Project | 2017-1-PT01-KA202-035859

TRUST

TAILORING LAW AND HEALTH INITIATIVES TO PROMOTE INCLUSION ON MENTAL ILLNESS

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2017|2020

TRAINING MANUAL

Tailoring Law and Health Initiatives to promote Inclusion on Mental Illness

Specialized Law Enforcement Training Manual on Mental Health

This project has been carried out with the support of the European Commission. The content of this project does not necessarily represent the position of the European Commission or does it involve any responsibility on the part. The opinions expressed in this publication are those of the participants of partnerships.

TECHNICAL SHEET

TITLE

SPECIALIZED LAW ENFORCEMENT TRAINING PROGRAM ON MENTAL HEALTH

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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 out with the police forces, and these interviews served as a basis for drawing up the contents of the training.

The main conclusions of the various interviews with members of the police force are described below.

- All the police officers have regular contact with people with psychopathology/in altered psychological states. Usually they're called to intervene with medical teams in situations where the altered individual doesn't cooperate with said teams. Police officers, in these situations, are asked to convince/persuade the individuals to accept medical intervention (at the location or at the hospital, depending on the needs). More rarely, officers are asked to intervene in family contexts (e.g: when an altered son is being aggressive towards their parents) or on the street. Either way, the officers intervention is about the same: to convince altered individuals to accept medical intervention. Only one officer recalled a different type of situation: intervention in suicidal/parasuicidal behaviors.

- The knowledge possessed by the officers about mental illness is, as they easily recognize, limited. They never had specific training in psychology/psychopathology and their intervention is based on common sense and gathered or shared experience. When asked about the criteria they use to evaluate if an altered individual has or doesn't have

psychopathology they usually come up with the same answers: the coherence of the discourse and the perceived attachment to reality.

- All the officers interviewed consider it would be deeply beneficial and helpful to have specific training in psychopathology and in dealing with such individuals and situations. They feel that specialized training would surely help them in better dealing and intervening with people with psychopathology: “sometimes I don’t know what to say to establish a trustful relationship with an altered individual… maybe then I would know better”. Some of them think that it could also improve their capability in the diagnosis of the situation. The training would be particularly relevant, officers said, if “real examples/situations” could be used.

- Officers can only transport people in a police vehicle when the person is arrested or when he/she puts his/her life at risk. When the situation involves someone with psychopathology/in an altered psychological state the police officers call health emergency care. In those situations, it’s common procedure for the police officer to accompany the health professionals for security reasons. Before the Mental Health Law, it was possible for these individuals to be transported in a police vehicle but now it’s not possible.

- When intervening with individuals in altered mental states/with psychopathology, officers claim that they do their best to remain calm. Considering that those are not easy situations to deal with, some of the police officers interviewed are especially cautious as they consider that those with mental disorders are commonly unpredictable in their behavior. The majority of the interviewed claim that they act with empathy and understanding towards these individuals. Major concerns are the “choice of words” and their potential impact. Some officers feel capable of easily intervening in such situations, referring to their ability to remain calm and to engage in empathic dialogue as well as their capability to maintain self-control. However, some of them criticized the more aggressive approach that some colleagues have while others told us that sometimes it’s not an easy task to manage their own emotions.

- Police officers exposed to situations with traumatic potential (e.g. suicide) recognize that these situations have strong interference in their well-being and disturb their emotional regulation for long periods of time.

- Police officers claim that the use of force/physical contention rarely happens and is only used as a last resource, when all the other strategies/approaches fail.

1.3. TRAINING MANUAL

The manual presented is targeted at Law Enforcement Authorities, on how to deal with people with mental illness to avoid escalation when they intervene in a crisis situation and how to work in cooperation with institutions that are promoting community-based responses.

Police officers can have significant advantages in learning some techniques that can help them assess the mental state of the individual at the time of the intervention, such as: content and possession of thought, speech and speech, level of insight, psychomotor abnormalities, emotional states, etc.

In this manual we present some of the most likely mental disorders that certain individuals who come across as police may have. We can start with a "lighter" content, a more psychoeducational approach, for example, starting by explaining the evolutionary advantage of anxiety and emotions for the survival of our species. The construction of self, others, the world and reality are a more specific topic of cognitive theory, being introduced in personality disorders.

Depression, PTSD and suicide-related behaviour can not only be important for individuals, for example, dealing with calls that someone is threatening to kill.

