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TRUST

TAILORING LAW AND HEALTH INITIATIVES TO PROMOTE INCLUSION ON MENTAL ILLNESS

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Associação de Paralisia Cerebral de Coimbra

Maastricht University

ESTUAR
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FUNDAȚIE CU ACTIVITATE ÎN DOMENIUL SĂNĂTĂȚII MINTALE

Spora
Consultoria Social

Centro de Direito Biomédico

TRAINING MANUAL

Tailoring Law and Health Initiatives to promote Inclusion on Mental Illness

LAW, JUSTICE AND HEALTH

TRAINING MANUAL FOR PEOPLE WITH MENTAL ILLNESS

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TECHNICAL SHEET

TITLE

LAW, JUSTICE AND HEALTH | TRAINING MANUAL FOR PEOPLE WITH MENTAL ILLNESS

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PART I | PROJECT TRUST

1.1. PRESENTATION

World Health Organisation (WHO) describes mental well-being as a fundamental component to health and places it as one of the major concerns for the years to come (Mental Health Action Plan, 2013-2020). Mental health is being targeted with major investment from all states worldwide, with strategies that empower people with mental health problems to engage on training and employment and also that encourage community-based services that will assure the maintenance of the family and friendship bonds. This is also a concern by the member states in their national strategies for mental health (Portuguese National Plan for Mental Health). For too long mental illness has been kept apart from crucial achievements in the sphere of basic rights, including education and training in its diverse modalities. Also, the lack of knowledge that population show when questioned about mental illness reveals they are full of pre assumptions and need more and better knowledge, including groups of professionals that need to work with people with mental illness, like Law Enforcement Authorities (Lurigio, 2011). Data show these people tend to enter the judicial system with

minor offenses, damaging the effectiveness of the system and themselves, and preventing them to receive proper treatment and assistance (https://csgjusticecenter.org/mental-health). Community agents, including courts, judges and police are making an effort to develop strategies to reduce the number of processes and help people with mental illness receive proper treatment and assistance.

1·2· INTERVIEW RESULTS

Interviews were carried the people with mental illness, and these interviews served as a basis for drawing up the contents of the training.

The main conclusions of the various interviews with people with mental illness are described below.

Presents contexts of interaction with police / authority forces: home / street, hospitals, school and court.
He says he felt always treated properly and dignified. He felt respected and never felt discriminated. He considers that the police action was, in all the interactions, the correct one. He was informed of his rights (orally or in writing). In court or in the interactions with lawyers, he feels that the language used was correct, in the sense in which was explained to him, in current terms, what was being discussed. He felt, in this context, at all times, well accompanied.
In the specific context of police vehicle transport, he says he felt "like a dog in a cage" and that thoughts like "what are the people out there thinking about me?" kept crossing his mind.
He states that in specific situations he was incorrect with the agents of authority, "mocking" them, and that at these moments he felt more abruptness and harshness in the way they addressed him.
He has no suggestions to give to the police intervention and reinforces the idea that it has always been treated properly.

He recalls only a situation of interaction with the police. This situation occurred in an institutional context. He explains that he called the police to file a complaint and that when the agents arrived at the institution, they asked who had filed a complaint. Hugo explained that it had been him but they didn´t listen to him, having the agents entered into dialogue and exchange information only with the staff of the institution. In this way, Hugo says that he did not get to speak personally with the agents, having felt "put aside". He adds that since the institution supports "patients and mentally disabled", the police will have acted with prejudice. He says that in a situation that he feels he needs police intervention; he will hardly call the police because he does not want to be treated again the way it was in that episode.
In relation to the suggestions, he said that he would have liked the agents to fulfil their duties, explaining" they have to listen to who makes the complaint."

The interactions with the police that she remembers have taken place in different contexts. The first happened in a street context. She explains that when she was harassed by an individual, she asked for help from two officers who were on patrol nearby and who were very solicitous and helpful: "they listened, they helped me ... they would not let me leave alone."
In a second moment she presented a complaint by domestic violence, following a discussion with the ex- companion. Once again the intervention quality stands out: "they helped ... they listened to me and they were helpful!".
The third interaction, however, was less positive. After being expelled from the house where she lived by the landlords and with her goods in the street, she asked for help to the police forces since there were missing goods. The agents identified themselves and asked for her identification, but after assessing the situation, they presented a speech that annoyed Ana and that she felt as discriminatory: the expression "you must be in bad life activities" was used and interpreted very negatively by her. In this situation Ana felt disrespected. She believes, however, that it was a one-time situation, adding that "there are good and bad professionals."
"In court, she a felt always supported and informed. She reinforces the idea that in this context she has always been told that if she did not understand a question, she should state her doubt and it would be clarified. In this context, a police officer has appeared in court as a witness and she has very positively classified the role of that agent in the proceedings in question.
As a suggestion, she states that she feels that sometimes, in view of what she observes and the experience of others around her, she feels that there is a great deal of discrimination regarding the issue of domestic violence directed at men and that, in these situations, the agents are often not very understanding and present discriminatory attitudes.

He highlights a similar set of interactions with the police in domiciliary context.
He explains that, taking into account the psychiatric symptoms he maintains, at different times the police went to his house to internalize him compulsively. He considers that, although they acted in a respectful way, there were some flaws: "I should have been treated differently ... I should have been heard." Nevertheless, he positively evaluates the work of the police: "they were only doing their job". In these situations, he was always transported in a police vehicle and, in this respect, he said that he felt "bad", since he had thoughts like "what are the people who see me thinking? They must think I'm a criminal! "
In another interaction, in a street context, he is more displeased with the police intervention. At one point in his life he had nowhere to stay and asked the police for help, heading to a police station. He considers that he was not helped and that the agents, unwillingly, simply told him to call a certain telephone contact.
He has no suggestions.

He begins by saying that he has many difficulties in dealing with the police. And he justifies these difficulties by presenting two experiences that he considers very negative.
The first, older one, concerns a situation where he was "picking with" with a boy ("I was picking with a kid ... boys things!") And then, in that situation, he was approached inappropriately by an agent: "the policeman came to speak to me but he spoke in a tone that he should not have spoken ... and said things he should not say ... he said that I was shit!"
The second situation arises following a minor theft. He and a colleague stole a video game on a commercial surface and while him, confronted by the police, assumed the theft and apologized by the mistake, the colleague ran away. After being caught by the agents, he says that his colleague was handcuffed, stuck in a chair and beaten with a phone book. He adds that the police did not ask any questions or give any information, but merely used force.
So he concludes: "the cops think they are the best! I do not trust them, I do not like them, I do not want to hear about them ... I do not want to see them! "

CONTEXTS OF INTERACTION WITH POLICE / AUTHORITY FORCES:

Home; shelter institutions; workplace; court; police station

M. in the situation concerning the context of home, mentions that the police had a very incorrect attitude, as the police force began to "punch the door" and entered abruptly. They only identified themselves later, as well as explained also after forcing entrance why they were there in their home. On this occasion, the police only listened to her companion, since they had gone to his house after a denunciation of the neighbours. The situation was clarified on the moment.

In the situation regarding the institution of shelter, M. mentioned that everyone involved was very concerned and caring about her, always having a very adequate behaviour and showing a constant concern for her well-being and her family.

In the workplace she said that the police, had a very adequate and assertive behaviour too, always concerned on protecting her from her aggressor. In this situation, the police officers identified themselves and listened to her, trying to alert her to the danger situation she was exposing herself.

In court she was as witness and considered the treatment was correct and adequate for all the parties involved.

In the police station, where she repeatedly complained of domestic violence, she felt discriminated against and "mocked", the police did not understand her situation and she was heard by the police without any privacy. She considers that police stations do not have adequate people to understand her situation as a victim of domestic violence. During the interview M. repeatedly stated that the police mentioned that she "was only in this situation because she liked to be beaten."

The only time she was transported in the police car, she does not remember any associated feelings, because she says "that the head was not there, only the body".

She has little contact with lawyers, however she considers that they have always been clear and she understood the language they used.

SUGGESTION:

She mentioned and repeatedly pointed out "I do not believe in justice ... how can taped audios and marks in the body and cases be archived?" Also mentions the time and bureaucracy associated with the processes. She says that other care should be taken when dealing with domestic violence, particularly when complaints are directly presented at the police station.

CONTEXTS OF INTERACTION WITH POLICE / AUTHORITY FORCES:

Street; school; police station

One time on the street he was called by the police to ask for his identification. He considers that they were aggressive, and says that he was astonished because they were plain-clothes policeman and they only identified themself afterwards, they did not explain why they asked for his identification. He considers that the intervention was not the correct one.

At school he got involved in beating with another person and the police did “not listen to his version or neither they explained why he was expelled from school, they said" I do not want to see you here ". He reaffirms they did not listen to any other intervenient. He obeyed the order of the police but considers it was not the most appropriate approach because he did nothing wrong.

At the police station he presented a robbery complaint. Later, he felt coerced to withdraw the complaint, as he was threatened by the police that he could not accuse anyone without evidence, that he could be arrested for that so he decided to withdraw the complaint he had made for theft.

He was already transported in the police car, he felt insecure and afraid, because he was afraid of what could happen.

SUGGESTION:

The police should have specific training in order to be able to hear and approach people appropriately.

CONTEXTS OF INTERACTION WITH POLICE / AUTHORITY FORCES:

Home; police station; court.

In home context the police were called by domestic violence because the father of her daughter frequently attacked her. They were always attentive and she was always treated properly. They have always been faultless. She never felt discriminated against.

At the police station the approach was as also as correct as possible, she was always welcomed and advised by the police. She felt that the police were concerned about her situation as a victim of domestic violence. The police provided the direct number for help whenever needed.

In court, A. considers that the approach was clear and precise, she always felt always supported and always had her doubts clarified.

She was transported in the police car; this transport took place with the purpose of protecting her from the aggressor and being transported from the public ministry to the place where she was doing the internship in a safe way. Thus, the feeling that she has concerning the transport in the police car is safety.

SUGGESTION

She reinforces her satisfaction with the police and makes no suggestions. She mentions that she has full confidence in the police and now, after the court's decision, she feels safe and at peace.

CONTEXTS OF INTERACTION WITH POLICE / AUTHORITY FORCES:

Home; police station; court.

He considers that in the context of home the police intervention was done correctly and with education, always managed to be heard and never felt discriminated against. The police explained the reason for their presence and also identified promptly. They were never aggressive and asked permission to search the house.

He reports the same type of behaviour in the police station, where they were adequate and correct, always demonstrating an assertive behaviour.

In court he says he was very nervous. The judge used clear language and the lawyer clarified all the doubts. Still, he mentions that he spoke very little with his lawyer, but the language used was easy to understand.

He was already transported in the police car and reported that the situation was quite uncomfortable, despite not being handcuffed, he felt the pressure of having a policeman on each side.

SUGGESTION:

He suggests that the police force could be more careful in dealing with the situations, particularly, he has experiencedless correct interventions by the police including physical assaults.

CONTEXTS OF INTERACTION WITH POLICE / AUTHORITY FORCES:
Police station; institutions; home; street; court.

He has been arrested three times, in three different countries, reporting different experiences. In Brazil, his experience was quite negative. He said there was a lot of corruption. In Portugal, he did not feel that there was any corruption within the authorities, instead of Brazil and the Czech Republic. In Portugal, he never suffered from organized crime.
In Portugal, when he had to file a complaint, he appealed to a police station and was treated correctly. In various experiences in police stations, he considers that in Portugal, Spain and England he has always been treated correctly and properly, as differently from of Brazil and the Czech Republic.
When he returned to Portugal he was arrested, but always treated appropriately. He regrets the lack of communication within the police, situation of which he has already been a victim. Thus, when the sentence was over, he was admitted to an institution. In the same institution he was approached by the court, which informed him that he would have to serve a prison sentence, which he had just completed. He presented his arguments, to which the police were attentive, requesting to present the documentation proving the fulfilment of the sentence. The situation was solved without further embarrassment. At first, he considered that the police did not have the right attitude ("they entered abruptly") but at the end they apologized and regretted the situation.
When approached at home, he considers that they were always correct and explained the reason for their presence. On the street, too, has already been approached by police considering they were correct. The place where he felt discriminated against was in the Czech Republic, considering them racist. In England he considers the police very cordial and helpful, and justice works swiftly. In Portugal, there is a lot of bureaucracy.
His contact with lawyers in Portugal is not very positive. When he had the necessity of recurring to lawyers, they were not prepared to defend his interests because they knew the case shortly before entering the trial, they were not well prepared. However, he always understood what was transmitted, both by the lawyers and by the judges.As far as being transported by the police car (specific carriages of prisoners) his experience is negative, he considers humiliating and felt "trapped". He was transported in these vehicles, where the interior is divided into compartments and they are handcuffed to the doors. In Brazil he was transported in the police car as a "pig", with his hands and feet tied and thrown into the trunk of the car.

SUGGESTION:
He reinforces the bureaucracy present in the Portuguese justice system, which makes it not very rapid and the lack of communication between the different organs of justice.

1.3. TRAINING MANUAL

This training manual is applied to people with mental illness to train them on how to relate with the health and judicial system and, in particular, with law enforcement authorities. This manual contain necessary and mandatory information on their rights and obligations, mental health law, social affairs issues and cooperation.

In order to more efficiently answer the needs of the target-group, the training program is based also on the results of the survey conducted previously in the project regarding what mentally ill, police officers and other key stakeholders.

There are several questions that need to be addressed when building a training program for people with mental disorders for it to succeed: a) the contents to develop need to be in synchrony with their needs b) select the trainers in order to assure high quality training c) make sure that the training techniques selected are the most adequate d) respect their resting and medication periods and e) keep continuous articulation and dialogue with them to maintain them involved.

The innovative character is both in its content and in the target-group. The possibility for transferability is major since there will be aspects concerning legislation that will be country specific,

and for that each country can introduce its particularities on the themes addressed.

1.4. TRAINING PLAN

TRUST PROJECT	2 HOURS
CONTENTS	
▪ Presentation ▪ Interview results ▪ Training manual	

MENTAL HEALTH	7 HOURS
CONTENTS	
▪ What is mental health? ▪ Mental disorder ▪ Curs vs recovery ▪ Discomfort in mental health ▪ The right place for the diagnostic ▪ Stigma and discrimination	

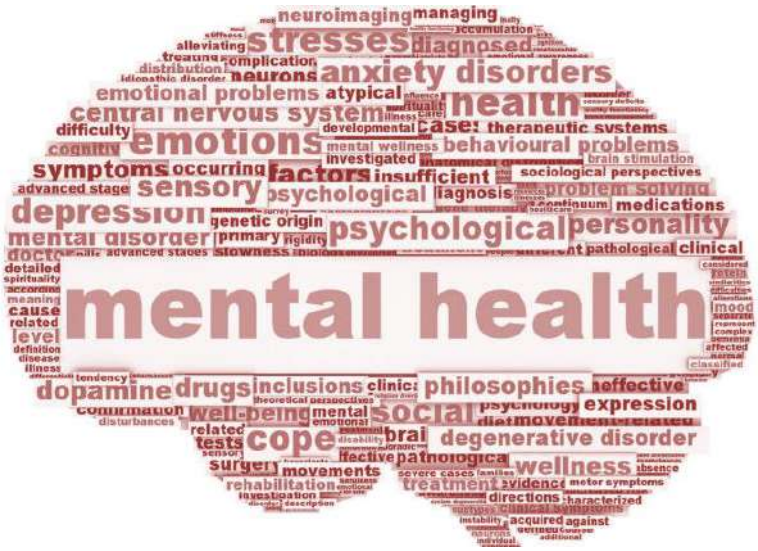
LAW, JUSTICE AND HEALTH	5 HOURS
CONTENTS	
▪ International mental health care law ▪ International standards and guidelines ▪ Mental health and human rights	

PSYCHO-EDUCATIVE INTERVENTION ON LAW, JUSTICE AND HEALTH	6 HOURS
CONTENTS	
▪ Challenging negative attitudes and beliefs about the police ▪ A structured approach to problem-solving ▪ Communicational skills and assertiveness	

TOTAL	20 HOURS

PART II |MENTAL HEALTH

2.1. WHAT IS MENTAL HEALTH?



https://mystoryyourtruth.com/what-is-mental-health/

Is saying something is “my mental health” necessarily indicating that there is a problem? No. We have discussed already that every individual has emotional, rational, and irrational perceptions of the world and their relationships with other people. Just like talking about ‘physical health’, we can talk about

‘mental health’ as the complete range of human experiences in the realm of mental well-being. And just like physical health, in mental health there is a range from the very fit to the very unfit - there is temporary interruption of mental health, and there is permanent, structural incapacity causing on-going mental health problems.

In the definition of health, there way we talk about health, about being healthy and about being unhealthy, has changed over time. We used to see much of ill health as a matter of morality even recently, some said that a particular illness was a punishment from God of particular behaviours - we used to say that of everything when we lived in highly superstitions times. Medical science brings more understanding of ‘health’, but it still has large gaps, not least around causation - why do particular exposures to risk trigger responses in some people and not others? And arguably, matters of the brain are ones where our scientific understanding of causation is least developed, leaving a lot of room for fear and prejudice. One of the recent developments in the definition of health is to suggest that being healthy is about being able to cope with one’s diseases, with the state in which one finds oneself. Perhaps it is worth considering at this point, how we feel about such a definition. I am not unhealthy when I have a par-titular disease, only when I cannot cope with it. Is this about empowering the individual, or is it dangerously close to blaming an individual?

So, we all have a “mental health”, and we all manage it in different ways, with different degrees of success. And it is related to our physical state as well. Some of us are not good on a morning without coffee, or need a sugar intake or a sleep to bring us back to ‘our usual selves’. For some of us, ‘our usual selves’ is cheery, others are melancholic, others angry, others

downright unpleasant. This is in no way to diminish mental health, and the problems the people have with mental health - but it is to start thinking about this by acknowledging that there is not an “us” and “them” in this - there is a spectrum, and recognising that we have a relationship with our mental health, and that it changes for things that are within and without our control might be a good way of thinking about the whole spectrum of mental health and individuals’ reactions to it.

What is this about Mental Health?

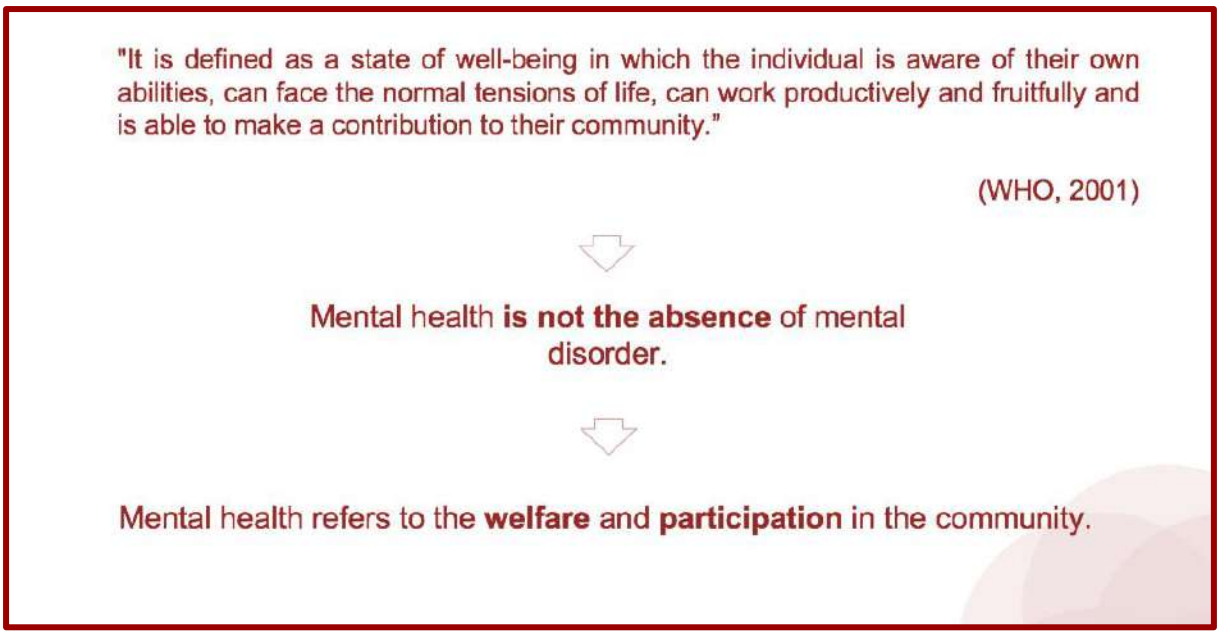
We let the participants participate freely and converse with each other for a while. It is important to promote the participation of people so that they define what they understand for mental health. While the different people define the concept, the trainer will point out the different definitions that are exposed. You can sign in a paper or in a notebook.

Our role in this question and the comments of the participants will be to do as if we did not know anything, as if it were the first time, we listen this concept.

Habitually, the definition of mental health that people of the session will do will focus on:

- Illness and mental disorder, something negative that happens to the individual (emotional malaise or perceptions of reality), and specifically focused on the brain as a representative organ, or in the treatments and medications we take;
- To a lesser extent, if it is the case, appear aspects that refer to the person's well-being, the relationships we have with others or the relationships with the community;
- Also, mental health is usually something that people locate the individual, and specifically the brain. It is as if talking about mental health was to speak of the functioning of a person's brain.

