp. 232–239). (Wellington: The New Zealand Psychological Society).

Sharkey-Orgnero, M. I. (1999). Anorexia nervosa: A qualitative analysis of parents' perspectives on recovery. Eating Disorders: The Journal of Treatment and Prevention, 7, 123–141.

Steinhausen, H. C. (1997). Outcome of anorexia nervosa in the younger patient. Journal of Child Psychology and Psychiatry and Allied Disciplines, 38, 271–276.

Steinhausen, H. C. (2002). The outcome of anorexia nervosa in the 20th century. American Journal of Psychiatry, 159, 1284–1293.

Steiner, H., Kwan, W., Shaffer, T. G., Walker, S., Miller, S., Sagar, A., & Lock, J. (2003). Risk and protective factors for juvenile eating disorders. European Child and Adolescent Psychiatry (suppl. 1) 12, 38–46.

The University of Hull: Student Welfare (2007) 'Eating Disorders' http://student.hull.ac.uk/support/health/Eating_Disorders.html [05/2007]

Tozzi, F., Sullivan, P. F., Fear, J. L., McKenzie, J. M., & Bulik, C. M. (2002). Causes and recovery in anorexia nervosa: the patient's perspective. International Journal of Eating Disorders, 33, 143–154

Treasure, J., Murphy, T., Szmukler, G., Todd, G., Gavan, K., & Joyce, J. (2001). The experience of caregiving for severe mental illness: A comparison between anorexia nervosa and psychosis. Social Psychiatry & Psychiatric Epidemiology, 36, 343–347.

Watson, R., Vaughn, L.M., 'Limiting the Effects of the Media on Body Image: Does the Length of a Media Literacy Intervention Make a Difference?', Eating Disorders, 14:5, 385 – 400

Wood, D., Flower, P., & Black, D. (1998). Should parents take charge of their child's eating disorder? Some preliminary findings and suggestions for future research. International Journal of Psychiatry in Clinical Practice, 2, 295–301