For the police themselves, rescuers are more likely to develop depression, PTSD and commit suicide. In relation to the suicide and suicide module, there should be a distinction between suicide-related (SRB) behaviour with and without the intention of dying (the latter generally known as non-suicidal self-injury or deliberate self-harm).

Another topic for police training should address a cooperative effort to reorganise police intervention strategies, within their own practices and rules, in addition to some knowledge and good psychological practices that the training modules will give them.

1.4. TRAINING PLAN

TRUST PROJECT	2 HOURS
CONTENTS	
▪ Presentation ▪ Interview results ▪ Training manual	
INTRODUCTION	**2 HOURS**
CONTENTS	
▪ Mental health ▪ Law, justice and mental health	
BASIC CONCEPTS OF PSYCHOPATHOLOGY	**4 HOURS**
CONTENTS	
▪ The line that divides the normality/abnormality of the human behaviour ▪ In a manner of speaking, we may all be a little “crazy” ▪ some techniques on evaluating situations of mental disorder	
SPECIFIC PROBLEMS AND MENTAL DISORDERS	**7 HOURS**
CONTENTS	
▪ Anxiety ▪ Conduct disorder and violence ▪ Personality disorders ▪ Psychosis ▪ Depression and bipolar disorders ▪ Post-traumatic stress disorder (PTSD)	
TOWARDS AN INTEGRATIVE APROACH	**5 HOURS**
CONTENTS	
▪ De-escalating techniques ▪ Better practice in compulsory hospitalization ▪ Intervention in a violence crisis approach	
TOTAL	**20 HOURS**

PART II INTRODUCTION

1.1. 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, and 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.

2.2. LAW, JUSTICE AND HEALTH

2.2.1. INTERNATIONAL MENTAL HEALTH CARE LAW

a) 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

b) 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

2.2.2. 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 physi-cal 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 III |BASIC CONCEPTS OF PHYCHOPATHOLOGY

3.1. THE LINE THAT DIVIDES THE NORMALITY/ABNORMALITY OF THE HUMAN BEHAVIOUR

Surely all of us know that what really separates the normal from the abnormal, regarding the human behaviour, is more of a continuum than a clear line. However, as noticed in the interviews, many police officers have questions and doubts about what this really is about. Therefore, what we propose here is an introduction module stating that all human behaviour is understandable, in a very simple way, through the concepts of cognitions (beliefs, thoughts and attitudes) and emotions (affective regulation systems), even the unusual, "abnormal" behaviour: the latter carrying suffering to people and dysfunction in every context of our life.

3.2. IN A MANNER OF SPEAKING, WE MAY ALL BE A LITTLE "CRAZY"

Highly related to the first point, we all are given our own idiosyncrasies and little things that make us ourselves. By having an open approach during the training session, a sharing and cooperative mentality may be useful to understand that no one really is average in every dimension – we all have our little craziness. However, some people "just" have some more difficulties than the "average" person – some feel trapped in their very selves; others may think that they can prevent the death of a loved one by knocking an uneven number of times on the wooden table… all day long.

3.3. SOME TECHNIQUES ON EVALUATING SITUATIONS OF MENTAL DISORDER

It is important that a more accurate analysis concerning the mental state of the individuals could be made by law enforcement. Police officers may have significant advantages in learning some techniques that can help them evaluate the mental state of the individual by the time of the intervention. It is not intended that police officers do the role of a psychologist or a clinician but to better inform on what main topics should be in mind when in an intervention that, supposedly, involves a person with a mental disorder.

The main aspects to be attentive to are:

1. Aspect, Attitude and Activity
2. Humour and Emotions
3. Language and Speech
4. Contents and Process of Thought and Perception
5. Cognition
6. Insight and Critical Judgement

3.3.1. ASPECT, ATTITUDE AND ACTIVITY

In what concerns Aspect we are aiming at the physical description of the individuals. By this we mean body type, physical visible anomalies or impairments, the way of dressing and hygiene. This is important because it can give us clues about other important areas like humour (for example a depressed individual is more likely to be negligent with his/her indumentary and hygiene), ageing, cognitive state, self-knowledge, some kind of thought distortion, motor agitation or disturbance and general state.

When we refer to Attitude, we are trying to see how the individual interacts with the agents (for example, he/she can be hostile, can be cooperative, can try to be to intimate). It is important to bare in mind that and individual may be responding in a hostile form not because he wants to but due to the fact that he/she can have a mental illness (for example a paranoid schizophrenia), so all sort of interactions give precious information about the possibility of a presence of a mental disorder and need for medical care. The attitude can modify during the time of interaction, for example, if the individual starts to fell less or more threatened or the anxiety levels increase or decrease.