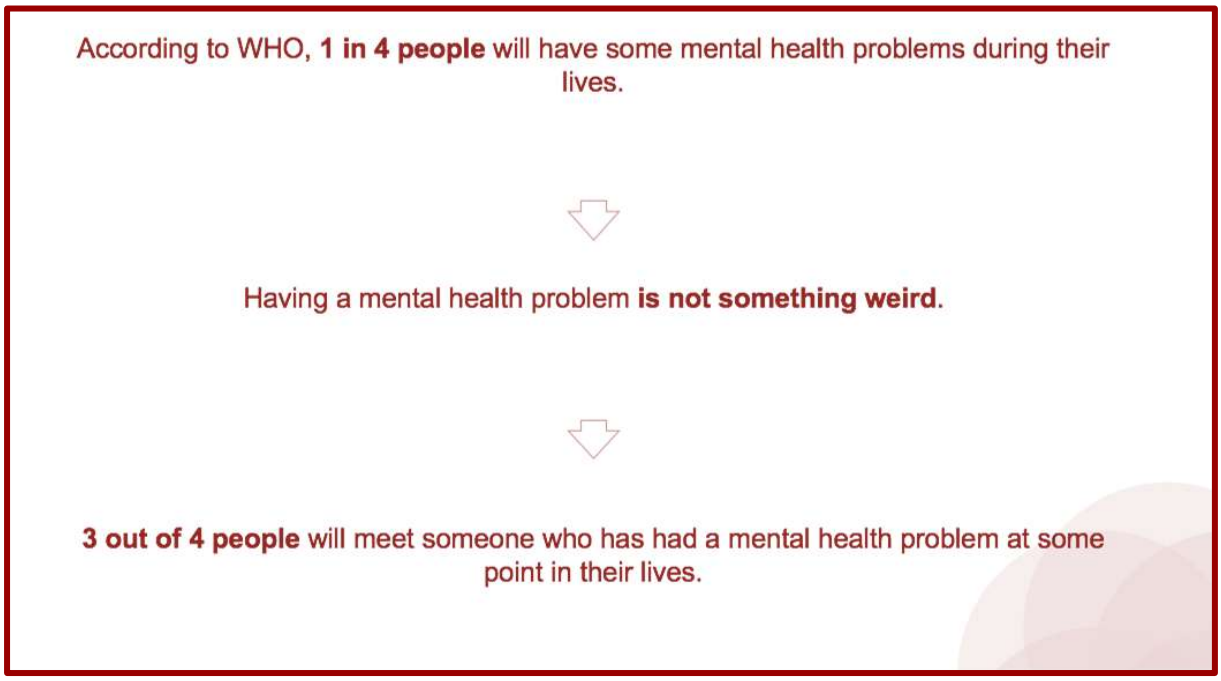
Once we have noted most of the comments that are made. It is advisable to group people's comments into groups of topics or definitions.



Once we have thought about what we meant for mental health, it is necessary to provide a set of key items. First of all, we will depart from WHO's definition of mental health:

"*It is defined as a state of well-being in which the individual is aware of their own abilities, can face the normal tensions of life, can work productively and fruitfully and is able to make a contribution to their community.*" (WHO, 2001):

- Mental health is not (only) absence of mental disorder. Mental health has to do with personal and collective well-being;
- Mental health has to do with participating and transforming the community in which one lives. Being locked in a centre or an institution for long periods of time is not mental health.



As WHO tells us, 25% of people (1 of 4) will have a mental health problem at some point in their lives. Thus, mental health problems are not something weird, they are rather commonplace.

In this line, when we think of mental health problems, we do it thinking of Serious Mental Disorders. We tend to think about the most serious or most affected cases (in terms of symptoms and in terms of disabling). However, mental health problems are diverse and heterogeneous. Psychological distress can be incapacitating for the person, and if it is prolonged in time, it may be the cause of a mental disorder.

Get hold of all the people who know someone you love that has a mental health problem. Although this exercise has no scientific validity, it shows something very clear: The discomfort in mental health is something that is every day that surrounds us, but we still treat it as a taboo and weird subject.

Talking about mental health refers to a concept that goes from the social determinants of mental health, going through well-being and psychological distress to mental disorders.

2.1.1. SOCIAL DETERMINANTS

Mental health is linked to a set of social determinants that make it possible. Housing, poverty, work, and gender violence are social determinants of health that can cause a person or a community to get sick or lose their mental health.

For example, losing your job or not finding it, not being able to pay the rent, be dismissed or not guaranteed the minimum basic foods can be situations that lead people to emotional distress and in the worst cases to generate mental disorders.

Mental health is an individual and collective state that depends on the social determinants of health. Thus, sometimes, our mental health is not linked to our behaviours or responsibilities but rather as a consequence of social circumstances that are harmful or favourable to us.

The intervention on the social determinants of mental health is aimed at generating the necessary social conditions for the well-being of people and communities.

2.1.2. WELL-BEING AND PSYCHOLOGICAL DISTRESS

Mental health also refers to our emotional or psychological states and how we can manage them. Thus, there are situations emotionally complex, painful and hard that if they persist in time can lead the person to trigger a mental disorder. For example, the loss of a loved one can generate a situation of psychological suffering and sadness that requires that the person needs a psychological support to travel in these vital moments.

At this point it is important to remember that there are situations of suffering and psychological distress that are not diseases, therefore, they do not need to be treated with psycho-pharmacists. Traveling through situations of sadness and discomfort are part of life, as well as traveling through situations of happiness and joy.

The intervention on psychological discomfort is aimed at giving the necessary tools to people and collectives to be able to face the experience of certain vital situations.

2·2· MENTAL DISORDER

According to DSM-5, *"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities"* (DSM-5, 2014).

Mental disorders need to be treated by specialist people in order to remit their negative effects. However, the type of treatment as the professional approach of the same may vary depending on the services and the professional people that work there.

In general terms the intervention on the mental disorder is oriented to be able to eradicate the symptomatology and to recover the project of life of the person.

Anyone can develop mental disorder in almost any moment of their lives, in the same way that they can suffer from a physical illness. Mental disorder can be triggered by a series of things, including apparently happy events.

Situations:

- A first job or a begin a new job.
- A bad relationship with the line manager or the boss.
- Getting married.
- Facing a greater workload or promotion.
- A mourning process.
- To have kids.
- Issues of health or physical illness.
- Divorce or rupture of affective relationships.
- Dismissal or fear of dismissal.

Other things can activate mental disorder:

- Trauma, neglect or abuse in childhood.
- Body chemistry
- Substance abuse.

Having a mental health or not having it is not a decision that falls to the person. People do not decide to become ill and, therefore, we are not guilty of having a mental disorder. Having a mental disorder depends on different factors and it is something that can happen to all of us.

Mental disorder can be treat

Mental disorders can be treated by specialists. The health network has specialized services in mental health. These health services have professional teams that provide a clinical response to the effects of mental disorder and can help the people who suffer it.

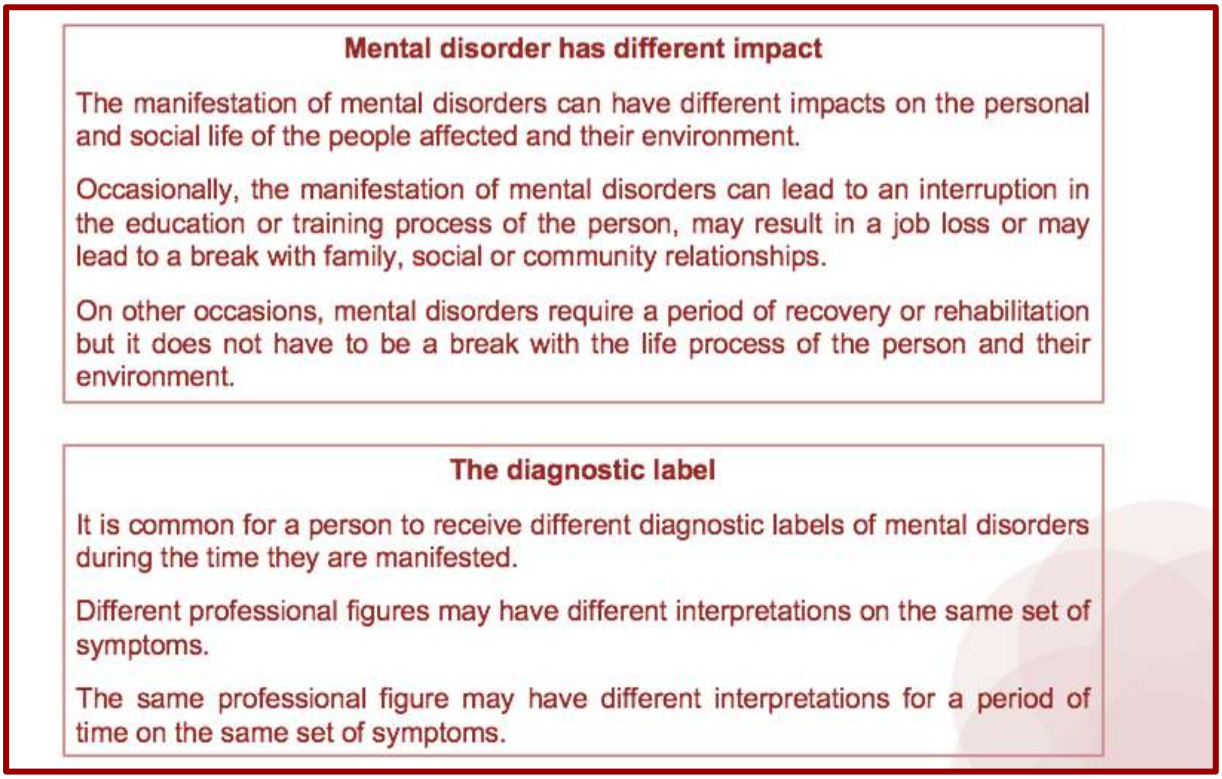
Mental disorder has different manifestations

Mental disorders has different manifestations in time:

- May be that mental disorder is a brief and timely episode, linked to a vital moment, which is not going to repeat again.
- May be that mental disorder has a temporary presence but is going repeat at different times in life.
- May be that mental disorder has a presence of a long period of time, but then it is not going to repeat again.
- It may be that mental disorder will perish over time.

Having a mental disorder is not a sentence; it is a situation that can happen to all of us. It is important to give a message of hope as long as mental disorder can be treated. Sometimes mental disorder can be cured and on other occasions, although not cured, a full life can be taken despite suffering a mental disorder (we will see later).

Having a mental disorder does not mean that you cannot be happy.



2.2.1. MENTAL DISORDER AND ITS IMPACT

Mental disorders can have different effects on the person. The case may be that the person can no longer continue living their lives just as he did before the manifestation of mental disorder. This change may be punctual until the person recovers or can become a change of non-return, as the person has to adapt their lifestyle to the specific needs that the treatment of mental disorder requires.

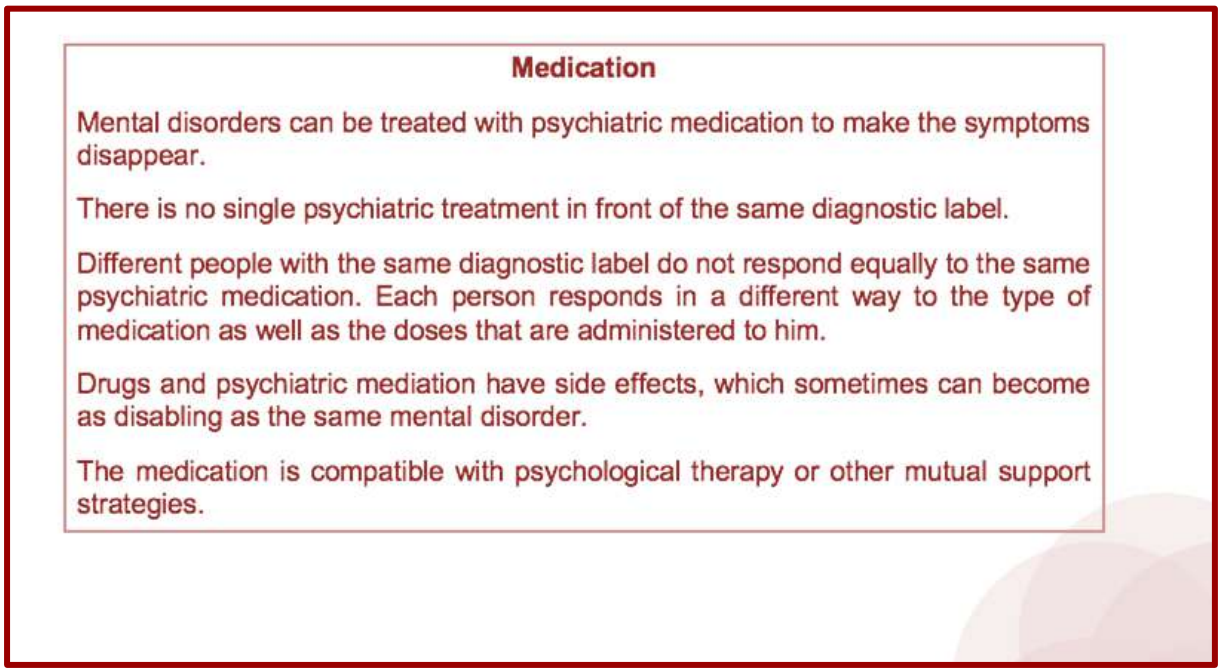
Sometimes the treatment of the mental disorder will suppose a convalescence in which the person must recover of the disorder and will return to his daily life. On other occasions, the treatment of mental disorder will suppose a break with the daily life of the person, a fact that will suppose a disruption with processes of socialization and education or work processes. In these cases, the impact of mental disorder has serious consequences for the person as basic social processes are interrupted to constitute the own project of life.

2.2.2. THE DIAGNOSTIC LABEL

The diagnostic label is a professional tool that is used to guide the intervention of clinical professionals towards mental disorders. However, the diagnostic label has many effects on the person suffering from mental disorder itself.

The diagnosis in mental health becomes an element that has a strong impact on self-perception of the person. While the diagnostic in health care indicates some aspect of our body that has some deficiency, in the field of mental health the diagnosis refers to aspects of behaviour or thinking that have some type of alteration. The diagnosis in mental health has an important impact on the person's identity, as it refers to the qualities and characteristics that define it.

This causes the diagnosis in mental health to become, for some with mental disorder, in a label that defines them. What happens to them, what can or cannot be explained by their diagnostic label. Then, the diagnostic label becomes an attribute of the person that is the first step of the process of stigma and auto stigma (we will see it further).



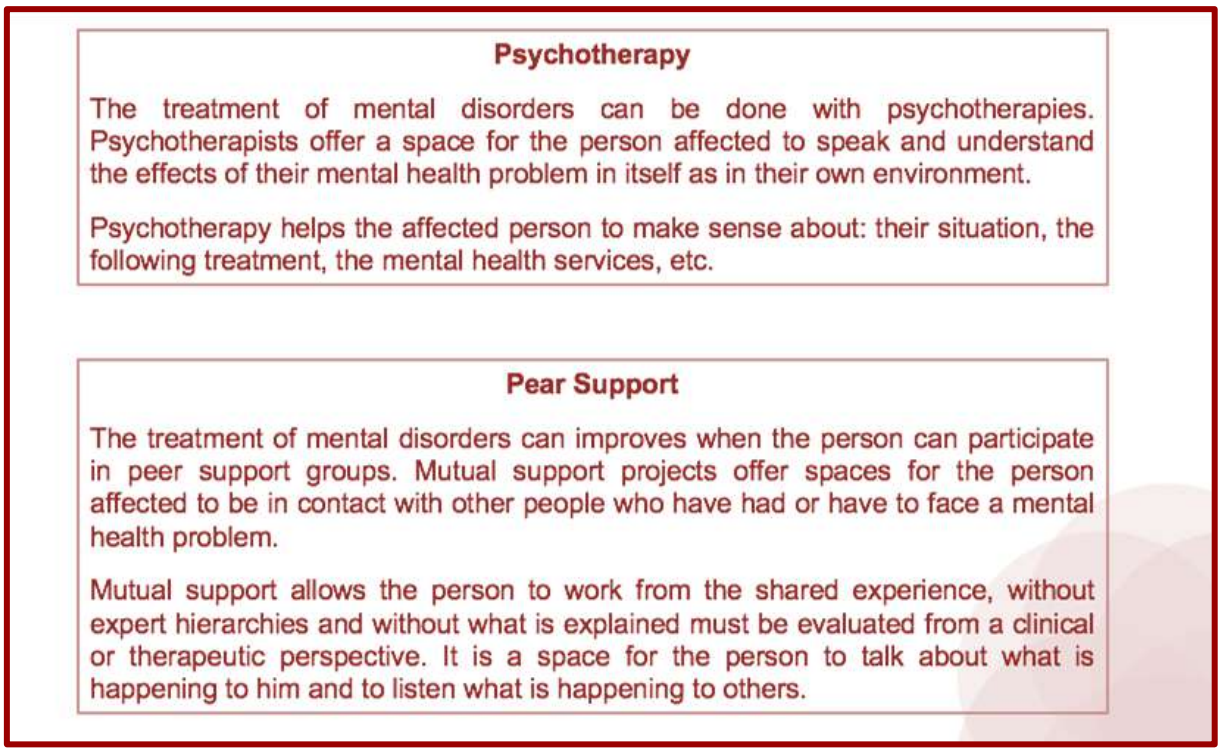
Medication is one of the most controversial issues in mental health. On the one hand, the medication is a fundamental instrument for the control of the symptoms of mental disorders. Thus, medication becomes a basic resource for the treatment of mental disorders, allowing the person to stabilize and, in the best case, can continue to do their daily life. On the other hand, the medication becomes a tool in which the hierarchy and the power relationship between the person with a mental disorder and the psychiatric figure are pronounced (the opinions of the person with a mental disorder are not listen). People with mental disorders comment that medication also generates side effects that do not help the person to become empowered.

It is essential that the psychiatrist and the patient jointly participate in the establishment of a type of medication and in the establishment of the doses so that the medication improves its effectiveness. On the one hand, the psychiatrist has the pharmacological and medical knowledge. On the other hand, the person with a mental disorder has the knowledge of the effects that the medication has on his body. The combination of both knowledge increases the effectiveness of the medication.

Leaving medication or changing its dose is a decision that requires the intervention of the psychiatrist. Medication is a drug that needs a process to be effective in the person's body. It

has no instant effects. And, medication, can generate dependency effects and, therefore, to lose the habit requires a controlled process by the psychiatrist.

The medication does not have to be a mandatory or perpetual treatment when you have a mental disorder. People with mental disorders can also be treated without medication.



Psychotherapy is a clinical intervention that allows people to speak of what they feel and what they live in order to perform a therapeutic work that improves their well-being. In psychotherapy the clinical intervention is done from the word in order to change the sense of live, attitudes and behaviours.

Psychotherapy is one of the most valued clinical interventions for people with mental disorders. Mainly, it is reported that psychotherapy allows the person to be able to talk about what happens to him, including delusions, without necessarily involving a pharmacological intervention or change of it.

Psychotherapy can have different theoretical guidelines (Cognitive Conductual, Gestalt, Psychoanalysis, etc.). This translates into that each psychotherapy has different ways of:

- Define the role of the psychotherapist and the patient;
- The methodology used to do the clinical work;
- The duration of each session and the overall time of the therapy.

Psychotherapy, although mostly performed individually, can also be done in a group format.

Mutual support covers social and emotional needs that are not covered by clinical interventions (pharmacological or Psychotherapy). The treatment is focused on responding to clinical needs, that is, its object of intervention is mental disorder. On the contrary, mutual support is focus towards responding to the vital needs of the person. Those that appear to be followed by psychiatric treatment (for example, understanding the functioning of mental health services, avoiding stigma and discrimination or rescuing self-esteem) as well as those that appear of any life project (for example, family, work or friends)[1].

A support group in mental health is a place for listening and understanding, which brings together several people who share a mental health problem to try to overcome or improve their situation[2].

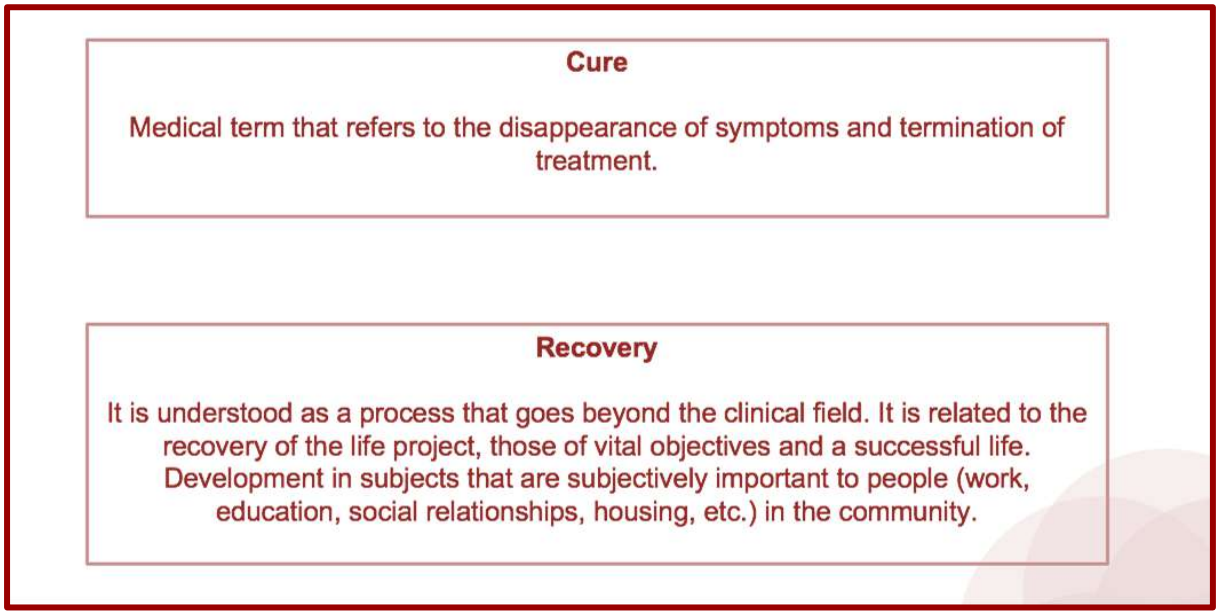
- **It is a collective activity.** It requires a small group of people who undertake to meet periodically to explain their experiences, share experiences and build a social bond based on trust and respect for others.
- **It is an activity to tackle a problem.** It needs all the people who participate in the group to open the support of others. At the time, they offer their experience and their support for the members of the group to improve their situation.
- **It is a horizontal activity.** It represents reciprocity among all the participants. The operation of the group requires co-responsibility. There are no users of pear support

[1] Pistrang (2008). Mutual help groups for mental health problems: A review of effectiveness studies. Am J Community Psychol (2008) 42:110–121.