Activity concerns the quality, level and frequency of the individual´s movements. Some individuals practically don't move, others can't stop still and other can show some type of abnormal movements.

3.3.2. HUMOUR AND EMOTIONS

Humour and Emotions are another fundamental aspect that is needed to be accounted for.

Emotions are how the internal state of the individual manifest itself externally and dynamically and they are observable in every human being. They may or may not be in coherence with the self-reported humour (for example, an individual can state he is calm and still won't stop moving from one place to another).

Humour is the internal set of emotions that are predominant in a person at a determined moment in time. Any person, with or without a mental disorder, can present a particular state of humour that derives from the internal and external circumstances. Neither one or the other give us one hundred percent information about the presence of a psychiatric disorder, as in the other points to be considered, but very exacerbated manifestations of paranoia, or grandiosity, or melancholy, or irritability, can provide information that the individual needs clinical evaluation.

3.3.3. LANGUAGE AND SPEECH

Language contains both semantic and motor components. The semantic component concerns its ability to contain a meaning that's understandable. The motor components concern the correct articulation of words and correct construction of sentences, fulfilling its grammatical rules, and facial and gestural expressions and writing. Some psychiatric disorders involve impairment on language and speech, for example, schizophrenia, anxiety and mania. Regarding this topic it is necessary to be attentive if the both the semantic and motor components of the language are intact or if they present some peculiarities, for example if the sentences don't make state an understandable content, if the individuals show difficulty in finding the words, if the sentences are mainly paranoid, if they state mainly depressed impressions, also the tone if is too high, these are remarks for clinical evaluation.

3.3.4. CONTENTS AND PROCESS OF THOUGHT AND PERCEPTION

There is no possibility that we can know what individuals are thinking, we can only infer it based on what we see and what they say. The Contents and Process of Thought are crucial to the understanding of a possible underlying mental illness. Serious impairment on the content and process of thought is a characteristic of the most severe and incapacitant typologies of psychiatric disorders. For example, an individual with schizophrenia can present delusional speech, hallucinations, difficulty in doing associations with very strict ideas of reference and a block of thought. Another example is the Personality Disorders, in particular, the Borderline

and Personality Disorder. Individuals with a Borderline Personality Disorder usually use immature defence mechanisms associated with psychotic contents and processes of thought and, sometimes, they can even present delusions and hallucinations. Also, a severe depression can show psychotic symptoms like hallucinations and delusions. All of these indicators show clear need of medical evaluation. A simple idea if how the psychotic thinking works is comparing it to the early stages of development if a child. Children have a primary process of thought, which is, for example, they can´t distinguish between real and fantasized monsters or ghosts or when they are involved in their magical thoughts, like they are super heroes or princesses or are talking to a friend who doesn't exist. This process is exemplificative of how the psychotic thinking works. A normal process of thought can distinguish reality from fantasy, distinguish between the self and the others and is conscious and alert.

Perception changes include hallucinations, delusions, de-realization, and depersonalization, among others less incident. These changes can occur within the scope of any of the senses: vision, tact, smell, taste and hearing.

3.3.5. COGNITION

Cognition is understood as the ability to use intelligence, knowledge, logics, reasoning, memory and all other superior functions of the cortex. This is the area where structured evaluation is required, by the use of tests and expertise of the clinician, so when intervening Cognition won't be possible to analyse, even at a superficial level. Still, the information, per se, is important as it is one of the axis of a procedure of evaluation of a psychiatric disorder, and can be hinted by other variables that were described earlier as Language and Speech and Process and Content of Thought and Perception. The topics concerning the evaluation of Cognition are:

a) Self, Time and Space Orientation
b) Attention and Concentration
c) Short Term Memory (verbal and non-verbal)
d) Long Term Memory (verbal and non-verbal)
e) Constructive and Visuospatial Capacity
f) Conceptualization and Abstraction

As an example, if we are in face of an individual who can´t say where he is from, in what year we are, what is his/her name, family, it's an indicator that further and more specific clinical evaluation should be performed.

3.3.6. INSIGHT AND CRITICAL JUDGEMENT

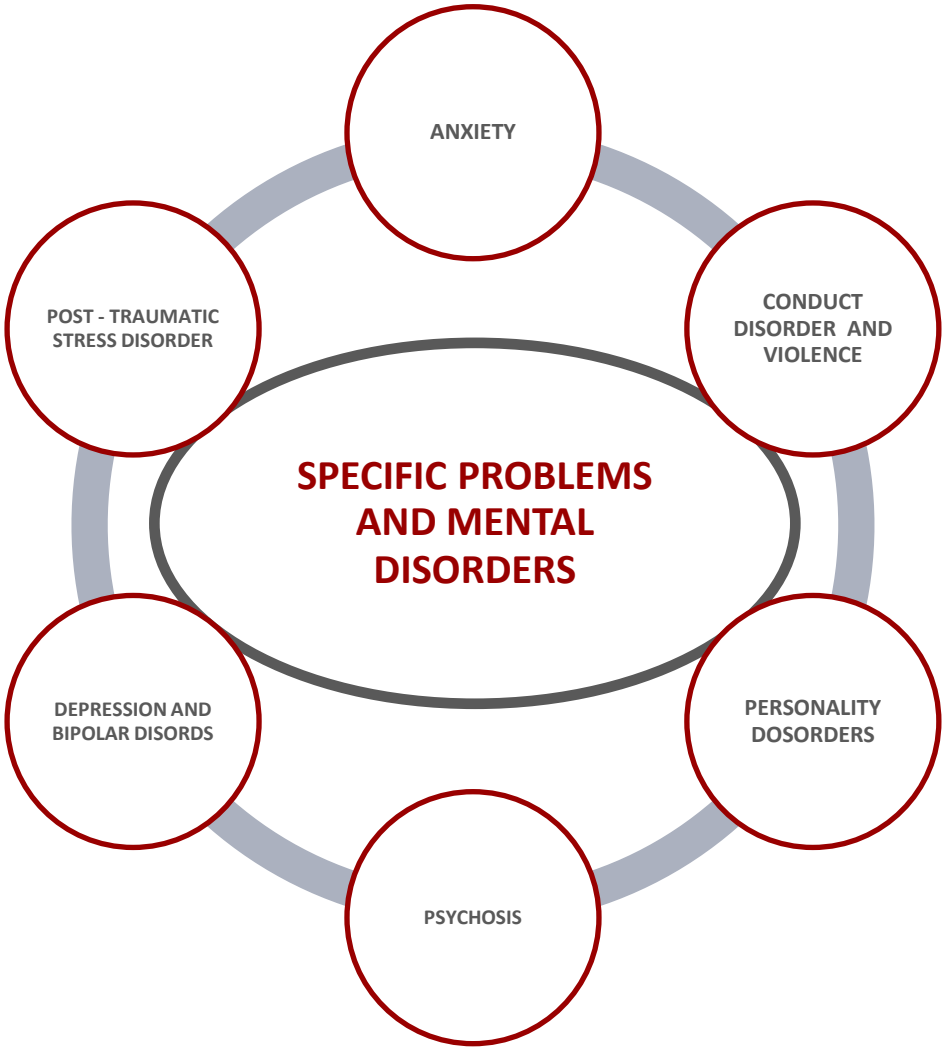
Insight and Critical Judgement are highly complex cognitive tasks that require the mobilization and integration of several different mental functions. Insight includes the ability for abstractive reasoning, communication (speech and language), intact cognitive functions, and absence of thought disruption, humour and emotional stability. Insight, like Cognition, is very difficult to evaluate, it is possible to do it within the scope of an organized interview in which it can be seen if the individual is able to perform correct judgements, either about him/herself, context, relations and other areas of functioning. The more severe the mental illness stronger are the chances that the Insight of the individual is impaired and the leads to incorrect readings of the reality and him/herself. Insight and Critical Judgement are interconnected. To critically evaluate a situation, an interaction, a relation, to evaluate the oneself adequacy of behaviour or thought, it also necessary to have the ability of Insight. To make a right decision or adopt the expected behaviour the individual needs to distance from him/herself so to be able to judge critically situations and the complications of his/her behaviour. For example, if you act quickly on your emotions disregarding consequences for yourself and others it means your ability for critical judgement and insight is impaired, which is very common for instance, in a Borderline Personality Disorder. If in contact there are indications that the individual is not understanding fully and deeply the contents and consequences of his/her behaviour this is important as an indicator for posterior and more accurate clinical analysis.