[2] Caussa, A. & Cordoncillo, C. (2018). Guia per a Grups d'Ajuda Mutua de Salut Mental de persones familiars: http://www.spora.ws/en/projects/guide-for-mutual-support-groups-for-mental-health-of-family-members/

group, but partners, and no one plays a professional role, knowledge is provided by the experience.

2·3· CURS vs RECOVERY



Healing has to do with the disappearance of the symptoms and therefore, with the completion of a clinical treatment. When the doctors give us the discharge is when the cure is terminated: the person is cured.

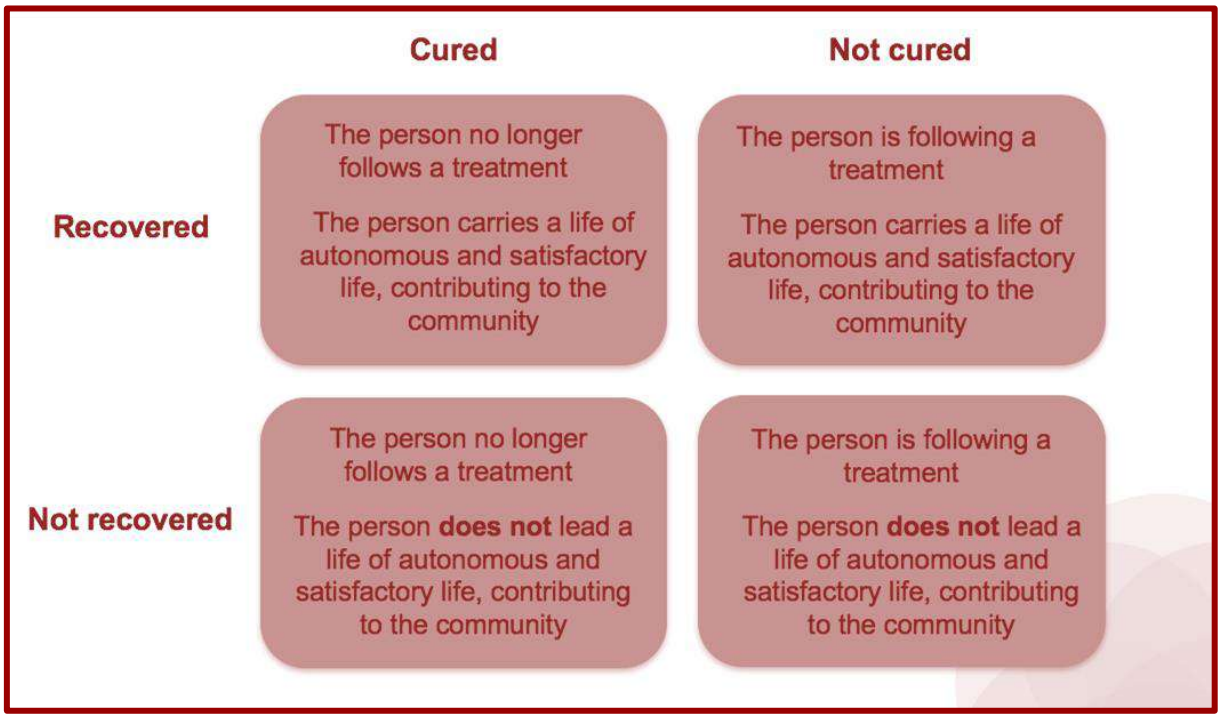
The recovery has to do with the fact that the person can return to govern their life, to be able to have a relation with the community independent of if it is cured. The person is recovered when he can return to lead a full life, transforming the community in which he lives and let himself transform by it.

To bring a full life you do not need to be cured. We can have a diabetes, broken knee ligaments or rheumatoid arthritis and we do not necessarily have to stop working, living in the

community or taking care of our children. Obviously, when we are not cured, we will have to take care of the needs we have due to our illness but this does not have to be a global impediment that affects all our vital areas and all our responsibilities.

The fact of talking about mental health gives us a very clinical approach (from the health scope) to mental disorders that can make it difficult to focus on recovery. From the clinic, traditionally, there is a binary relationship with health: cured or non-cured.

However, crossing this clinical look with a recovery perspective brings us much closer to WHO's definition of health. Which contemplates the relationship with the community and the life project itself as defining health issues.



This double entry matrix shows us the different situations in which a person can be found in relation to a mental disorder. We face four situations if we look at the crossing of the healing and the recovery dimensions.

SITUATION 1: CURED AND RECOVERED The person or has not yet had a mental disorder or has already had it but is no longer treated because they have been given medical discharge.

The person does not do pharmacological treatment or clinical treatment. Likewise, the person is recovered, takes an independent life, participates in the community and attends to their commitments or responsibilities.

SITUATION 2: UNCURED AND RECOVERED The person follows psychiatric and / or psychological treatment for his mental disorder. Continue taking medication and do not have medical discharge. Also, treatment is not an impediment to the person being recovered. The person besides following a treatment also has an independent life, participates in the community and attends to their commitments or responsibilities.

SITUATION 3: CURED AND NON-RECOVERED The person is no longer treated because they have been given medical discharge. The person does not do pharmacological treatment or clinical treatment. However, the person has not resumed an independent life, being able to participate in the community in equal opportunities and being able to attend to their commitments and responsibilities.

This is a typical situation of discrimination in which the person suffers stigmatization due to having had a mental disorder. Thus, the person is at high risk of getting sick because he can not have the same opportunities as the rest of society. Abuses and aggressions that involve stigmatization can lead the person to situation 2 or 4. That is to say, in situations of non-cure.

SITUATION 4: NON-CURED AND NON-RECOVERED The person follows psychiatric and / or psychological treatment for his mental disorder. Continue taking medication and do not have medical discharge. Likewise, the person has not resumed an independent life, being able to participate in the community in equal opportunities and being able to attend to their commitments and responsibilities.

This is a typical situation of admission or convalescence, when mental disorder is disabling us due to its effects.

2·4· DISCOMFORT IN MENTAL HEALTH

"The suffering of the mad exists and is real. What happens is that I have not been able to determine how much of this suffering belongs to the disease itself and how much is the result of the moments of rejection, marginalization and social contempt that a person in my situation has to go through. "

(Princesa Inca)

Discomfort in mental health is not explained only by the effects of mental disorder.

People who have or have had a mental disorder report that the discomfort that causes the stigma and discrimination they experience is more impaired than their own mental disorder[3].

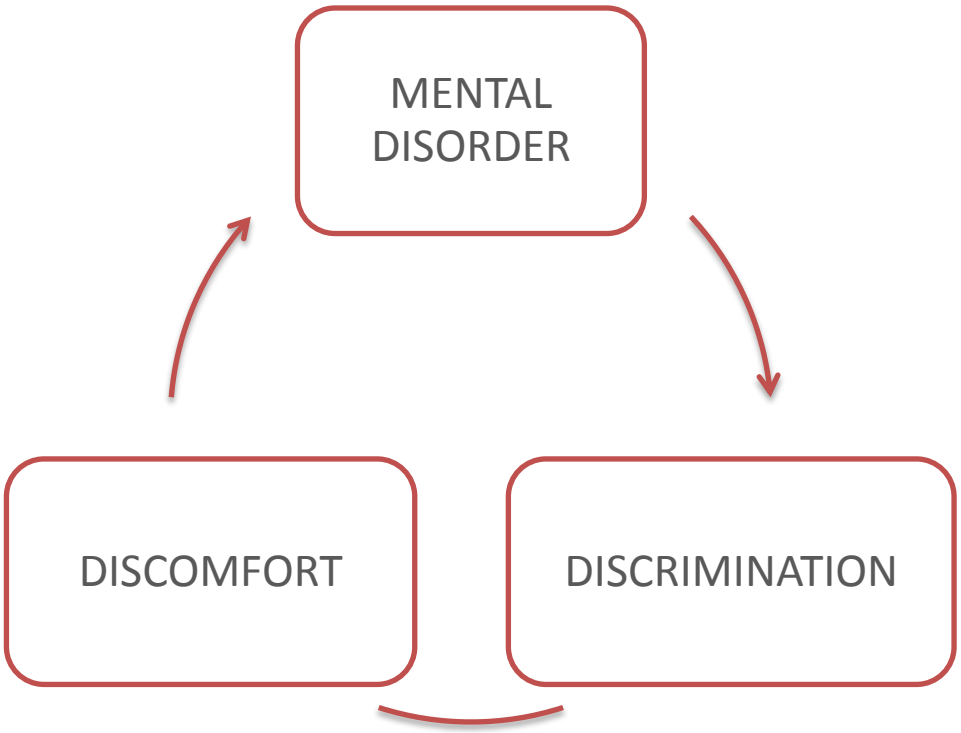
As we have already commented with the Social Determinants of Health, living stigma and discrimination can cause the person to lose their health. Therefore, when you have a mental

[3] Marsh, D.T. i Jonson, D.L; (1997). The Family Experience of Mental Illness: Implications for Intervention. *Professional Psychology: Research and Practice*, 28(3): 229-237.

disorder you can fall into a vicious circle in which the person is constantly experiencing situations of discomfort due to mental disorders and the negative treatment they receive.

The manner that the person receives is decisive for their recovery and well-being. A negative manner also hinders psychological and psychiatric treatment. Hardly a person can solve their discomfort with psychiatric or psychological treatment if they receive a negative and discriminatory behaviours.

Therefore, it is essential to understand that the discomfort experienced by people with mental disorders is not explained only by the effects of the disorder.



2·5· THE RIGHT PLACE FOR THE DIAGNOSTIC

The mental disorder does not explain all the situations that the person lives in his life and all the behaviours that this one unfolds to face them.

THE PERSON IS MORE THAN THE DIAGNOSTIC

"It is important to understand that a person who has been diagnosed with mental disorder does not necessarily live permanently in pathology, nor does he cross the whole day in a state of delirium."

(Radio Nicosia. Barcelona)

"I do not understand how they can relate to me as a total crazy person; I exercise crazy only 10% of my life time "

(Natxo. Barcelona)

Likewise, people have desires and illusions, we have expectations and hopes or we have interests and opinions that go beyond mental disorder. In this sense, what a person done and stop to do in his day to day does not have to be related to his mental disorder. Obviously with

this we are not denying that the circumstances of the person, the mental disorder, can influence or determine the person at different vital moments.

Thinking about the whole person from the diagnosis becomes a discriminatory act. Clinical diagnosis is a professional tool that can become a stigmatizing label when it becomes to be the element that explains all the circumstances that the person lives. Stigmatization behaviour is when the diagnosis becomes a label that accounts for everything that happens to the person.

We recall that the diagnosis is a professional tool to be able to guide the treatment and the recovery of the person. It is a tool that determines a person's specific situation so that professional people can intervene and guide themselves in the intervention.

The fact of having a mental disorder does not presuppose that we are in crisis 365 days a year 24 hours a day. The person is more than a diagnosis label of mental health.

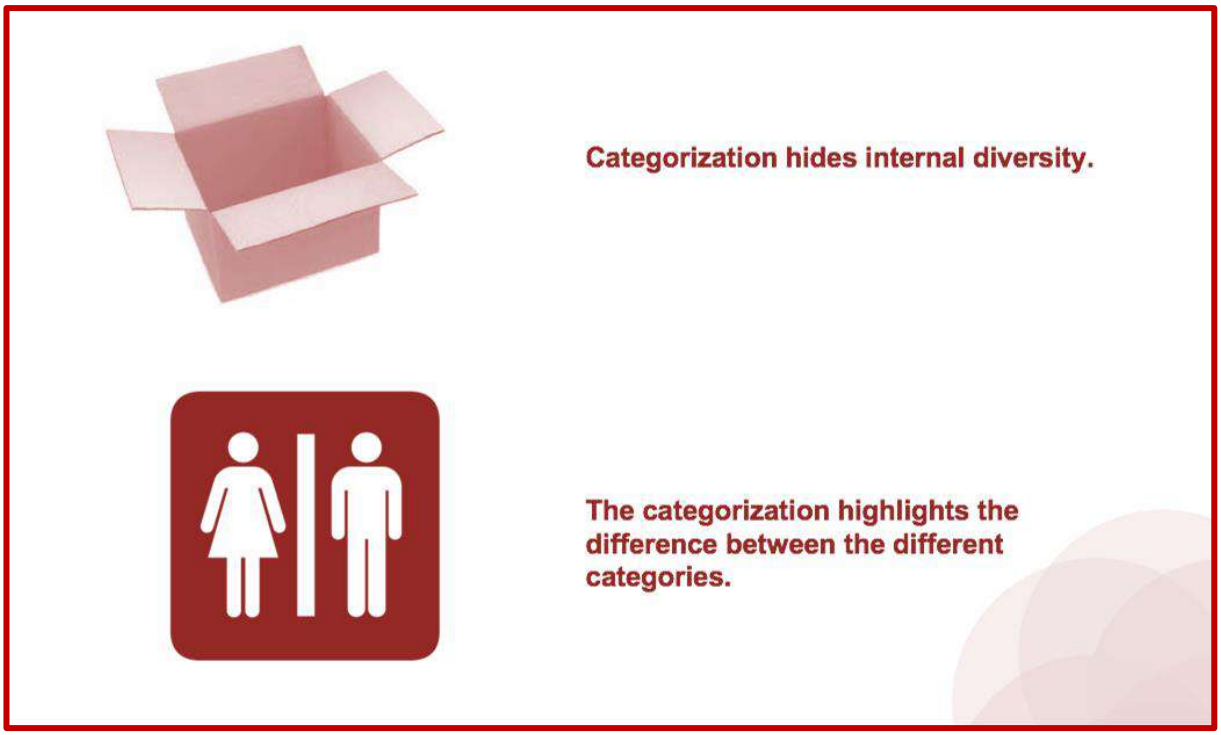
2·6· STIGMA AND DISCRIMINATION

One of the things that characterizes the human beings of the rest of the living beings is that we categorize the world with the purpose to order it. One of the great virtues that Darwin conveyed to us with his work Origin of Species is all the tradition illustrated to classify species living in categories: species, families, subfamilies, etc.

The classification serves us to order the world and to be able to transform and act on it. Categorizing is a cognitive mechanism that we use to classify and understand. In this way, we relate to the world as categorized.

According to Mary Douglas (1986), there are pre-established, collective ways of classifying the world that we tend not to question, that help us to make generalizations in our everyday lives that save us cognitive effort. By creating categories, we avoid having to analyse each and every one of the situations we're met with. This classification of the world is a naturalized "legitimized social grouping," which allows us to interpret the world in a quick and simple manner[4].

[4] Balasch, M. et all (2016). http://www.spora.ws/en/projects/stigma-and-discrimination-in-mental-health-in-catalonia-2016/



According to Muñoz (2006) we can define stereotypes as socially-acquired knowledge structures that represent a general consensus on what characterizes a certain group of individuals.

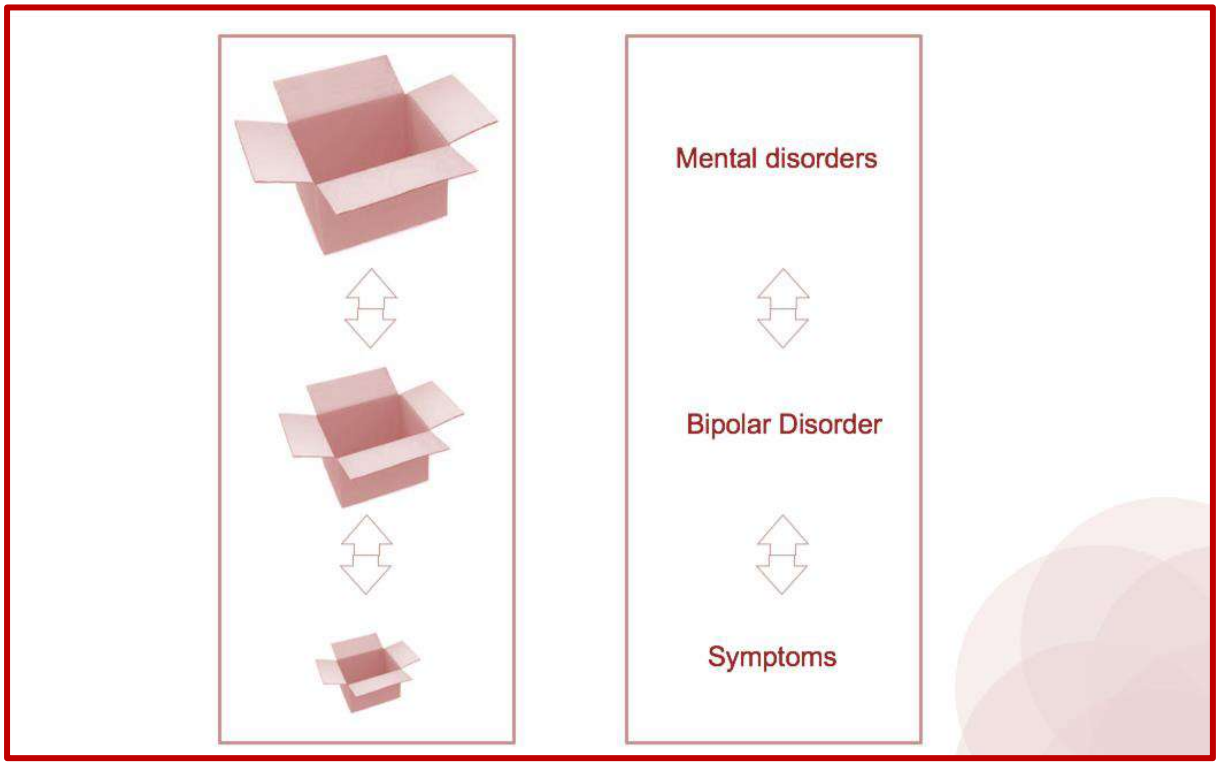
Stereotypes are an efficient strategy for classifying information on different social groups. They are “efficient” inasmuch as they allow us to rapidly generate impressions and expectations on individuals belonging to a certain social category. As a result, attributing certain characteristics to individuals that make up a single social group produces a simplification of reality that allows us to understand it more rapidly. When we meet someone, the stereotypes we’ve built around whatever category they belong to automatically activate.

Obviously, these simplifications include many inaccuracies and generally do not correspond with the reality of the individual being stereotyped. Nevertheless, eliminating stereotypes is a complex task, precisely because of the important role they play when it comes time to interpreting the world around us in an “efficient” way, with as little cognitive effort as possible.

As we have said, by cognitive economy, these stereotypes and prejudices allow us to understand and anticipate social phenomena. For example, in the face of certain stereotypes, we determine if a person is dangerous without making an exhaustive analysis, and we quickly put on a defensive attitude and behaviour (regardless of whether the person is really dangerous).