It is of high importance that, in a situation of intervention, the team or agent remains calm and transmits safety to the person. Sometimes it may be difficult if he/she is very irritated or delusional, but the state of the individual changes as emotions and thoughts change also. The interaction should use, preferably, open questions for the individual to start talking so some of the points above can be assessed, of course at a superficial level. Questions like “How have you been feeling lately?” “It seems like you are a bit shaken, feel free to tell me about it if you wish”. It is necessary to show empathy and comfort so that the person feels they are relevant and important. Another point is to say that anything that is told (safeguarding the information’s as foreseen in law as mandatory to report) is confidential so the individuals can tell how are they are feeling, what happened, what have they been trough. In some situations, rarer, if the individual is paranoid or delusional, it is important to be aware of the non-verbal clues like looking away from the agents or staring at something non-visible. This doesn’t mean the person is not cooperative, it may mean that he/she is too scared or confused to share anything because is in a state of activation, suspicious, paranoid or delirious. Also, the content of the speech may not be congruent with the behaviour, for example if a person says it’s not depressed but feels sad and its crying or for example answer’s in a hostile tone to a question like “Are you feeling well?”.

The key note is not to engage in the individual behaviour, meaning, it is of the outmost importance to show empathy and safety abut also if the person is reacting aggressively, not to engage in an aggressive answer, or if the person is hostile not to engage in a hostile tone of voice or behaviour, even though maintaining authority. To engage in the person´s reaction would be counter-producent and unprofessional because it will damage the possibility of a good, or less bad, outcome of the interaction. Criticism should not be used; laughter should not be used. It is possible that in an interaction with an individual with a personality disorder some we feel some comments should be made like, for example, “You are of enough age to control your behaviour.”, or in an interaction with a person with hallucination he/she may say something funny and we laugh. These types of behaviours should be controlled. A psychiatric

disorder means a huge suffering for the person, and as above seen, some of them don't have the ability to critically understand and judge their behaviour so at all times full respect and compassion for the person must be shown.

PART IV | SPECIFIC PROBLEMS AND MENTAL DISORDERS



4.1. ANTIETY

WHAT IS ANTIETY?

Anxiety is a psychological, physiological, and behavioral state induced in animals and humans by a threat to well-being or survival, either actual or potential.

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4.1.1. CHARACTERISTIC AND PATHOLOGIES

ANXIETY - CHARACTERISTICS

- Increased arousal
- Expectancy
- Autonomic and neuroendocrine activation
- Specific behavior patterns.
- The function of these changes is to facilitate coping with an adverse or unexpected situation

PATHOLOGICAL ANXIETY

- Pathological anxiety interferes with the ability to cope successfully with life challenges.
- Vulnerability to psychopathology appears to be a consequence of predisposing factors (or traits), which result from numerous gene-environment interactions during development (particularly during the perinatal period) and experience (life events)

NORMAL VERSUS PATHOLOGICAL ANXIETY

- Anxiety is a natural adaptive reaction
- It can become pathological and interfere with the ability to cope successfully with various challenges and/or stressful events, and even alter body condition (eg, formation of gastric ulcers)

VULNERABILITY FACTORS FOR THE DEVELOPMENT OF HUMAN ANXIETY DISORDERS IN HUMANS

These predisposing factors, either innate or acquired, determine individual "or coping strategies", which are thought to play an important role in vulnerability to psychopathology:

- A generalized biological vulnerability, mainly of genetic origin
- A generalized psychological vulnerability, resulting in particular from early life experiences
- A specific psychological vulnerability, focused on particular events or circumstances. This is probably implicated in the development of specific anxiety disorders (as opposed to generalized anxiety disorders), ie, social phobia, obsessive-compulsive and panic disorders, and specific phobias

EMOTIONS

Experienced or expressed at three different, but closely interrelated levels:

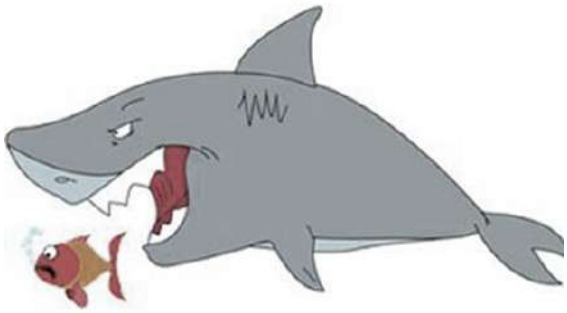
- Mental or psychological level
- The (neuro)physiological level
- The behavioral level

These three complementary aspects are present in even the most basic emotions, such as fear.