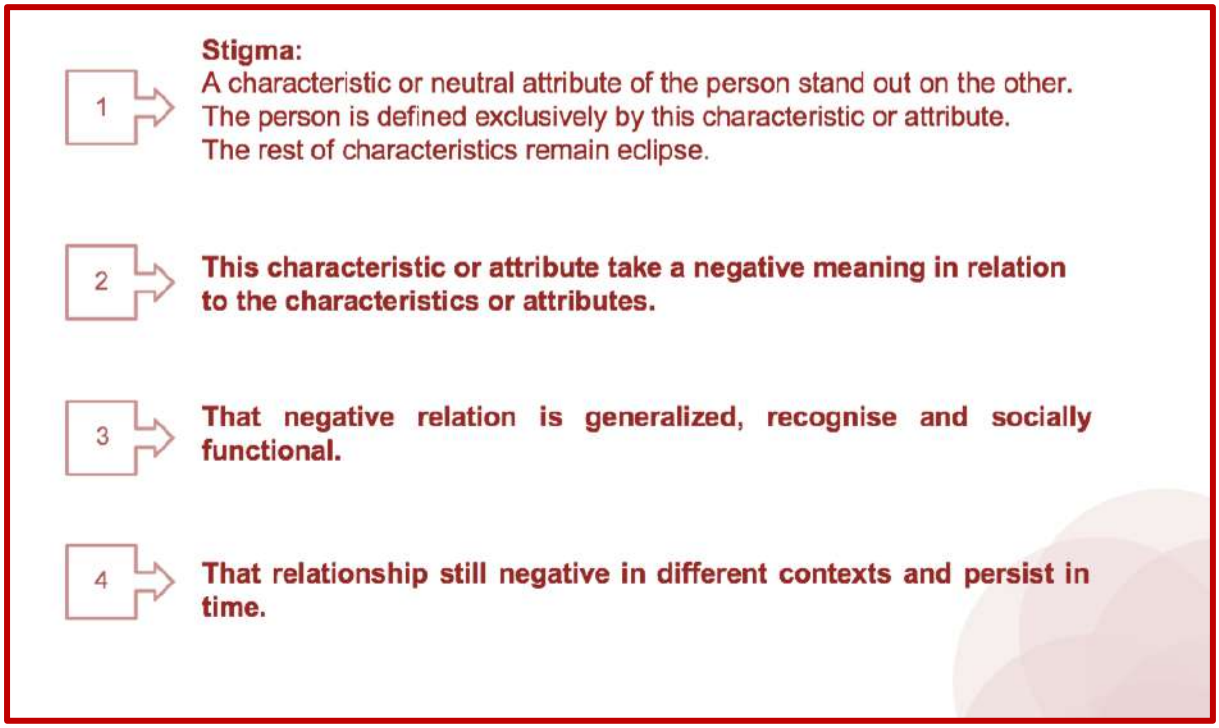
The effect of categorization is to homogenize all categorized elements or all individuals that are within the social category. Although the differences between individuals within the same social category are significant among them. The strength and functionality of categorization makes us perceive them as equals as we have them labelled as equals.

In the same way, the categorization highlights the differences between the elements or people of different categories. Those attributes or differential characteristics between two categories are highlighted above the other attributes that are similar among categories. For example, talking about men and women causes common aspects of both gender categories to lose relevance when defining them.



In addition, we can make categories within categories. As we already anticipated with the example of the Origin of Species of Darwin, we can have species, families of species and sub-species.

In the case that concerns us, mental health, we can categorize symptoms, which when grouped together generate specific categories of mental disorders (for example, bipolar disorder), which when grouped together generate the category mental disorders.



Here we explain the social mechanism in which the stigma is built and constitutes a social collective. Here we are an example with the gender category of woman.

1. We define a person as a woman. And the characteristic woman eclipses the rest of the person's characteristics. The rest of the characteristics are not keep it in mind: it doesn't matter if the person is a multinational directorship, family mother or professional sportswomen.
2. The female category takes on a negative meaning in relation to the other attributes of the person. Women are passive and fragile.

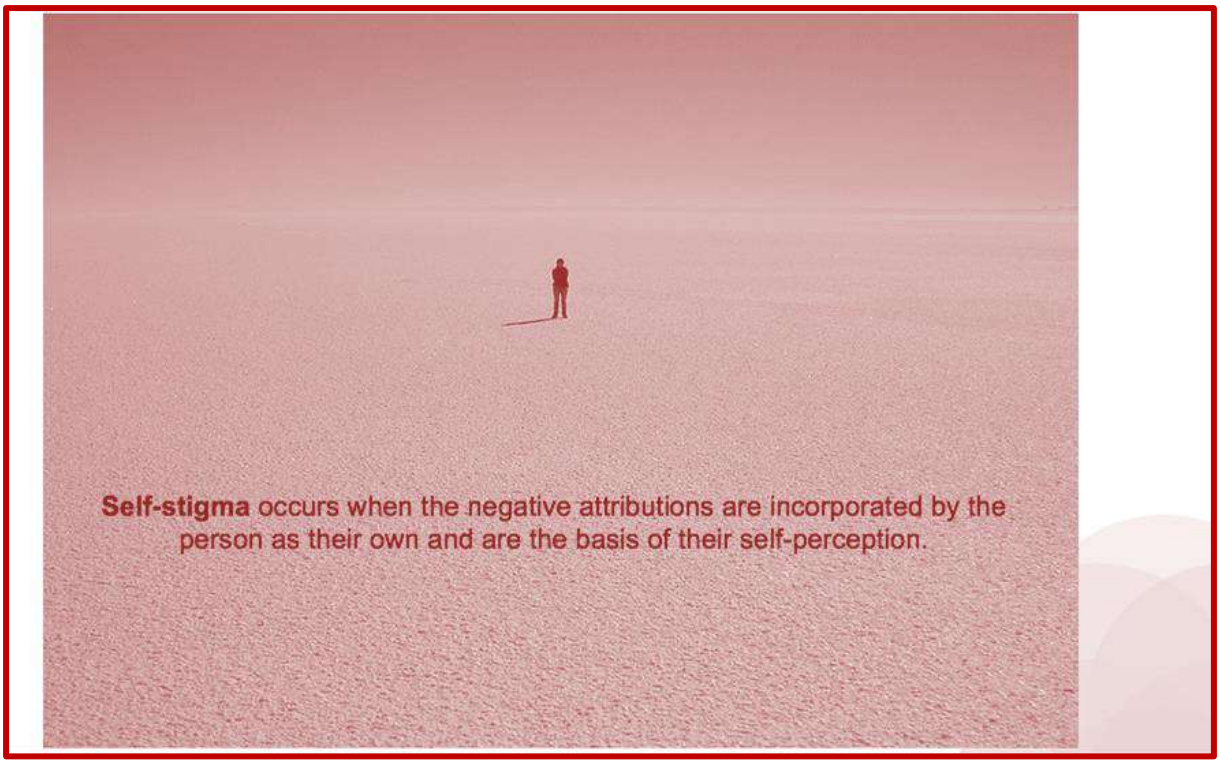
3. This negative relationship of the characteristic woman is transformed into a social category. All women are passive and fragile. In addition, this category is socially recognized. Women do not drive cars well because they are passive and fragile. And it is also functional, that is, we accept that they are driving badly and that are the cause of traffic problems or traffic accidents.
4. This negative relationship of being a woman happens at all times and in all contexts. The women are fragile and passive and therefore they drive badly day and night, on vacation or working, alone or accompanied. They were fragile yesterday, today and they will be tomorrow, and therefore, they have always driven badly and will continue to do so in the future.

Instead of women, we can talk about the characteristic mental disorder, sexual orientation or skin colour. In all cases, the stigma is constructed follow these 4 steps.

"The term stigma will be used, then, to refer to a profoundly discrediting attribute; But what is really needed is a language of relationships, not attributes. An attribute that stigmatizes a type of possessor can confirm the normality of another and, therefore, is neither honourable nor ignominious in itself. (...)

The lasting attributes of a particular individual can turn it into a stereotype; he will have to play the role of stigmatized in almost all social situations that he has to live, and it will be natural to refer to him, as I have done, as a stigmatized whose life situation places him in contrast with the normal ones."[5]

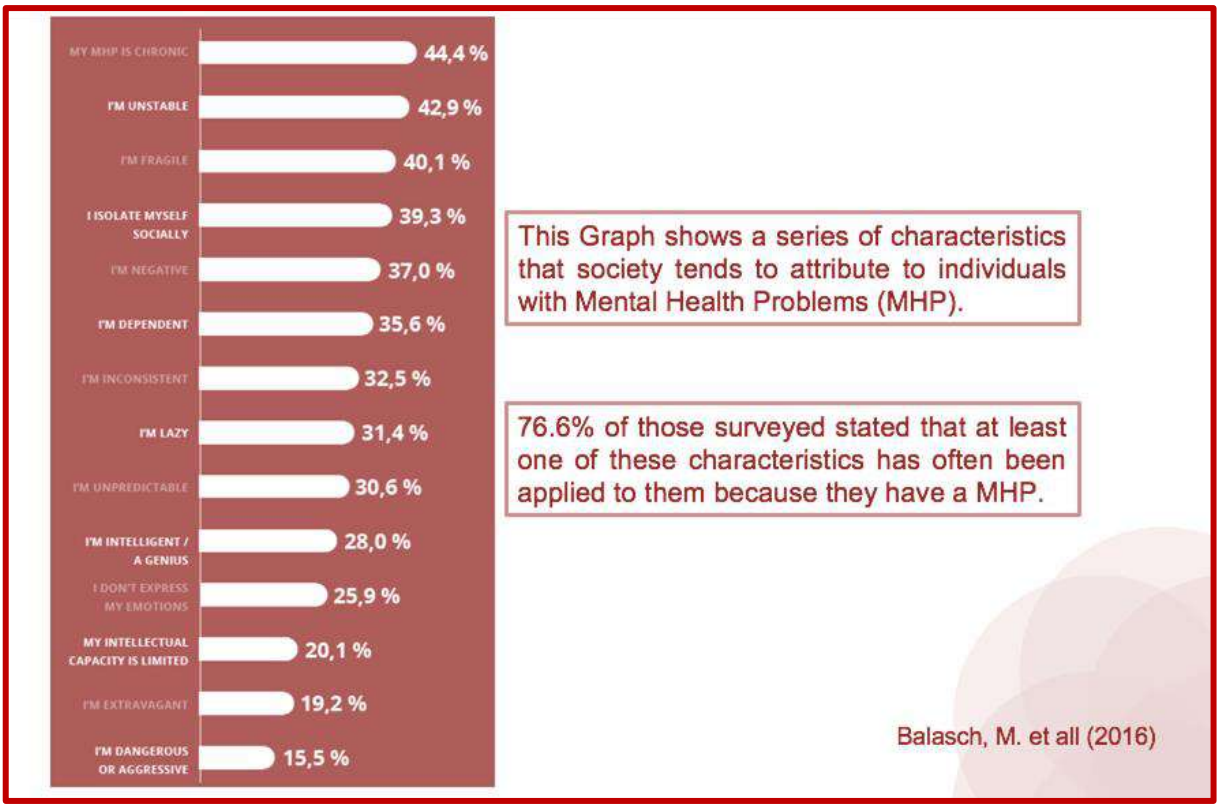
[5] Goffman, E. (1963). Stigma.



The concept of self-stigma shows us the close relationship between categorization and the social construction of identity.

Our identity is built based on the relationships we establish with others. If the relationship with others is determined by negative stereotypes (stigma and discrimination) because of mental health the identity will be affected. It will be built in a negative way because the prejudice. Finally, the person ends up internalizing stigma as part of their own identity. For example, the person has defined himself as ill and incapable of the negative stereotypes attributed to him for years.

However, we like it or not, people have a place or position in society when are stigmatized. Just as time and efforts have been necessary for the stigma to be a part of the own identity, time and efforts are also necessary for the identity of the person to become another without a stigma self-perception.



CHRONICNESS

According to this stereotype, once MHPs appear they become chronic and do not subside. Chronicness is a characteristic that's principally associated with psychotic disorders and schizophrenia.

As can be seen in the quote above, this assumption strengthens the relationship between MHPs and the identity of the individuals that have them. Instead of having them, they are them; the individual no longer has a MHP, they become a MHP, and instead of having schizophrenia, they are schizophrenic. As we will see, this totalization of the relationship between the individual and their MHP has negative effects, and strengthens auto-stigma.

The chronicness of MHPs doesn't simply refer to a situation that will remain unchanged throughout the individual's life; it also serves to underline the fatality of the future with which the individual is faced. It allows others to assume that if an individual is affected by a MHP,

there's nothing they can do to improve their quality of life, and they'll be condemned to suffer from it for their entire lives. To this end, the idea that MHPs are always chronic promotes an irreversible fatality with strong negative connotations.

PERMANENT INSTABILITY

The attribution of instability tends to include the idea that individuals with MHPs6 are permanently in a crisis situation or suffering from an outbreak. This generalization casts the typical characteristics of an outbreak on all individuals with MHPs and assumes these are constantly present. This idea doesn't take into account periods in which the symptoms of the disorder recede, nor does it contemplate periods of stability. It assumes that individuals with MHPs are permanently divorced from the reality around them, or that their perception of reality is perpetually altered.

UNPREDICTABILITY

This characteristic refers to the idea that individuals with MHPs might unexpectedly begin to act in a socially unacceptable manner at any moment. This assumption includes certain reactions and behaviours that place those around them at risk and that, in addition, happen at random. According to this explanation, the reactions of people with MHPs don't follow any sort of pattern, they can't be predicted, and they appear unexpectedly. As a result, those AROUND THEM HAVE NO WAY OF PREDICTING THEIR BEHAVIOUR.

[6] Mental Health Problems (MHP).

DANGEROUSNESS / AGGRESSIVENESS

According to this perception, individuals with MHPs tend to be dangerous and aggressive. It's considered that the characteristics of their disorder –voices, negative thoughts,

impulsiveness, etc.— cause them to commit violent acts. It's considered, as a result, that individuals with MHPs are potentially more dangerous than others.

As we can see, this is the prejudice that appears to a lesser extent when we asked to people with a mental disorder what stereotypes attribute due to their mental disorder. However, this fact radically contrasts with the approach given by the media and, above all, with the impact they have as a social loudspeaker.

The discourse analysis of the information published in 2016 from international communication agencies or correspondents abroad, stand out the connection that is made between people who have mental health problems and danger. The 68.18% are news that reinforce social perception that people who experience mental disorder can be dangerous, violent and with a tendency to crime[7].

INTELLIGENCE / GENIUS

This characteristic is based on the idea that the brains of individuals with MHPs have a different structure. This causes individuals with MHPs to have certain traits or qualities that place them above the rest, and explains why they have superior intelligence or are very creative. This idea is related to the myth of the "mad genius," according to which individuals with MHPs aren't limited by social conventions, and as a result they filter information and stimuli in unexpected, creative and innovative ways. Their MHPs are gifts that allow them to process information in an unconventional manner.

[7] Media Observatory and Mental Health of Catalonia. 2016-2017 Report.

This is the only prejudice that sends a positive feature to people with mental disorders. It is what is called a false positive. However, as we discuss the WHO statistics and against this prejudice, one in four geniuses will have a mental health problem.

AFFECTIVE FLATTENING / SOCIAL ISOLATION

This stereotype assumes that individuals with MHPs suffer from affective flattening, whether because of their medication or because of their mental disorder. In other words, they are absent, they don't express emotions, and they have a lost gaze and little emotional feeling. This trait supposedly prevents others from establishing an empathetic relationship with them, since emotional expression is necessary for quality relationships.

CONTAGIOUSNESS / SOCIAL CONTAGIOUSNESS

Firstly, there's the idea that the probability of developing a MHP is higher among those who interact with individuals with a MHP. This doesn't happen because of physical contact or proximity, but because of being in contact with an individual who lives in a disordered and chaotic reality. Associating and interacting with individuals with MHPs includes the risk of being drawn into this disorganized "other world," and, as a result, of developing a MHP or suffering from some kind of mental disorder.

The second manifestation of the idea of "contagiousness" is on a more symbolic and social level. According to this idea, interacting with individuals with MHPs involves the risk of being socially rejected. Since individuals with MHPs are socially discriminated, those who openly interact with them can also attract discrimination. In this case, what is contagious isn't the MHP itself, but the discrimination and stigma that are associated with it.

INABILITY / DEPENDENCE

The stereotype of inability refers to a diverse group of activities from everyday life that individuals with MHPs can't correctly execute. As a result, it's assumed that they are dependent on others supervising and managing those activities. It's assumed that individuals with MHPs don't have the abilities they need to manage their finances, they aren't prepared to be parents, or they're not capable of driving.

When individuals are stereotyped as incapable and dependent, this idea becomes a self-fulfilling prophecy (Merton, 1968). In other words, if the individual's social surroundings – family and friends, for example: assumes that they are incapable of doing certain things, the way they are treated will coincide with this expectation. This causes the person to doubt themselves, to feel insecure about their abilities, and this ends up confirming the suspicion. The phenomenon of the self-fulfilling prophecy happens, then, when expectations regarding the abilities of an individual influence how they see themselves.

EXTRAVAGANCE

This stereotype is based on the idea that individuals with MHPs don't follow the social norms and codes that regulate interaction and communication. It's believed that one of the traits of individuals with MHPs is strange behaviour, a non-empathetic communication style or the absence of the ability to connect with others.

When this stereotype is present, anything an individual with a MHP does that doesn't fit with social norms and conventions is explained as a symptom of their MHP. And, on the other hand, behaviours that don't respond to social conventions tend to be associated with MHPs, whether the individual has one or not. This stereotype can result in what is sometimes referred to as a 'false positive', meaning that individuals without a MHP are considered "mentally ill."

COGNITIVE DEFICIT

Since individuals with MHPs are believed to be divorced from reality, this is interpreted as a cognitive deficit. According to this explanation, individuals with MHPs have difficulty with learning, abstract reasoning or correctly understanding aspects of everyday life, since the MHP must significantly reduce their cognitive abilities.

THE FALLACY OF THE SINGLE CAUSE

This fallacy arises when any attitude or behaviour is seen as a symptom of the individual's disorder, and no other possible factors or variables are taken into account. The MHP becomes the explanation for everything. This simplification of causal reasoning denies the existence of the individual beyond their disorder. The person becomes their MHP.

Because of this, any way the person with a MHP behaves is understood as a symptom of their disorder, which causes them to lose legitimacy when it comes time to express their emotions or express their opinions, which are pathologized and seen with contempt.

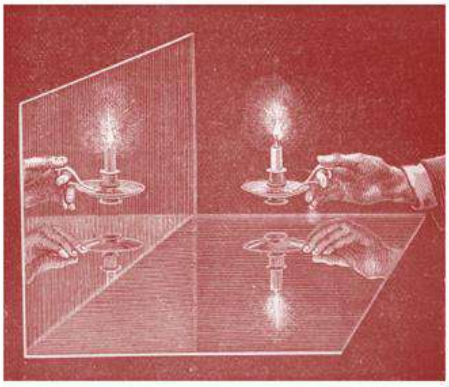
LAZINESS

Similarly, to what happens with other disorders or illnesses, it's often assumed that individuals with MHPs tend to be lazy, and that they don't recover from their illness because they have no desire to do so. This explanation assumes that people with MHPs take advantage of their medical situation so that they don't have to work or manage their lives, etc. Laziness is not considered to be a direct consequence of the disorder, but rather an attitude adopted once the individual is granted leave or is recognized as having a disability.

FRAGILITY

This stereotype assumes that individuals with MHPs that don't externally show any imbalance are really in a state of precarious balance. Even though they seem to be fine, the smallest thing might bring them crashing down. In addition, because of the nature of their MHP, it's impossible to know what might provoke the collapse of their state of balance.

This stereotype suggests a cardboard box with "fragile" marked on it. Externally, it doesn't seem fragile, but we've been informed that it is. We don't know what is inside, we don't know if what we're supposed to avoid is dropping the box, turning it upside down, or shaking it.



80% said they had been **treated unfairly** in some area of their lives (personal, social, work and / or social health) because they had a Mental Disorder.

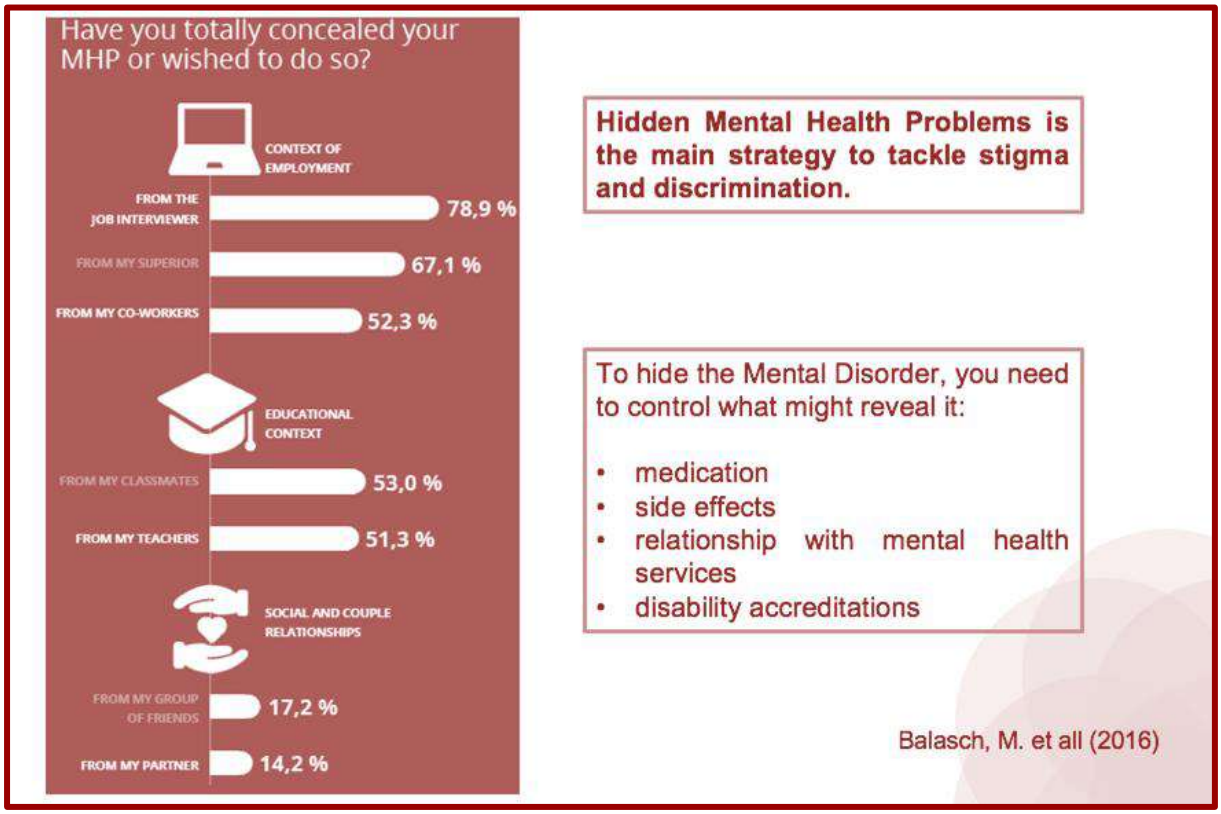
55% say that this negative treatment has been **quite or very frequent.**

Balasch, M. et all (2016)

Stigma and discrimination are frequent social phenomena for people who have or have had a mental disorder. One in two people live in frequent discrimination in one of their vital areas.

Thus, the prejudices and stereotypes that have been explained in the previous ones end up triggering discriminatory behaviours that suppose a loss of opportunities and rights of the people who have or have had a mental disorder.

2.6.1. THE MAIN STRATEGY AGAINST DISCRIMINATION



Hidden is the strategy most often used by people who have or have had a mental disorder to dealing with stigma and discrimination. Having a mental disorder is not something that is obvious, that it can be easy perceived or detected. Unlike gender discrimination or racism, (we cannot hide our condition as a woman or our skin colour) people who have or have had a mental disorder can hide it (more easily). Thus, people hide the fact of having a mental disorder to avoid being discriminated against.

As shown in the chart:

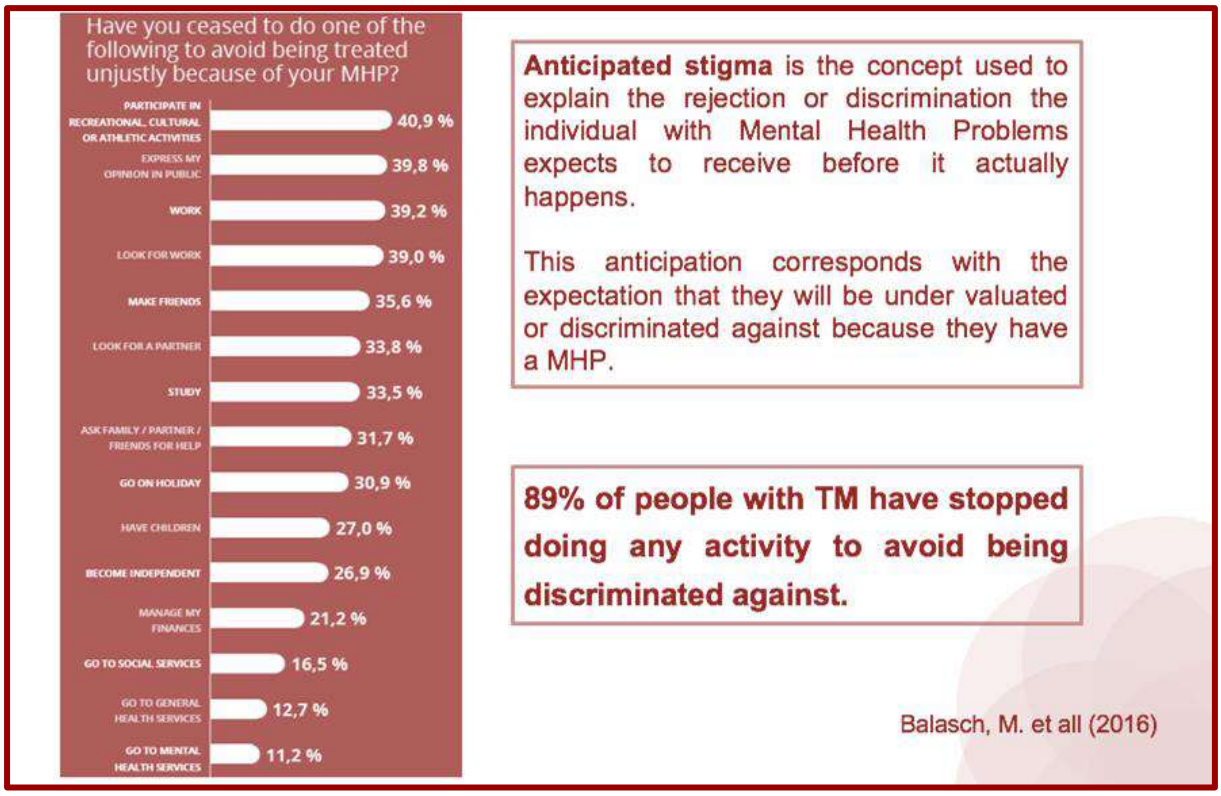
- 78% of people with mental disorders conceal their mental disorder in job interviews and 51.3% for teachers
- In contrast, in affective relationships of proximity the concealment is reduced significantly: 17.2% with friends and 14.2% with the couple

However, concealing mental disorder also has negative effects on the person. Hiding the mental disorder effectively has a cost to the person, since he must be constantly controlling what his environment perceives and knows about itself.

Thus, for example, you will have to:

- Hide the medication. Many people report going to the baths to take the psychiatric medication to not have to give explanations about it
- Many people try to hide the side effects of the medication or explain that they are due to other reasons (other socially accepted illnesses)
- Many people have to hide their relationship with mental health services and their professionals. Then, they must request that the documents of the visit do not specify the reason or the disease they are receiving
- They do not want to access the certificate of disability or the aids they receive due to a mental disorder so that they cannot be known.

2.6.2. ANTICIPATED STIGMA



People stop doing everyday activities for fear of being discriminated against. People anticipate situations and value if they will be discriminated against before this happens. At the root of these assessments, which in no case are imaginary (one in two people is often discriminated against), people stop doing basic social activities.

The social imagination presupposes that people with mental disorders are less sociable than the rest. However, it would be appropriate to say that people with mental disorders are discriminated against and that this has a negative impact on their development of social activities.

As the graph shows, people stop:

- Express the opinion in public (39.8%)
- Search for a partner (33.8%)
- Leisure activities (40.9%)
- Work (39.2%)
- Search for a job (39%)

2.6.3. STIGMA'S PRINCIPAL EFFECTS

Stigma and discrimination can have negative effects on well-being and recovery in many ways:

1. Discouraging people when they ask for help when they feel that something is not going well, which is delaying the treatment.
2. Disturbing the people affected by a mental disorder in being able to speak with their friends or with the family; and generating social isolation, a fact that in itself can further aggravate mental disorder.
3. Acting as a strong mechanism of exclusion that can have effects of social isolation when the person is diagnosed.
4. Generating barriers to the recovery of the life project by reducing job opportunities, education or participation in the community.

The combination of these factors can result in a lower quality of physical health, higher levels in the ratios of morbidity and mortality and at poor levels of social and economic participation.

PART III |LAW, JUSTICE AND HEALTH

3·1· INTERNATIONAL MENTAL HEALTH CARE LAW

3.1.1 INTERNATIONAL PRINCIPLES

- Promotion of Mental Health and Prevention of Mental Disorders
- Access to Basic Mental Health Care
- Mental Health Assessments in Accordance with Internationally Accepted Principles
- Provision of the Least Restrictive Type of Mental Health Care
- Self-Determination
- Right to be Assisted in the Exercise of Self-Determination

3.1.2. INTERNATIONAL STANDARDS AND GUIDELINES

International standards and guidelines are all general statements of principle meant to guide governments and service providers. They are not binding or enforceable in any way if they are not followed.

The following international documents set out a range of standards and guidelines that are particularly relevant to people with mental illness:

- United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities
- United Nations Basic Principles for the Treatment of Prisoners
- United Nations Standard Minimum Rules for the Treatment of Prisoners
- United Nations Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment
- World Health Organisation Mental Health Care Law: Ten Basic Principles (1996)
- United Nations World Program of Action Concerning Disabled Persons

3.1.3. MENTAL HEALTH AND HUMAN RIGHTS

- The UN convention on the rights of persons with disabilities - Convention on the Rights of Persons with Disabilities (CRPD)
- The Convention on the Rights of Persons with Disabilities (CRPD) was developed by the United Nations. Australia ratified this treaty in 2008 and has also ratified its Optional Protocol. The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all hu-man rights and fundamental freedoms for all people with disability, and to promote respect for their inherent dignity.

- The CRPD does not define 'disability' or 'persons with disability' but in Article 1 it is made clear that the class of persons to whom it applies includes persons with long-term impairments. This certainly includes people with mental health conditions.
- The Optional Protocol to the CRPD allows an individual to make a complaint to the United Nations Committee on the Rights of Persons with Disabilities if they believe one or more of their rights set out in the CRPD have been violated, where there is no reasonably available domestic remedy for that violation.
- The CRPD comprises 50 articles, 20 of which articulate specific human rights as they relate to the needs and concerns of persons with disability. Among these rights are some that have particular significance to the specific forms of human rights violation disproportionately experienced by persons with mental health conditions. These include the right to equal recognition before the law (Article 12), which recognises and protects the right of persons with disability to exercise legal capacity, protecting the integrity of the person (Article 17) which seeks to protect persons with disability from unwanted, non-consensual interference with their person, and living independently and being included in the community (Article 19) which recognises the right of persons with disability to live in the community with support and prohibits institutionalisation. The right to Health (Article 25) and the right to Habilitation and Rehabiliation (Article 26) also contain elements that have specific significance for persons with mental health conditions in that they both stipulate that health care and rehabilitation must be provided on a voluntary basis, and seek to protect persons from involuntary treatment. Additionally, the right to Habilitation and Rehabilitation recognises and protects the rights of per-sons with disability to receive rehabilitation in the community in a manner which supports inclusion rather than segregation from community life.
- International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR)
- The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) are the two main international treaties that expand in detail on the principles in the Universal Declaration of Human Rights and set them out in a legally binding agreement between countries. Both are treaties developed by the United Nations. Together with the Universal Declaration of

Human Rights, these treaties are sometimes referred to as the 'International Bill of Rights.' The Second Optional Protocol to the ICCPR enables individuals to make a complaint to a United Nations committee if they believe one or more of their rights set out in the ICCPR have been violated, in circumstances where there is no reasonably available domestic remedy for this violation. Article 12 of the ICESCR recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

- Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- Convention on the Rights of the Child (CRC)

PART IV | PSYCHO-EDUCATIVE INTERVENTION ON LAW, JUSTICE AND HEALTH

4.1. CHALLENGING NEGATIVE ATTITUDES AND BELIEFS ABOUT THE POLICE

Survey research has shown that most people generally support the police and are satisfied with the way the police perform their duties. While these findings are encouraging, our experience tells us that not all the people have the same perception. The people we work with, under the probable influence of either negative personal experiences or neighborhood and peer contacts, tend to evaluate the police negatively, maintaining beliefs that hamper their confidence in the police forces.

EXERCISE

1) Promote an open dialogue about police, police intervention and the role of the police forces in our society. Listen actively to everyone's opinion and try to softly challenge some of the negative beliefs and attitudes towards police.

2) Questions to be asked (examples):

a) How do you feel around police officers? Do you feel safe or threatened?

b) Do you think all police officers are the same and act the same way?

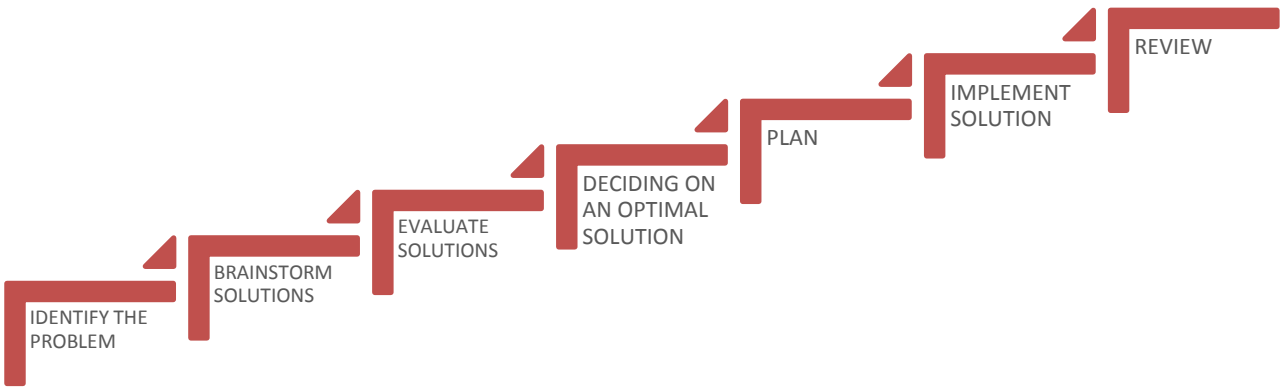
c) Have you ever had a negative contact with police? And a positive one?

d) What do you think is the role of the police?

4.2. A STRUCTURED APPROACH TO PROBLEM-SOLVING

STPEPS

The following steps offer a structured approach to the resolution of problems



STEP 1: IDENTIFY THE PROBLEM

Getting a clear definition of the problem is critical to successful resolution. Understanding the specific problem also helps us to know when the problem has been resolved, that is, how thing will be different.

STEP 2: BRAINSTORM SOLUTIONS

Brainstorming involves coming up with as many alternative solutions as possible. Encourage everyone to use their imagination – no matter how absurd the idea may seem. Ridiculous solutions can sometimes lead to discovery of a better solution than those that were more obvious at first. At this stage, possible solutions are just generated – not discussed. It is helpful to write these down for evaluation later.

STEP 3: EVALUATE SOLUTIONS

List all the positive and negative features of each solution. Remember even bad solutions can have positive features such as being easy to apply but not really solving the problem.

STEP 4: DECIDING ON AN OPTIMAL SOLUTION

The goal at this point is to pick a solution or set of solutions that seem the best option for resolving the problem. It is best if this solution is one that is not too difficult to implement. This may mean deciding upon a solution that may not be the “ideal” one. A workable solution can help get started toward a resolution of the problem. Even if it doesn’t work, what is learned from it can be helpful if further action is needed. This is likely to be a better course of action than choosing a solution that is impossible to achieve.

STEP 5: PLAN

Resolution of a situation often involves taking a number of steps. Working out the details of the plan will help to ensure its success. Does everyone involved know what they need to do? Have you planned any strategies for coping with unexpected difficulties?

STEP 6: IMPLEMENT SOLUTION

Once you have the plan and the steps figured out, put it into action!

STEP 7: REVIEW

Problem-solving can require a number of attempts. It is important to evaluate the process as you move along. The first attempt to resolve the problem may not succeed – hitches or unexpected difficulties may arise. Some steps may need to be changed or new one added. It is important to remember what has been learned and to praise the efforts of those involved. If the solution does not work, ask yourself (and those involved) the following questions:

- What actions or steps were successful?
- What actions weren't successful?
- What could have been done differently?

a) Encourage everyone to acknowledge feelings of disappointment but don't dwell on them. Failure is usually the result of poor planning or events beyond anyone's control rather than inadequacy of the person.
b) Any attempt is a small success that should be praised. It may help to consider the first few attempts as practice or as steps to resolving the problem. Even partial solutions are useful. Encourage the individual to try again.

PROBLEM-SOLVING SCENARIO

Mary is bothered by the fact that John comes to her at the end of each month for money. Although he has a part-time job and receives disability benefits, he always seems to be broke at the end of the month. John doesn't like having to ask Mary for money. They decide to see if they can think of a solution to this problem.

a) Define the problem
b) Vague: John is always broke.
c) Specific: John runs out of money at the end of each month and asks Mary for additional funds.

BRAINSTORM SOLUTIONS

a) John could keep a record of spending – dates and items purchased. This will help him to set up a budget.
b) John could ask for more hours.
c) John could ask an increase in his salary.
d) John could make fewer purchases.

EVALUATE ALTERNATIVES

a) A record of spending will help to know where his money is going.
b) More hours will bring in more money.
c) John has been doing good work at his job and deserves a raise.
d) By not buying as much, John will have more money in his account. He wouldn't have to ask Mary for money and could start saving for more expensive items he'd like to buy.

- John has never ha d to keep a record and may find it difficult to do
- John is reluctant to work more as it puts more stress on him
- John is scared to ask his boss for a raise
- John would have to change his route home to avoid going by the stores

DECIDE ON OPTIMAL SOLUTION

John and Mary decide that John will keep a record of spending so they can create a budget for him and figure out where he can cut his spending

PLAN STEPS TO BE TAKEN

They work out a plan so that it is easy for John to remember what he buys

IMPLEMENT PLAN

John keeps a record of the purchases he makes and bills that need to be paid

REVIEW

- At the end of the following month, John and Mary review John's record of spending. Although he still ran out of money, the record provides useful information about what John spends his money on.
- John notices that he spends too much money on lunches when he goes to work. He decides to start making his own lunch in order to save money.

MORAL DEVELOPMENT

OBJECTIVES

- To gain conscience about the influence of moral values in one's thoughts and behavior
- To assume social perspectives and not only personal views
- To increase empathy towards the feelings of others
- To improve critical thought and problem solving abilities

1. THE OVERCROWDED LIFEBOAT

In 1842, a ship struck an iceberg and more than 30 survivors were crowded into a lifeboat intended to hold 7. As a storm threatened, it became obvious that the lifeboat would have to be lightened if anyone were to survive. The captain reasoned that the right thing to do in this situation was to force some individuals to go over the side and drown. Such an action, he reasoned, was not unjust to those thrown overboard, for they would have drowned anyway. If he did nothing, however, he would be responsible for the deaths of those whom he could have saved. Some people opposed the captain's decision. They claimed that if nothing were done and everyone died as a result, no one would be responsible for these deaths. On the other hand, if the captain attempted to save some, he could do so only by killing others and their deaths would be his responsibility; this would be worse than doing nothing and letting all die. The captain rejected this reasoning. Since the only possibility for rescue required great efforts of rowing, the captain decided that the weakest would have to be sacrificed. In this situation it would be absurd, he thought, to decide by drawing lots who should be thrown overboard. As it turned out, after days of hard rowing, the survivors were rescued and the captain was tried for his action. If you had been on the jury, how would you have decided?

2. THE TROLLEY PROBLEM

A trolley is running out of control down a track. In its path are five people who have been tied to the track by a mad philosopher. Fortunately, you could flip a switch, which will lead the trolley down a different track to safety. Unfortunately, there is a single person tied to that track. Should you flip the switch or do nothing?

3. THE FAT MAN AND THE IMPENDING DOOM

A fat man leading a group of people out of a cave on a coast is stuck in the mouth of that cave. In a short time high tide will be upon them, and unless he is unstuck, they will all be drowned except the fat man, whose head is out of the cave. [But, fortunately, or unfortunately, someone has with him a stick of dynamite.] There seems no way to get the fat man loose without using [that] dynamite which will inevitably kill him; but if they do not use it everyone will drown. What should they do?

4.3. COMMUNICATIONAL SKILLS AND ASSERTIVENESS

https://www.indiamart.com/proddetail/assertive-communication-skills-8764464033.html

It is impossible not to communicate. This is one of the axioms of the pragmatics of human communication as enunciated by Watzlawick et al. (1966) that defines the non-existence of no communication since all behaviour has a value of communication.

In this sense, all behaviour has a communicational value, whether it is the communication of a message, whether it is a silence or a behaviour.

Many individuals with difficulties in interpersonal relationships, socially ineffective or even individuals with antisocial behaviour exhibit communicational difficulties. It is often observed that the communication process depends, among other factors, on the type of groups in which communication occurs. However, individuals with more pronounced behaviour a dysfunctionality have difficulty adapting communication to the social context in which they perform it and tend to use a rigid and stereotyped communication style. Among individuals with antisocial behaviour, the way the individual communicates, the messages he/she transmits, may not be problematic since they have learned to communicate in an accepted way by the group of belonging, which obeys the tacit rules governing the operation of it and guarantee the maintenance of social cohesion.

Inserted in a different social or interpersonal context, they will present a communication mismatch insofar as they use maladaptive readings of reality that cause systematic distortions in the emission and decoding of the messages. Such distortions influence the rest of the communication sequence and, assuming behavioural co-determination in an interaction, often lead to dysfunctional communication cycles.

This session begins with the presentation of a tacitly explanatory video of communication and assertiveness, for better processing of the contents to be addressed:

https://www.youtube.com/watch?v=h7726xhyS6c

Brief sharing of the message taken from the video, focusing on fundamental aspects such as difficulty in communication, difficulty in passing the message, and difficulty in behavioural assertiveness.

The session gives rise to the development of group dynamics that intend to contribute to the reflection on some points related to the communication process.

Subsequent to each dynamic, there should be a group exploration to reflect on the ambiguity of the communication processes, emphasizing the difficulties experienced in the process of group information transmission and the identification of some obstacles that make the communicational process sometimes more difficult.

EXERCISE

Verbal Communication - "… Who tells a story..."

With this activity, we intend to show the effect of information passing from person to person.

You begin by asking all the group members to leave the room.

On entering the room the first participant (the receiver) will listen to a story read to them by one of the animators who, in turn, will invite the next participant into the room. The receiver should not ask questions or comment, but should tell the next participant what he or she has learnt from the story. After all of the group have entered the room, heard the story and retold it, the animator will repeat the original version of the story.

STORY - "WHO TELLS A STORY..."

Sofia had been dating Daniel for a few months. One day, Daniel left her at the bus stop, as he always did every morning on their way to work. She worked at the supermarket and he worked for a construction company, 10 miles away.

Sofia accidentally boarded the wrong bus, but by the time she noticed she was already downtown. Frustrated, she got off the bus at the next stop and waited for another bus. What she was not expecting was to see Daniel drive by with a pretty young woman in the passenger seat.

Sofia was fuming. What was he doing there? How could he do this to her? But she waited to see what would happen, and soon afterwards the young woman got out the car and went into a shop. Just then, Sofia thought about going over to talk to Daniel, but as she approached him, another young woman appeared and stayed with him.

"It's always the same, he tells me he's working all day but he's actually out with other women," Sofia thought. But she continued to wait, and in the meantime the first young woman returned whom Daniel embraces and kisses, causing the second to leave.

Sofia was numb; after all, her suspicions were confirmed. She did not want to believe what she had seen. She decided to take a cab and return to her house. She did not go to work, neither that day nor following. Daniel was looking for her but she did not want to know about it.

On Sofia's birthday, Daniel gave her a gift with a note that said "Sofia, for all this silence without explanation, I want this gift to fill your heart. I hope you like it my cousin helped me choose it as you're a similar size. Kisses Daniel.

DEVELOPMENT OF THE THEME

After the dynamics have been completed, all participants should be invited to express their opinions regarding the activity.

The animator, following the principle of guided discovery, should note that the reading of the text has revealed some discrepancies between the original information and the information that was transmitted to the last participant in the group. Thus, the participants should reach the notion that the presence of barriers makes it difficult to transmit information and, in this case, reference the extension of the text, the content of the message, among others.

It is also important to note that sometimes incorrect interpretation of messages can lead to conflict, since each person tends to interpret the story in their own personal way and. As such, when they relay the story it may not be delivered factually.

In this sense, and to guide the plenary, some questions may be raised:

- What do you think happened?
- Why do these differences occur between the initial story and the final version?
- What could we have done to lessen these differences?
- Has something similar happened to you in relation to real situations?
- Why do different versions of the same story occur?
- What can we do when this happens?

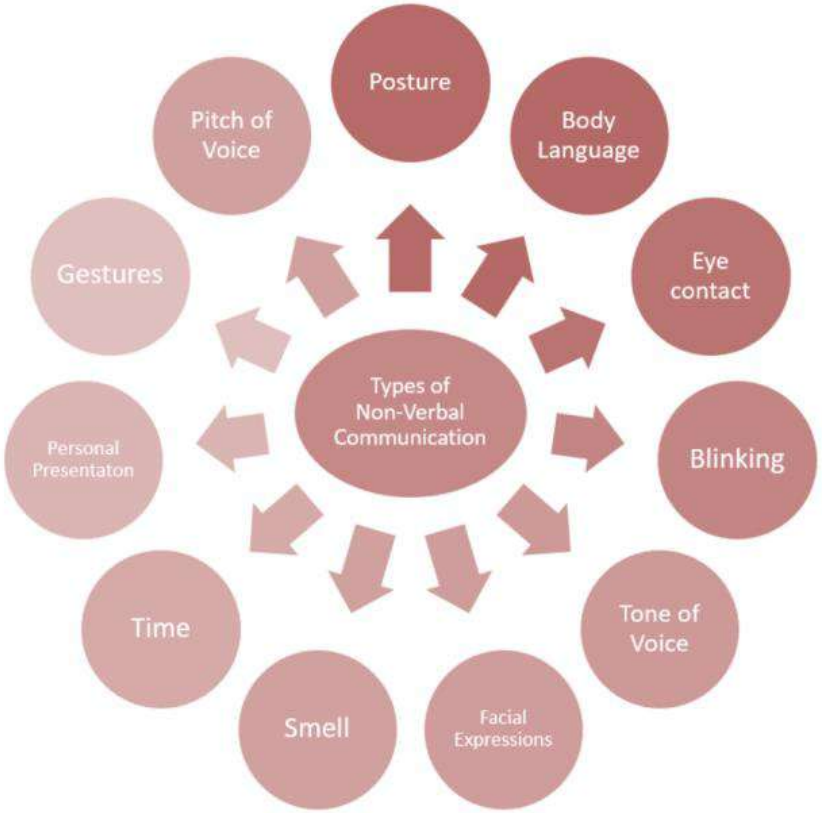
There may be difficulties in identifying the causes of failures in the communication process because participant's experiences do not allow another kind of more functional interpretation.

In the synthesis/devolution of information, the following points must be taken into account. The ideas transmitted by the young people throughout the session, safeguarding some that seem important and that should be transmitted:

- Sometimes others do not respond to our messages because they do not perceive what we mean;
- This is because what I know, which I know, sometimes has a different meaning for others;
- The same is true of what they also know and know about me;
- What causes us to communicate, sometimes, misunderstandings;

The important thing is to think that to communicate we must take into account ourselves, others and also sometimes the environment that surrounds us.

GROUP ACTIVITY: NON-VERBAL COMMUNICATION



https:// verbal+communication&rlz=1c1giwa

The main goal of this activity is to raise the awareness of the participants to the importance of non-verbal communication and to make them aware of the fact that we need to take into account not only the words that we chose but also the way we transmit our ideas. Even without words, we communicate with our bodies, through gestures, body expressions or postures that have a meaning to others.

1. One of the trainers selects three to four trainees and asks them to leave the room for a moment and gives instructions to the remaining, chosen to be observers: "You will observe the behavior of your colleagues and try to apprehend what each one of them is trying to tell you. You should focus on their facial expressions, posture, gestures, etc, even if they don't really say anything. After your observation, you should write down what you thought they were communicating"

Paper and pens/pencils are given to the trainees.

Rule: The observers cannot ask anything to their colleagues and the interpretation and observation must be done individually.

2. The trainer leaves the room and has a talk with the trainees that have been outside:

"You'll enter the room, one at a time, and sit on the chair next to the board and, for about one minute, you'll do your best to avoid communicating, and you'll try to not transmit any information to your colleagues! You can't speak and pay attention to your posture, your facial and body expressions, your gestures… the goal is to "not communicate"".

3. After the observation, the trainers must question the trainees on an observing role about their perception on the scene and register the answers on the board.

"What did you think your colleague was trying to communicate? And that second colleague? And the third one? Just tell us your opinion, there are no right or wrong answers".

4. Ask the trainees that first left the room about their objectives, about what they were trying to achieve when they were sitting in front of the colleagues. Supposedly, they'll explain they were trying to "not communicate".

5. Initiate a discussion about the impossibility of not communicating. Probably, the trainees that were trying not to pass on any messages to their colleagues will argue that being passive, unemotional or quiet means that there is no communication being done and the other

colleagues will stand up for their interpretation of those first colleagues behavior. The trainer should guide the participants to this simple conclusion: it is impossible to “not communicate” because, even if we don’t say a word, our body or our expressions will always transmit something that will be interpreted by others.

Furthermore, we may infer that non-verbal communication is ambiguous and unclear, difficult to truly apprehend, but it has an extremely important role in the communication process.

The trainer can ask the participants some more questions, taking the discussion even further:

- What were the efforts done by those trying to “not communicate”?
- Why did you think your colleagues couldn´t achieve their goal?
- Could they have done something different?
- Those who were observers, what meanings did you give to your colleagues expressions?
- Were there different interpretations?
- Why were there different answers?
- Do you think we can misinterpret non-verbal communication?
- In your opinion, is non-verbal communication easy to decode?
- How can we make it easier to understand by others?

We conclude that non-verbal language maybe unclear and may lead bad interpretation as such, we should strive to convey "non-verbal signals" consistent with what we are saying in words. It is necessary have attention as a way of expressing the things because it is as important as what we say.

It is impossible not to communicate. When it is not a verbal language, we send messages to others through gestures, touch, facial and body expression. Often it is what happens to others that "read our body". However, it should be noted that this reading is not always correct, because non-verbal language is ambiguous and can be interpreted in multiple ways.

We must be aware the importance of non-verbal language in communication and in the relation with others, because is so important what you say, is the way you say.

It is fundamentally ensure a good at expressing our ideas and emotions, as a way to avoid misunderstanding with others.

To conclude the session, it is suggested to use the "**Assertiveness Pot**" in order to consolidate, promote, and enhance assertive communication out of the context of group intervention.

The dynamizers should have a pot containing little papers so the participants can randomly choose and, so, leave the session with the thought of experiencing the suggestion that they chosen.

The "**Assertiveness Pot**" should contain the following phrases:

- A story told may not tell the whole story;
- It is important to listen to what the other has to say;
- The way that I communicate may induce the other to misinterpret what I mean,
- Sometimes, others may not understand what I mean;
- There are sometimes misunderstandings when we communicate.

Each one reads the phrase raffled. The dynamizers give way to sharing. Participants take with them the message of ultimate dynamics. The session is closed.

"Pot of Assertiveness" | Phrases to raffle:

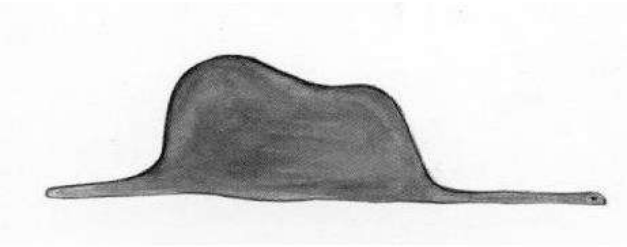
A story told may not tell the whole story
It is important to listen to what the other has to say
The way that I communicate may induce the other to misinterpret what I mean
Sometimes, others may not understand what I mean
There are sometimes misunderstandings when we communicate

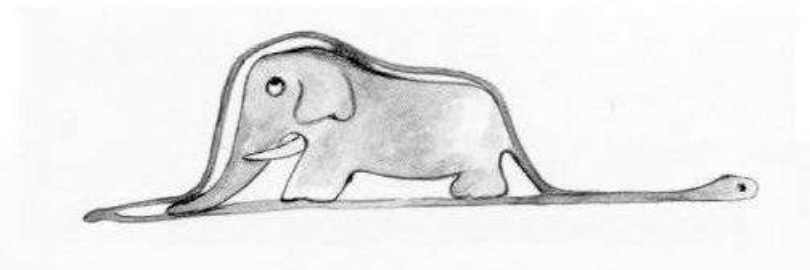
4.4. ACTIVITIES

4.4.1. SELF AWARENESS

INTRODUCTORY EXERCISE

1. Show picture
2. Ask participants what they think the picture represents.
3. After they finish guessing show them the second picture.

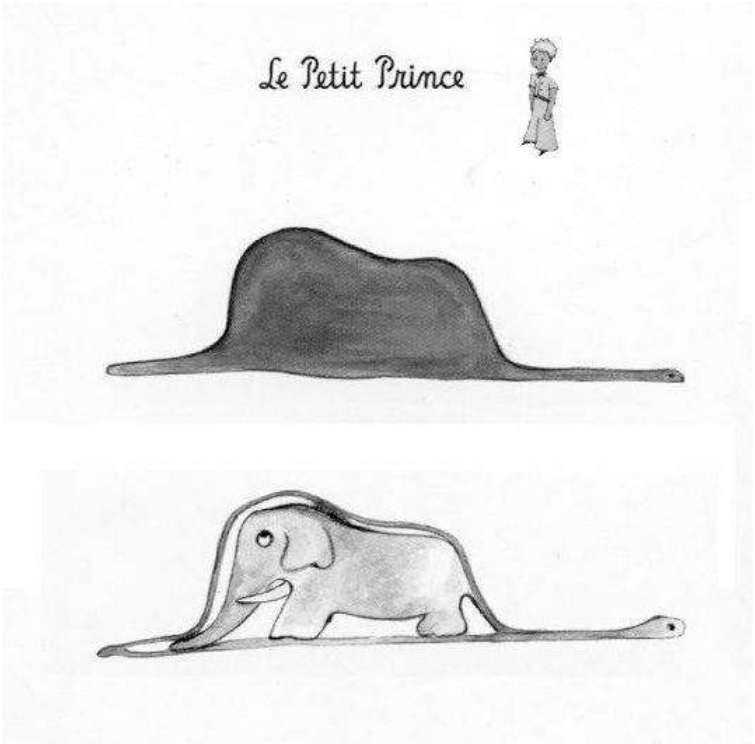




If you've ever read The Little Prince by Antoine de Saint Exupery, you are familiar with the pictures the narrator presents at the beginning of the book. These are shown as his reasons why he was unable to become an artist. The first picture is of what most people would think is a hat, which in fact is a boa constrictor who has swallowed an elephant. Now, the "grown-ups" discouraged the narrator from being an artist because they could not see beyond the simplicity of the drawing to the true creativity that lived (or perhaps, more accurately, no longer lived!) inside.

PRESENT STORY

ISSUE



There are many situations in which we do not see the full picture, there are many factors affecting our interpretation and consequently affecting our relationship with the outside world or with our self.

We are facing similar issues every day but react differently or we encounter new ones and we try to figure out how to deal with them.

So, what is an issue?

An issue is anything (situation, event, experience, awareness) that concerns or is important to you or the ones that you interact with. Issues get your attention.

Some issues refer to a TOPIC such as:

- Housing
- Education
- Work
- Friends
- Children, Parents, Partner
- Money
- Time
- Career
- Projects
- Leisure
- Moving
- Travel

Or RELATIONAL like:

- Trust
- Affection
- Acceptance
- Commitment
- Appreciation
- Communication
- Closeness/Distance
- Togetherness/Apartness
- Inclusion/Exclusion
- Conflict/Harmony
- Collaboration/Competition

Others are PERSONAL such as:

- Self Esteem
- Health
- Energy
- Skills
- Freedom
- Appearance
- Responsibility
- Discipline
- Travel
- Values
- Expectations
- Recognition
- Goals
- Success
- Failure
- Attitude
- Habits

While we focus on a specific type of issue most of the time these are mixed.

For example, if the issue is work (TOPIC) it will involve for sure self-esteem (PERSONAL) and the appreciation of others (RELATION)

Issues require varying amounts of mental, emotional and physical energy.

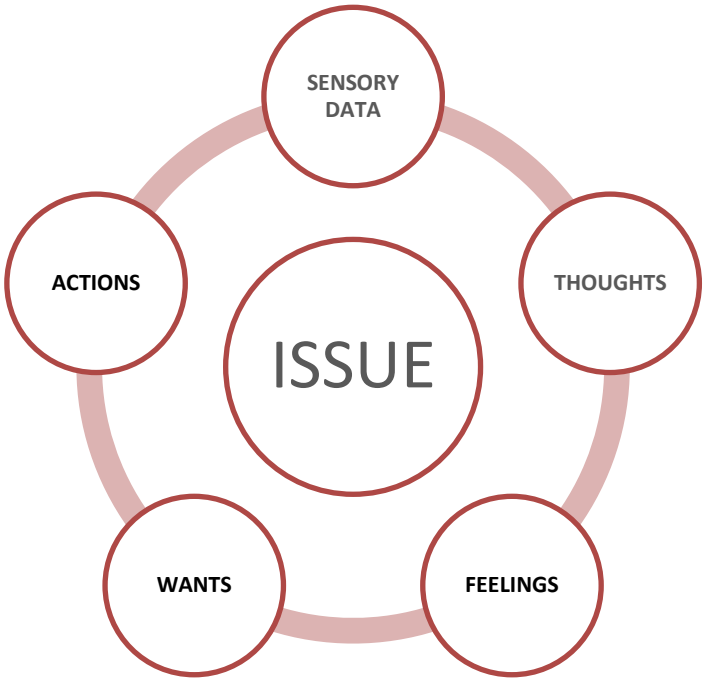
The process of dealing with issues usually involves making decisions and sometimes resolving conflicts. It is important to identify the issue you are dealing with in order to deal with it. In this respect the Awareness Wheel will help analyze your reactions and improve your self-awareness and self-control.

The Awareness Wheel is a map to help you become more aware of yourself - what you are experiencing at any point in time. Once you are familiar with the awareness wheel it can help you better understand and care about you and the others.

The awareness wheel includes 5 zones: sensing, thinking, and feeling, wanting and doing.

Each part contains important information about yourself. All five parts are distinct yet interact with each other. All five are present in your experience even though you may not be conscious of them. They become available when you tune in to them.

AWARENESS WHEEL



SENSORY DATA - VERBAL AND NON-VERBAL INPUT

Your five senses – sight, smell, taste and touch - are your immediate points of contact with the outside world. Through these channels you collect stimuli. In a conversation sensory data come to you as:

Gesture, tones, posture, numbers, words, comments, stories, scent.

The more you pay attention to the subtleties of what you see, hear, smell, taste and touch, the more you will be aware of what is going on around you.

The behaviors of other people, both verbal and non-verbal, become your sensory input - so do time, place and other contextual cues.

NON-VERBAL INPUT

Without even hearing a word you can observe these kinds of sight data:

Show slides as examples.

- context - location and who is present
- time - when during the day and promptness or delay in response
- space – physical position of people (closeness or distance), clutter or orderly arrangement
- body language - posture, eye contact, facial expression, hand and arm gestures, general body movements
- energy level – alertness, involvement, fatigue
- objects – dishes, furniture, paper, equipment
- clothing – formal or informal, neat or unkempt
- media – television, newspaper

SOUND DATA INCLUDE

- background noise - people talking, radio, television, appliances running
- rate and pace of speech – slow, medium or fast, steady or halting
- pitch and tone – low, medium or high; flat, fluctuating, strained, strong or confident

- volume of voice – soft, medium, loud
- diction and clarity – precise, mumbling

TOUCH

- hard, soft, hot, cold, rigid, flexible, smooth, scratchy

EXERCISES

1) EXERCISE

Time: 10'

Give randomly different objects of different textures and ask them to describe it.

SMELL and TASTE are important sources of nonverbal data too.

2) EXERCISE

Time: 10' (5'+ 5')

Give participants on a cotton ball to experiment various smells, cinnamon, vinegar, vanilla.

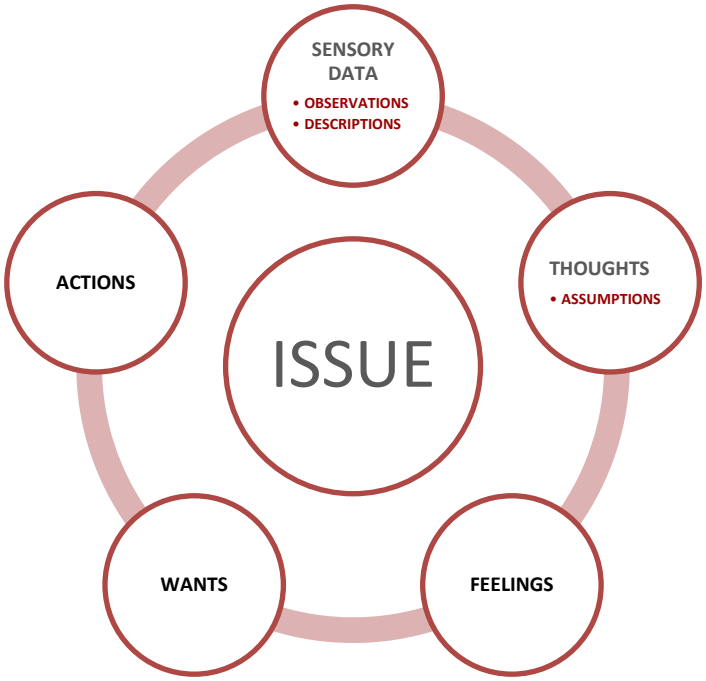
What thoughts come to their mind?

Have some of the snacks and drinks prepared for the coffee break and ask them to taste it and describe if they like it not.

INTUITIVE SENSATIONS

Another important kind of data is that of intuitive sensation - data that do not come from your immediate, external, physical world but rather from your internal world of memories, associations, insights, knowledge, dreams, hunches and so forth. When one of these intuitive Sensations occurs, it may be difficult to document your perceptions with physical data. This is true in part because intuitive sensations often draw on bits and fragments of both internal and external data.

AWARENESS WHEEL



Thoughts - the meaning you make to help you understand yourself, other people and situations. You form thoughts from the beliefs you bring to a situation, the interpretation you make of immediate and recollected sensory data, and the interpretation and anticipation you have of the future.

OTHER WORDS THAT SIGNAL THINKING PROCESSES INCLUDE:

- attitudes, assumptions, conclusions, opinions, evaluations, judgements, impressions, ideas, predictions, objections, principles, rules, needs, values, reasons, benefits.

This zone of the awareness wheel refers to the logical analytical and rational process of weighing data in order to arrive at a conclusion. However sometimes thoughts can be quite illogical.

Ehen you are dealing with an issue your beliefs, interpretations and expectations play a part in them. Recognizing these influences helps you to understand the issue better.

BELIEFS

The beliefs you bring from your past experience either limit or expand what can grow out of a circumstance. Beliefs are powerful. They influence your perceptions - would you actually see and hear - as well as other parts of your awareness wheel.

For example, your self-esteem is a distillation of your beliefs and judgements about yourself in different circumstances across time. If you judge yourself to be innovative competent and responsible you'll carry confidence into different situations. Likewise, if you have doubts about your abilities, you will broadcast this self-evaluation as well. In this way, beliefs often become self-fulfilling prophecies.

3) EXERCISE

Time: 25'

Divide participants in 3 groups.

Each group will receive a statement and they will split according to the position the believe is TRUE or FALSE and give arguments for it.

1. It is not acceptable to be late for a meeting.
2. If a friend who you know that has a bank debt asks you for 100 euros for a week you should refuse.
3. You should not recruit the person that applied for a job in your organization if you see that she/he changed 7 companies in 5 years.

The examples may be changed by the trainer.

Each group will debate and defend their position – true and false + arguments for 10 minutes

In the large group each small group will share briefly their conclusions. 10 minutes.

No matter what the answer is, point out that this reflects our past experiences, stereotypes, cultural background and it does not necessarily be the data we receive through our senses. 2-3 minutes.

INTERPRETATIONS

Whereas beliefs represent what you bring to a situation, interpretations are the meanings you make out of sensory data you perceive at the moment. We use this term to include the analysis of facts.

Interpretations represent the way you put your world together – the way you make sense of the data. What is real for you counts? Other may see and hear the same data and come to very different conclusions. For example, you and your partner walk into your house and see dirty dishes scattered around. You think your twelve-year-old has been irresponsible for not cleaning up after himself. Your partner however thinks your son has been quite responsible and has shown initiative to make a meal on his own.

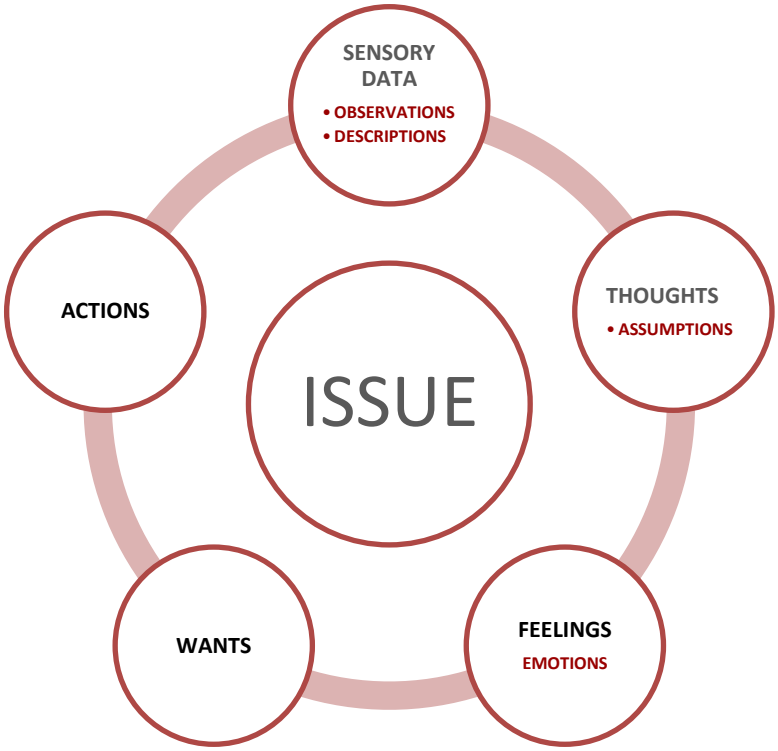
EXPECTATIONS

Expectations are what you think will happen. You expect (think) that you will meet your friend at two o'clock for lunch….. An expectation is an anticipated experience – waiting to happen.

In the process of forming thoughts it is easy to filter (delete) or imagine (add) data because other zones of your Awareness Wheel influence your thoughts.

FEELING | YOUR EMOTIONAL RESPONSE

AWARENESS WHEEL



Feelings are your spontaneous psychological response to the match between your sensory data and your thoughts or wants in a situation. Your senses are constantly scanning the environment for signs of fulfilled or unfulfilled expectations or desires. The match or mismatch between your external input and your internal evaluation triggers positive or negative emotions. The greater your expectations and desires, the stronger the resulting feelings.

For instance, if you are expecting to receive a particular job offer and it goes to someone else, you might feel hurt, angry, and jealous. On the other hand, you might feel a little relieved, if part of you believed the job might be over your head or too demanding.

Emotional responses register in your body. Your body gives clues to your feelings. For example, anger shows in tight muscles and flushed skin and sounds loudand strident in the speech. When you are contented your breathing is deep and slow: muscles in your face, neck and shoulders are relaxed.

It is not unusual to find it difficult to identify feelings. To help you here are some examples of feeling words:

Happy, proud, lonely, disappointed, sad, trusting, annoyed, eager, satisfied, confident, comfortable, disinterested, angry, frustrated, uneasy, fascinated, peaceful, excited, bored, fearful, hesitant, irritated, surprised, hurt, anxious, jealous, glad..

The more you're positive expectations and desires are fulfilled, the more the feelings you experience are likely to be pleasant ones. However, the more you do not know what to expect, the more uncertain anxious you fee. Uncertainty is a major cause of stress disorders. And repeated expectations or desire's without fulfillment lead to anger and frustration.

The way you feel depends on how you interpreted the sensory data.

When you enter a room and your friend does not respond to your greeting you may think he is ignoring you and will feel upset, rejected, angry. Or, you may think something is troubling him and you will be worried about him, sad or concerned. Same behavior but different feelings according to the interpretation you give to the data you gather through your senses.

This is why is important to identify how we feel and to think back of how we interpret all the data in front of us combined with all the association and memories we have inside.

The interpretation stage is crucial for how is going to make us feel, and, later on, react.

While it is difficult to say exactly how we feel in specific situation our body might give us signals.

4) EXERCISE

Time: 20'

Ask your participants to answer the questions in pairs one with another, or if you feel one or more are willing to volunteer, then one at a time with the whole group.

Slide but also on Flipchart

How do I know that I feel (what are the manifestations in my body):

- Annoyed / Bored
- Excited / Glad
- Happy / Mad
- Nervous / Sad
- Scared / Sick
- Upset / Worried

The next pair will start with the first statement again and the next pair with the following.

If the exercise was done in pairs ask them to share in the large group. If for a statement there were more pairs see if there are differences.

5) EXERCISE FEELINGS

Time: 30'

Divide participants in small groups of 3-4 persons.

Give each person the HO with "Last time I was…"

Ask participants to fill in the blanks for at least 4 statements and the rest to complete at home.

The purpose of the exercise is to think of how they interpreted the data.

Ask them to discuss - share in the small group 4 feelings each.

After they finish, ask participants if they consider that they interpreted correctly the situation. The feelings are authentic, cannot be denied, but feelings are the result of the way we interpret a certain situation, the only stage where we can intervene.

THE LAST TIME I WAS….	WAS …(DESCRIBE WHY, WHAT HAPPENED, THE SENSORY DATA)	WHICH MADE ME THINK…
HAPPY		
SAD		
GRATEFUL		
LONELY		
CONFIDENT		
FRUSTRATED		
RELAXED		
JOYFUL		
ACCEPTED		
ANXIOUS		
LOVED		
NERVOUS		
ENTHUSIASTIC		
ANGRY		
CALM		

6) EXERCISE FOR WANTS AND ACTIONS

Time: 10'

Start with this exercise before presenting the theory.

Have biscuits or candies or crackers on a plate. Make sure that the total number of whatever you put on the plate is with 3-5 PIECES LESS THAN THE NUMBER OF PARTICIPANTS.

Put the plate on a table in the middle of the room and ask the entire group to stay around the plate and help themselves and then return to their place.

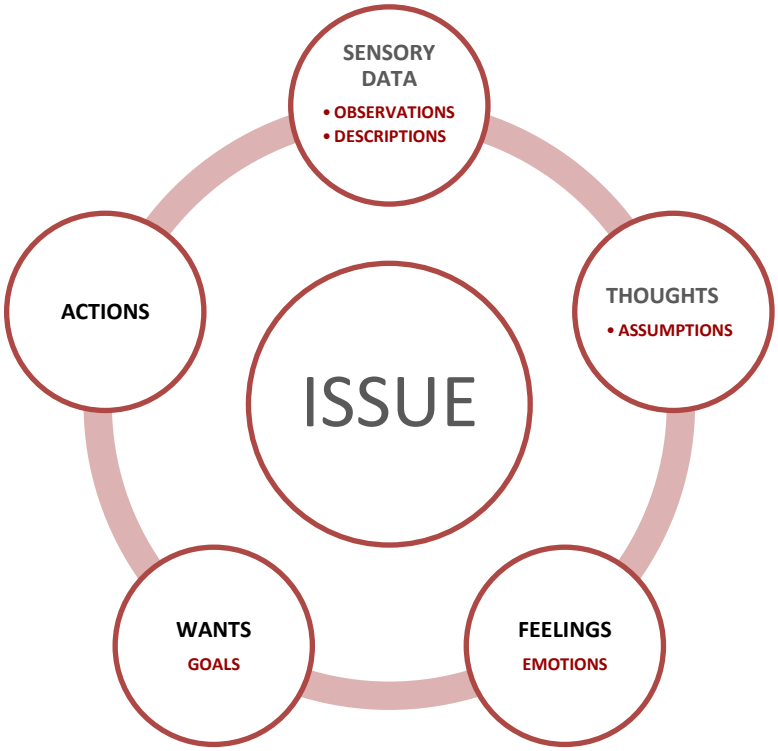
When they are all sited, ask if they all ate a candy or biscuit. Ask the ones that did not what happened. Ask what they wanted when they came to the plate. Did they notice that there were fewer cookies than participants?

Was there anyone that wanted more than one biscuit? Did anyone shared? Anyone that did not like what was on the plate and was not interested?

Present theory, pointing with examples from what happened during the exercise such as: Sometimes we just think of our own want, sometimes we give up what we want for others, sometimes because we want to be perceived in a socially acceptable manner, sometimes because we think about our relationship. Sometimes we hope others would take care of our wants or desires.

THEORY

AWARENESS WHEEL



Wants - Your Desires

Wants are your desires and wishes for yourself, for others and for your relationship. Wants can be small or large, short-term or long-term. They generally imply a moving toward or moving away from something or someone.

Think of your wants as mini plans - your priorities. They often start as a dream or fantasy and are translated into specific goals and objectives. They can be shuffled about and reordered as you consider alternatives. They are tentative until translated into action WANTS are motivators.

Everybody wants something! Wants motivate and energize you and others from moment to moment. When you connect with your wants, you focus your energy and release a strong force. Not knowing what you want can keep you stuck.

Wants for me - My Self

Most of the time when we think of wants we think of ourselves: what I want for myself.

Wants for Other(s)

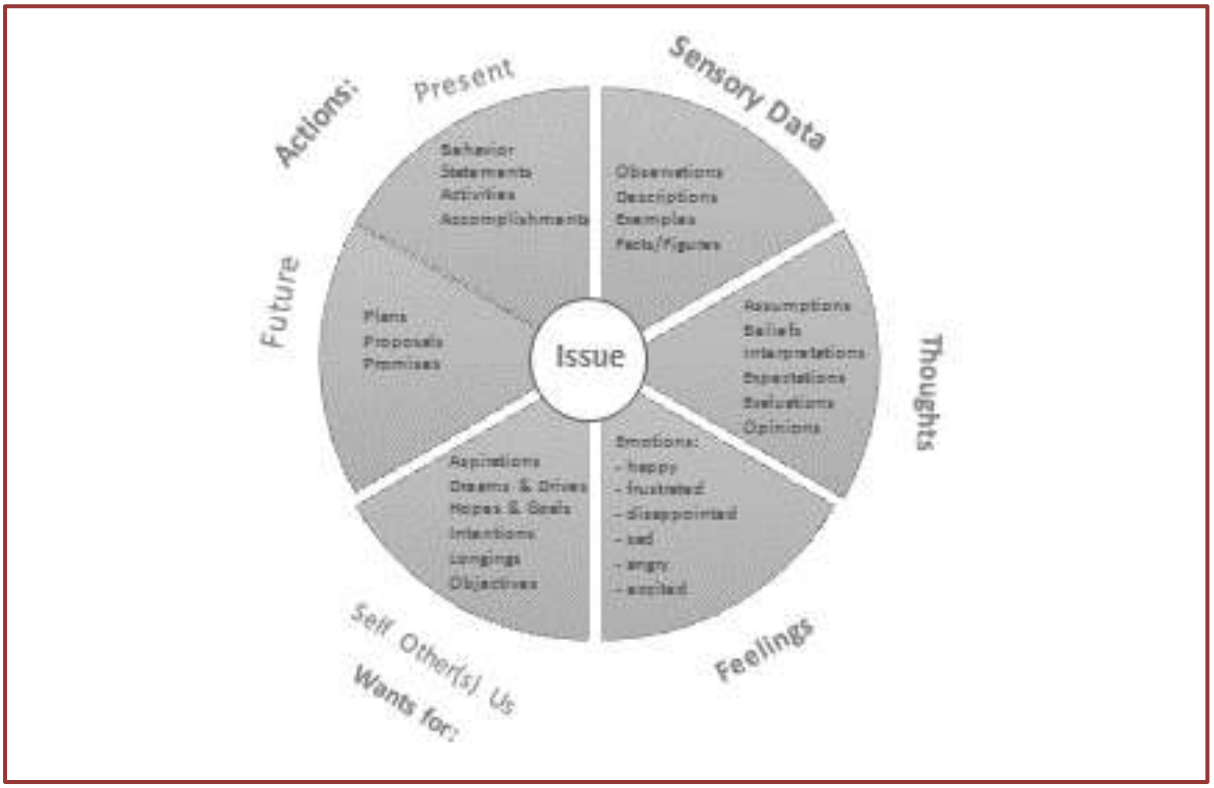
When it comes to thinking about others, often we think about what we want FROM others (for self) - not FOR others. However the difference between FROM and FOR is big and has implications for how you relate to the other people in your life.

When you think about what you want from others you are still really thinking what you want for yourself. Your attention is focused on what they can do to help you achieve your desires… The things or actions you want from other people can easily become something you demand of them.

When you think about what you want positively FOR others, with no strings attached, you are truly in their court. Thinking about their interest instead of your own really captures the notion of wants for others and shows you care about them.

ACTIONS| Your Behavior

AWARENESS WHEEL



Actions are your behavioral output. They are the results of how you process sensory data, your thoughts, your feelings and your wants. They are what you choose to do.

What we decide to do could be translated into:

- Behaviours, statements, activities, plans, promises, proposals, accomplishments, consequences, achievements
- All of the above are broad categories of actions and most of them are conscious of them. What we are less aware of are the little things we do that punctuate our conversations for example: the pauses, foot-tapping, frowning, finger pointing or laughing
- All of this output becomes sensory data for the perceptions others have of us

7) EXERCISE

Ask participants to give you exmples for each situation

Time: 15'

INCOMPLETE AND INCONGRUENT SELF-AWARENESS

When the five different types of information are not interrelated, certain behaviors may occur that are inadequate expressions of self-awareness. Communication is ineffective—incomplete and/or incongruent.

There are many types of *incomplete self-awareness,* but they all share one characteristic: at least one type of information is missing from the person's awareness. Several common types of incomplete awareness are described here.

1.INTERPRET-ACT. This configuration represents a very common behavior pattern, i.e., "assume and do." People who assume and do but have no consciousness of feelings or wants typically communicate feelings indirectly or without emotion.

2.INTERPRET-FEEL-ACT. This configuration represents behavior that does not take into account data received from the other person or situation. Because important available information is not recognized, the person's behavior appears to have little relationship to "reality." The person's reactions seem to be based only on internal cues and are not responsive to the other person's communication or the social context. In short, the person seems to be in his or her "own world."

3.CONFUSION OF INTERPRETATIONS WITH FEELINGS. This configuration represents confusion between thoughts and emotions. Often, such behavior exhibits what might be called "language pollution." For example, a person might say, "I feel that we should decide," or the person might shout, "I'm not angry, I just think my point is important."

Sometimes this kind of statement is simply a result of sloppy language but often it represents a real confusion between thoughts and emotions. This confusion may be manifested in over-emotionality or under-emotionality or, more generally, in indirect emotional responses.

4.SENSE-FEEL-ACT. Behavior based on this configuration indicates little thinking. Actions primarily are emotional reactions, an "acting out" of feelings rather than an "acting on" feelings.

5.INTERPRET-FEEL. This configuration involves no action. Usually, the individual's responses are purely reactions to others and, therefore, are controlled by them. The person collects impressions and feelings but seldom translates them into appropriate action. The person is not actively making choices.

In each of these five configurations, want (intention) is not involved. In each case, behavior occurs without the individuals recognizing their intentions (wants, desires). A sixth configuration does include intention, but other cognitive processes are missing.

6.INTEND (WANT, DESIRE)-ACT. This configuration represents behavior that is essentially devoid of both interpretation of the other's message and of awareness of one's own emotional reaction to that message. The actions usually express an intention relative to another person, typically an intention to manipulate the other person or control that person's behavior in some way. Behavior based on this configuration often appears to be cold and calculated.

In addition to incomplete awareness, people can experience *incongruent awareness.* Incongruent awareness happens when two or more aspects of the Awareness Wheel are in conflict. For example, if I do not feel good about what I want (conflict between feelings and intentions), I may ignore my feelings, carry out an action, and get what I want, but the feelings are likely to remain—and along with them, the incongruence. If incongruence is chronic, it affects my life style.

People can use incongruence as a "growing point"—to find the incongruent parts of their awareness and do something to regain congruent awareness. This may require changes in values, expectations, meanings, or intentions or even alteration of some behaviors.

SKILLS IN DISCLOSING SELF-AWARENESS

Making a clear statement about an aspect of awareness involves a communication skill. There are five types of information in the Awareness Wheel, and five skills are involved in expressing complete awareness:

- Making sense statements
- Making interpretive statements
- Making feeling statements
- Making intention statements
- Making action statements

A sixth crucial skill is used when we disclose complete self-awareness—speaking for self. Speaking for self involves expressing one's own sensations, thoughts, feelings, and intentions.

The language used in speaking for self is "I," "my," "mine", as in "I see . . .," "I think . . .," and "My opinion is . . . ." This skill is crucial because it clearly indicates that the authority on my experience is *me.* When I speak for myself, I increase my autonomy, but, at the same time, I take full responsibility for what I say. Thus, I avoid the two dangers at either extreme of a continuum, under-responsibility and over-responsibility.

At one extreme, under-responsible people do not accept ownership of their thoughts and feelings. They do not even speak for themselves. They believe that their points of view are not important and cannot be useful to themselves or to others. As a result, they depreciate themselves and avoid acknowledging their own thoughts, desires, and feelings. Such people often behave indirectly to achieve their goals. For example, they may attempt to make others feel guilty because the others are overlooking them, thus hoping to receive the attention that they do not ask for directly.

At the other extreme, over-responsible people try to speak for others (e.g., “You are sad,” “Men should be dominant in relationships”). Speaking for others often takes the form of normative appeals; for example, “you should” feel a certain way, or “you ought” to do something. Little or no respect is shown for the rights or autonomy of others. Typically, speaking for the other is an attempt to persuade and manipulate other people into thinking, feeling, or doing something that they would not do on their own.

Speaking for self, on the other hand, increases both one’s own and other’s personal autonomy and personal responsibility. First, speaking for self clearly indicates that the responsibility for one’s own interpretations, feelings, intentions, and actions is oneself, not other people. When we speak for ourselves we also allow others to report *their* own perceptions, thoughts, feelings, intentions, and actions—and take responsibility for them.

Summarize by stressing how important is to interpret correctly the data we get from our environment as our feelings and actions are affected by it.

Tell them that the awareness wheel can help them analyze various personal actions backwards, starting from the action and trying to find out if there were unfulfilled wants, or unexpressed feelings or misinterpretations.

4.4.2. OCUPATIONAL HEALTH

Presentation or discussion on the theory | **10'**

Many people living with mental health conditions lead happy, successful lives. Some continue to work while others are preparing to return to work after treatment.

It is important to learn more about your legal rights, finding a job, and how to stay healthy during stressful transitions.

Researchers identified four aspects of the individual's relation with the work environment:

1) the demands on them;
2) the constraints under which they have to cope;
3) the support they receive from others in coping;
4) their personal characteristics and coping resources.

Certain characteristics of the work environment have been identified as affecting well-being:

- opportunity for personal control;
- opportunity for skill use;
- externally generated goals;
- Variety;
- environmental clarity;
- availability of money;
- physical security;
- supportive supervision;
- opportunity for interpersonal contact;
- valued social position.

The generally accepted terminology uses “stressor” as the cause and “stress” as the effect. It is important to identify correctly the stressors in your work environment and to proactively find solutions to deal with them.

These “stressor” in the work environment are:

- Change to different kind of work;
- Major change in the work schedule;
- Change in level of responsibility;
- Trouble with boss;
- Trouble with colleagues.

Examples of reasonable accommodations for people with mental health conditions may include:

- Providing self-paced workloads and flexible hours;
- Adjusting your job responsibilities;
- Allowing leave (paid or unpaid) if you are hospitalized or temporarily unable to work;
- Assigning a flexible, supportive, and understanding supervisor;
- Changing your work hours to allow you to attend psychiatrist or therapist appointments;
- Providing more support or supervision, such as writing to-do lists and checking in more often with your supervisor.

An employer does not have to provide these specific accommodations, but these types of accommodations are often considered reasonable for some jobs.

1) EXERCISE

Time: 40'

Ask participants to think about their ideal job conditions and write them down.

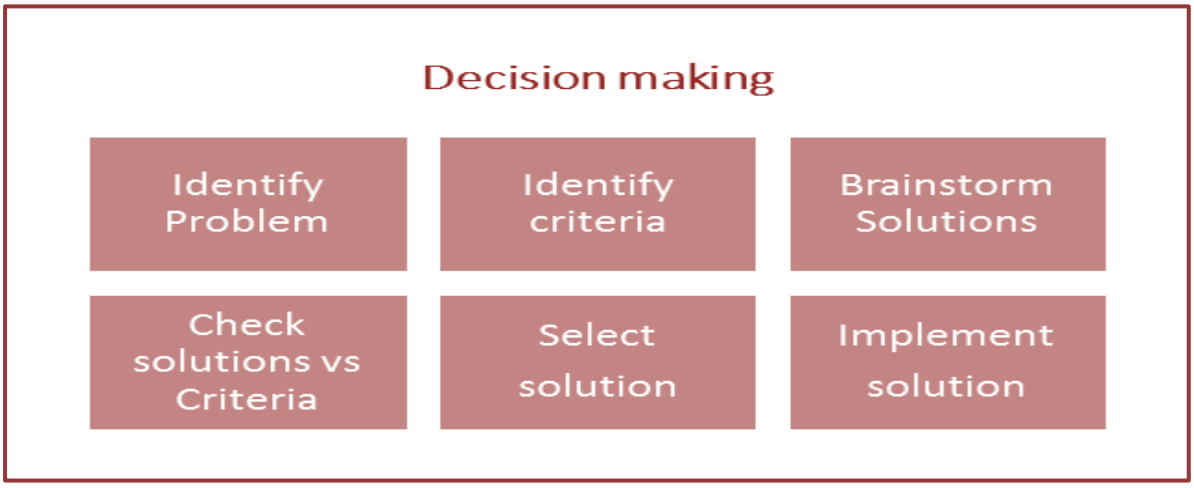
Ask participants to share in the large group.

Then ask them to focus on an issue where they think they may need to get the support of people or institutions in the law, justice or health system.

List the issues on the flipchart.

From the list ask them to pick up one issue.

Present the decision making diagram.



Explain that the criteria means whatever they consider important for them, whether is to be quick, to maintain the relationship, to require minimum resources, etc. and that any solution will have to be evaluated from this point of view.

Work on one issue agreed with the group as the most important from the ones listed on the flipchart in order to find a solution.

Challenge group to decide at the problem identification stage if the problem is correctly identified, if the problem is about them or about the others.

4.4.3. SOCIAL SKILLS

Present with PPT theory: competencies and skills, use explanations below

COMPETENCY	SKILLS REQUIRED
SELF AWARENESS	▪ Label and recognize own and others' emotions. ▪ Identify what triggers own emotions. ▪ Analyze emotions and how they affect others. ▪ Accurately recognize own strengths and limitations. ▪ Identify own needs and values. ▪ Possess self-efficacy and self-esteem. ▪ Identifying emotions ▪ Accurate self-perception ▪ Recognizing strengths ▪ Sense of self-confidence ▪ Self-efficacy
SELF MANAGEMENT	▪ Set plans and work toward goals. ▪ Overcome obstacles and create strategies for more long-term goals. ▪ Monitor progress toward short- and long-term goals. ▪ Regulate emotions such as impulses, aggression, and self-destructive behavior. ▪ Manage personal and interpersonal stress. ▪ Attention control (maintain optimal work performance). ▪ Use feedback constructively. ▪ Exhibit positive motivation, hope, and optimism. ▪ Seek help when needed. ▪ Display grit, determination, or perseverance. ▪ Advocate for oneself.
SOCIAL AWARENESS	▪ Identify social cues (verbal, physical) to determine how others feel. ▪ Predict others' feelings and reactions. ▪ Evaluate others' emotional reactions. ▪ Respect others (e.g., listen carefully and accurately). ▪ Understand other points of view and perspectives. ▪ Appreciate diversity (recognize individual and group similarities and differences). ▪ Identify and use resources of family, specialized institutions and community.
RELATIONSHIP MANAGEMENT	▪ Demonstrate capacity to make friends. ▪ Exhibit cooperative learning and working toward group goals. ▪ Evaluate own skills to communicate with others.

	▪ Manage and express emotions in relationships, respecting diverse viewpoints. ▪ Communicate effectively. ▪ Cultivate relationships with those who can be resources when help is needed. ▪ Provide help to those who need it. ▪ Demonstrate leadership skills when necessary, being assertive and persuasive. ▪ Prevent interpersonal conflict, but manage and resolve it when does occur. ▪ Resist inappropriate social pressures.
RESPONSIBLE DECISION MAKING	▪ Identify decisions one makes in various settings. ▪ Discuss strategies used to resist peer pressure. ▪ Reflect on how current choices affect one's future. ▪ Identify problems when making decisions, and generate alternatives. ▪ Implement problem-solving skills when making decisions, when appropriate. ▪ Become self-reflective and self-evaluative. ▪ Make decisions based on moral, personal, and ethical standards. ▪ Make responsible decisions that affect the individual and the ones he relates to. ▪ Negotiate fairly.

SELF-AWARENESS

WHAT IS SELF-AWARENESS?

The first main skill associated with Social Skills is self-awareness. Self-awareness is the ability to accurately recognize one's own emotions, thoughts, and values, and how they influence behavior. It is the ability to accurately assess one's strengths and limitations, with a well-grounded sense of confidence, optimism, and a "growth mindset." In short, self-awareness is the ability to understand one's self.

WHAT SKILLS ARE ASSOCIATED WITH SELF-AWARENESS?

In order to be self-aware, one must be able to do the following:

- Identify emotions - It is important to be able to recognize and identify emotions. In order to be aware of their own emotions and participate in activities that address those emotions, individuals must first be able to label them.

- Have an accurate self-perception - Because self-awareness is based on an awareness of the "self," it is necessary for one's perception of self to match reality. In order to have accurate self-awareness, it is important to be reflective and open to feedback in order to develop a true sense of self. A realistic understanding of ourselves will allow uss to better manage our behavior.
- Recognize strengths - We each have unique strengths, and it is vital that we each recognize and build on them. An important piece of social emotional health is a focus on positive attributes.
- Possess self-confidence - When people are able to recognize their strengths, their self-confidence grows. Again, self-confidence is an integral piece of a healthy social emotional state.
- Demonstrate self-efficacy - Self-efficacy is an individual's belief in their ability to achieve a goal. Recent research suggests that by believing you are capable of something, you help yourself on the path to achieving it.

SELF MANAGEMENT

WHAT IS SELF-MANAGEMENT?

Self-management is the ability to successfully regulate one's emotions, thoughts, and behaviors in different situations. This regulation is achieved by effectively managing stress, controlling impulses, and motivating oneself. In short, self-management is the ability to set and work toward personal and professional goals without significant deviation.

WHAT SKILLS ARE ASSOCIATED WITH SELF-MANAGEMENT?

To possess self-management, one must develop the following skills and abilities:

- Impulse control – Impulse control relates to the idea of delayed gratification. This refers to the ability to distract oneself from a desire in order to delay that impulse. Impulse control, then, is the ability to not act on immediate impulses, but rather delay that action for a period of time.

- Stress management – Stress management can occur through a variety of strategies. Having a solid foundation of self-awareness will allow us to determine when we are stressed so we can implement practiced strategies with more success.
- Self-discipline – Self-discipline requires an individual to control one's feelings and impulses. Also known as willpower, self-discipline allows us to ignore other stimuli in order to focus on the goal at hand and follow our plans despite distractions.
- Goal setting – Research has found that people tend to find more success when working with individually set goals. These goals, however, need to be SMART (Specific, Measurable, Attainable, Realistic, Timely) so as to better prepare us to successfully meet them.
- Self-motivation – Intrinsic motivation is a skill that is difficult to teach. Individuals must develop their own internal push that will keep them moving toward a goal. Having developed a specific goal is a great start to employing self-motivation.
- Organizational skills – Organizational skills can refer to the organization of physical space and materials, mental pictures and information, and time. Keeping our work areas uncluttered, as well as storing materials in a neat and organized manner for easy access, allows for more productive work time. Filtering information to be relevant to the topic at hand with a clear big picture can help to keep us on track. Lastly, keeping track of time and being aware of time commitments can help us to meet expectations.

SOCIAL AWARENESS

WHAT IS SOCIAL AWARENESS?

Social awareness is defined as the ability to take the perspective of and empathize with others, including those from diverse backgrounds and cultures. It is the ability to understand social and ethical norms for behavior and to recognize family and community resources and supports. A developed sense of social awareness allows for successful interactions with others based on reactions and modifications that take place during the interaction.

WHAT SKILLS ARE ASSOCIATED WITH SOCIAL AWARENESS?

Based on the above definition, there are several skills that are associated with social awareness.

- Perspective-taking: Perspective-taking involves the ability to look at and understand a situation or concept from an alternate point of view.
- Empathy: Empathy is defined as the ability to understand and share the feelings of another. A common saying associated with empathy is to "put yourself in his/her shoes."
- Appreciating diversity: The value in recognizing that each individual is unique and that differences in race, creed, gender, sexual orientation, or belief should be celebrated rather than ignored or argued.
- Respect for others: Respect requires to view the world with an open mind and to ask questions rather than make judgments. Despite our differences, we should treat each other with kindness and curiosity rather than hatred or prejudice.

RELATIONSHIP SKILLS

WHAT ARE RELATIONSHIP SKILLS?

Relationship skills are the ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups.

To demonstrate appropriate relationship skills, one must must learn to:

- **Communicate clearly**: Effective communication requires the use of verbal and nonverbal skills to express oneself. Communication involves not only speaking clearly and conveying ideas appropriately, but also understanding body language, facial expressions, and gestures that can contribute to accurate delivery and perception. A strong sense of self-awareness can assist in building communication skills.
- **Listen well**: Active listening depends on the ability to consciously make the effort to hear and comprehend what the other person is saying and respond appropriately. Some basic skills involved in active listening include appropriate eye contact,

regulating thoughts to limit distractions, utilizing facial expressions, and providing oral responses.

- **Cooperate with others**: When people cooperate, they each become active members working toward a common goal. Cooperation requires that flexibility, an awareness of self and others, take turns, respect each other's thoughts and opinions, listen well, and practice effective problem-solving.
- **Resist inappropriate social pressure**: Strong self-management skills can help anyone to communicate and commit to their decision not to engage in unwanted, unsafe, unethical behavior. This type of behavior could range from professsional integrity issues to self-destructive patterns.
- **Negotiate conflict constructively**: Conflict resolution involves achieving mutually satisfactory resolutions to conflict by addressing the needs of all concerned. In order to resolve an issue in a relationship, one must know how to calmly discuss the problem, brainstorm solutions, and come to an appropriate decision.
- **Seek and offer help when needed**: Individuals should be encouraged to check their understanding in both personal and social situations. If someone hits a roadblock while working to achieve a goal, he/she need to know how and when to ask for help.

RESPONSIBLE DECISION MAKING

WHAT IS RESPONSIBLE DECISION MAKING?

Responsible decision making is defined as the ability to make constructive choices about personal behavior and social interactions based on ethical standards, safety concerns, and social norms. Essentially, all aspects of a potential decision and its consequences must be considered before a choice is made. To make the most appropriate behavioral choices, one need to learn how to evaluate the situation, analyze their options, and consider the potential consequences of each of those options for themselves and others.

WHAT SKILLS ARE ASSOCIATED WITH RESPONSIBLE DECISION MAKING?

In order to effectively make responsible decisions, one must develop competency with the following abilities:

- Identify the problem: The person must be able to accurately recognize when he/she has encountered a problem. Problems can range from difficulty meeting the expectations in a situation, to choosing whether or not to complete a task, or even deciding to engage in unhealthy behavior, such as lying or using banned substances. It is important to appropriately acknowledge when faced with a problem. For some, recognizing that they are in a difficult situation can be challenging as a result of their personal difficulties or social communication weaknesses.
- Analyze the situation: Once the person has succeeded in identifying the problem, he/she must then learn to analyze the situation from a variety of angles, which includes identifying how and why the problem arose.
- Solve the problem: After the problem was sufficiently identified, analyzed, and considered, the individual needs to develop and practice methods for solving problems. He/she needs to identify possible options and explore the potential consequences of each option. Individuals may need to be creative in their solutions to fit their own profiles.
- Consider ethical responsibility: In addition to the natural or identified consequences of a decision, one must also consider any ethical or moral obligations they may feel or be held to.
- Evaluate and reflect: Evaluating and reflecting on what happened is almost as important as the decision making process itself. When we take the time to evaluate how successfully we identified, analyzed and solved a problem, we are more apt to engage in appropriate reflection on what went well and what could be improved. This reflection allows us to note any necessary changes and work to incorporate those in their next decision making opportunity.

1) EXERCISE

Depending on time and the level of energy of the group the trainer may choose option 1 or 2.

OPTION 1

Have a FC prepared with the 5 Social skills competencies.

Print all skils, cut each one separateley (there are 48), turn them face down and invite participants to pick up X statements (divide the no of statements to number of participants).

ASK EACH PERSON TO COME TO THE FC AND MATCH IT WITH THE APPROPRIATE COMPETENCY.

BLUE TACK NEEDED !!!

TIME: 10 MINUTES.

After all skills have been placed, read what it is under each competency and place in correct place, if necessary.

TIME: 5 MINUTES

TOTAL TIME: 15'

- Label and recognize own and others' emotions.
- Identify what triggers own emotions.
- Analyze emotions and how they affect others.
- Accurately recognize own strengths and limitations.
- Identify own needs and values.
- Possess self-efficacy and self-esteem.
- Identifying emotions
- Accurate self-perception
- Recognizing strengths
- Sense of self-confidence
- Self-efficacy

- Set plans and work toward goals
- Overcome obstacles and create strategies for more long-term goals
- Monitor progress toward short- and long-term goals
- Regulate emotions such as impulses, aggression, and self-destructive behavior
- Manage personal and interpersonal stress
- Attention control (maintain optimal work performance)
- Use feedback constructively
- Exhibit positive motivation, hope, and optimism
- Seek help when needed
- Display grit, determination, or perseverance
- Advocate for oneself
- Identify social cues (verbal, physical) to determine how others feel
- Predict others' feelings and reactions
- Evaluate others' emotional reactions
- Respect others (e.g., listen carefully and accurately)
- Understand other points of view and perspectives
- Appreciate diversity (recognize individual and group similarities and differences)
- Identify and use resources of family, specialized institutions and community
- Demonstrate capacity to make friends
- Exhibit cooperative learning and working toward group goals
- Evaluate own skills to communicate with others
- Manage and express emotions in relationships, respecting diverse viewpoints
- Communicate effectively
- Cultivate relationships with those who can be resources when help is needed
- Provide help to those who need it
- Demonstrate leadership skills when necessary, being assertive and persuasive
- Prevent interpersonal conflict, but manage and resolve it when does occur
- Resist inappropriate social pressures
- Identify decisions one makes in various settings
- Discuss strategies used to resist peer pressure

- Reflect on how current choices affect one's future
- Identify problems when making decisions, and generate alternatives
- Implement problem-solving skills when making decisions, when appropriate
- Become self-reflective and self-evaluative
- Make decisions based on moral, personal, and ethical standards
- Make responsible decisions that affect the individual and the ones he relates to
- Negotiate fairly

OPTION 2

Have a FC prepared with the 5 Social skills competencies.

Print the skills corespondent to each competency as a block and cut them.

Divide the large group in 5 and ask each group to pick up one and then discus for 10 minutes in each group where do the skills match and write it on top of the paper.

Time: 15 minutes

Ask each group to come to the FC and place it.

Blue Tack needed!!

Correct and explain if necessary.

Time: 5 minutes

Total time: 20'

SKILLS REQUIRED FOR ….
▪ Label and recognize own and others' emotions. ▪ Identify what triggers own emotions. ▪ Analyze emotions and how they affect others. ▪ Accurately recognize own strengths and limitations. ▪ Identify own needs and values. ▪ Possess self-efficacy and self-esteem. ▪ Identifying emotions ▪ Accurate self-perception ▪ Recognizing strengths ▪ Sense of self-confidence ▪ Self-efficacy
SKILLS REQUIRED FOR ….
▪ Set plans and work toward goals. ▪ Overcome obstacles and create strategies for more long-term goals. ▪ Monitor progress toward short- and long-term goals. ▪ Regulate emotions such as impulses, aggression, and self-destructive behavior. ▪ Manage personal and interpersonal stress. ▪ Attention control (maintain optimal work performance). ▪ Use feedback constructively. ▪ Exhibit positive motivation, hope, and optimism. ▪ Seek help when needed. ▪ Display grit, determination, or perseverance. ▪ Advocate for oneself.
SKILLS REQUIRED FOR ….
▪ Identify social cues (verbal, physical) to determine how others feel. ▪ Predict others' feelings and reactions. ▪ Evaluate others' emotional reactions. ▪ Respect others (e.g., listen carefully and accurately). ▪ Understand other points of view and perspectives. ▪ Appreciate diversity (recognize individual and group similarities and differences). ▪ Identify and use resources of family, specialized institutions and community.
SKILLS REQUIRED FOR ….
▪ Demonstrate capacity to make friends. ▪ Exhibit cooperative learning and working toward group goals. ▪ Evaluate own skills to communicate with others. ▪ Manage and express emotions in relationships, respecting diverse viewpoints.

▪ Communicate effectively. ▪ Cultivate relationships with those who can be resources when help is needed. ▪ Provide help to those who need it. ▪ Demonstrate leadership skills when necessary, being assertive and persuasive. ▪ Prevent interpersonal conflict, but manage and resolve it when does occur. ▪ Resist inappropriate social pressures.
SKILLS REQUIRED FOR ….
▪ Identify decisions one makes in various settings. ▪ Discuss strategies used to resist peer pressure. ▪ Reflect on how current choices affect one's future. ▪ Identify problems when making decisions, and generate alternatives. ▪ Implement problem-solving skills when making decisions, when appropriate. ▪ Become self-reflective and self-evaluative. ▪ Make decisions based on moral, personal, and ethical standards. ▪ Make responsible decisions that affect the individual and the ones he relates to. ▪ Negotiate fairly.

CLOSURE

Recap with the group the topics presented and solicit one learning from each participant.

Have a a diploma for each participant printed in advance but do not fill in the names and the quality of the person.

For example something like this can be used

Divide participants in 3 groups.

- Group 1 will give diplomas to group 2
- Group 2 will give diplomas to group 3
- Group 3 will give diplomas to group 1

Each group will have to write the names of the people in the group they will have to write diplomas. Together they will decide a positive atribute for each person, then write the name and the atribute.

Ask each group to hand over the diplomas.

Total time -20'

BIBLIOGRAPHY AND GENERAL WEBLIOGRAPH

- Balasch et all (2016). Stigma and Discrimination in Mental Health. Obertament. Barcelona: Apunts.
- http://www.spora.ws/en/projects/stigma-and-discrimination-in-mental-health-in-catalonia 2016/
- **Documental Voices:**

  Romanian version: https://vimeo.com/9675627

  Portuguese version: https://vimeo.com/9679113

  English version: https://vimeo.com/9331285
- **Time to Change 'Schizo Movie' advert:**

  https://www.youtube.com/watch?v=5kh2SpZP4Cg
- Pinto Gouveia, J., Matos, A., Rijo, D., Castilho, P., Galhardo, A., Navalho, F., & Perdiz, C. (2000). O pensamento pró-social — Versão portuguesa adaptada. Instituto de Reinserção Social (tradução e adaptação do original: Ross, R., Fabiano, R., & Garrido, V., Él pensamento pro-social).
- Rijo, D., Sousa, M., Lopes, J., Pereira, J., Vasconcelos, J., Mendonça, M., Massa, S. (2006). G. P. S. Gerar Percursos Sociais - Programa de prevenção e reabilitação para jovens com comportamento social desviante. Ponta Delgada: Equal.
- Miller, S., Nunnally, E.W., & Wackman, D.B. (1991). Talking and listening Together. Interpersonal Communication Programs, Inc
- Occupational Medicine Vol. 50, No. 5, pp. 289-293, 2000, Copyright © 2000 LippincoH Williams & Wilkins for SOM.

- Mammadov, R. (2009). “An American writer Ernest Hemingway’s life style and its influence to his creative activity”, НАУЧНИ ТРУДОВЕ НА РУСЕНСКИЯ УНИВЕРСИТЕТ. (2009), том 48, серия 6.3, pp. 81-86
- Martin, C. D. (2006). Ernest Hemingway: A Psychological Autopsy of a Suicide. Psychiatry 69(4) Winter 2006, pp. 351-361
- Metts, T. J. (2016). Ernest Hemingway, A Comprehensive Psychological Case Study: His Life, Works
- Post, F. (1994). Creativity and Psychopathology- A Study of 291 World-Famous Men. British Journal of Psychiatry (1994), 165, pp. 22-34
- Rijo, D, (2018/2019). Aulas de Terapia Cognitivo-Comportamental nas Perturbações da Personalidade, Mestrado Integrado em Psicologia: Psicologia Clínica e da Saúde: Intervenções Cognitivo-Comportamentais nas Perturbações Psicológicas e Saúde, Ano Lectivo 2018/2019
- Wainer, R. & Rijo, D. (s.d). O Modelo Teórico – Esquemas Iniciais Desadaptativos, Estilos de Enfretamento e Modos Esquemáticos, Capítulo 4, Terapia Cognitiva Focada em Esquemas, pp. 47-63
- Pinto Gouveia, J., Matos, A., Rijo, D., Castilho, P., Galhardo, A., Navalho, F., & Perdiz, C. (2000). O pensamento pró-social — Versão portuguesa adaptada. Instituto de Reinserção Social (tradução e adaptação do original: Ross, R., Fabiano, R., & Garrido, V., Él pensamento pro-social).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