ANXIETY VS FEAR

- Anxiety is a generalized response to an unknown threat or internal conflict
- Sense of uncontrollability focused on possible future threats, danger, or other upcoming potentially negative events
- Fear is focused on real, known, objective external danger
- In fear the danger is present and imminent

FEAR| STRESS RESPONSE TO IMMEDIATE DANGER



ANXIETY| STRESS RESPONSE JUST FROM YOUR THOUGHTS

4.1.2. DEFENSE AND COPING STRATEGIES

DEFENSE AND COPING STRATEGIES

- Fear or anxiety are adaptive or defensive behavior
- The aim is to escape from the source of danger or motivational conflict.
- These behaviors depend on the context and the repertoire of the species.
- Active coping strategies are used when escape from threat is possible
- This is the fight-or-flight
- Passive coping strategies, such as immobilization or freezing, when threat is inescapable
- Active coping behaviors are unconditional responses to proximate threat
- Passive coping strategies, such as freezing, are conditioned responses to distal stimuli predictive of danger
- The proper decision about the best strategy to be used in a particular context depends on the risk assessment

- The choice between an active or passive defense strategy does not entirely depend on contextual clues
- Individual differences in coping styles do exist and may also influence this choice
- In a given situation, some individuals may react actively (“proactive” style), whereas other individuals may react in a more passive way (“reactive” style)
- The capacity to cope successfully with life challenges, whether innate or acquired, is a primary determinant of resistance to stress-induced diseases

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4.2. CONDUCT DISORDER AND VIOLENCE

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When addressing the topic of Conduct Disorders and Violence it is imperative to bear in mind that several different typologies of psychopathological profiles are included in this general designation.

The disorders of disruptive behaviour, impulse control generally include pathological conditions that are marked by problems of emotional self-control and behaviours. Other pathological profiles can involve a lack of impulse and emotional regulation but, concerning this topic, we are addressing specifically the disorders that manifest themselves by the adoption of behaviours that violate the rights of others (for example aggression, property destruction) and/or involve the individuals in significative problems and conflicts with law and justice authorities and the normative rules of societal living.

Even though all disorders of disruptive behaviour and control impulse work within the framework of these two main topics, they are distinctive between them in the frequency, modality, and variation of the two types of problems of self-control. Disruptive disorders are associated with an elevated degree of externalization like disinhibition and negative emotionality.

4.2.1. OPPOSITIONAL DEFIANT DISORDER

DIAGNOSTIC CRITERIA

A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful

Argumentative/Defiant Behavior

- Often argues with authority figures or, for children and adolescents, with adults
- Often actively defies or refuses to comply with requests from authority figures or with rules
- Often deliberately annoys others
- Often blames others for his or her mistakes or misbehaviour

Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months

NOTE

The persistence and frequency of these behaviours should be used to distinguish a behaviour that is within normal limits from a behaviour that is symptomatic. For children younger than 5 years, the behaviour should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behaviour should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviours are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behaviour is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviours do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

4.2.2. INTERMITTENT EXPLOSIVE DISORDER

DIAGNOSTIC CRITERIA

A. Recurrent behavioural outbursts representing a failure to control aggressive impulses as manifested by either of the following:

- Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.
- Three behavioural outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/ or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).

D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

E. Chronological age is at least 6 years (or equivalent developmental level).

F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). For children ages 6-18 years, aggressive behaviour that occurs as part of an adjustment disorder should not be considered for this diagnosis.

NOTE

This diagnosis can be made in addition to the diagnosis of attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.

4.2.3. CONDUCT DISORDER DIAGNOSTIC

DIAGNOSTIC CRITERIA

A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 1 5 criteria in the past 1 2 months from any of the categories below, with at least one criterion present in the past 6 months:

AGGRESSION TO PEOPLE AND ANIMALS

- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others (e.g., a bat,
- brick, broken bottle, knife, gun)
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- Has forced someone into sexual activity

DESTRUCTION OF PROPERTY

- Has deliberately engaged in fire setting with the intention of causing serious damage
- Has deliberately destroyed others' property (other than by fire setting)

DECEITFULNESS OR THEFT

- Has broken into someone else's house, building, or car
- Often lies to obtain goods or favours or to avoid obligations (i.e., "cons" others)
- Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

SERIOUS VIOLATIONS OF RULES

- Often stays out at night despite parental prohibitions, beginning before age 1 3 years
- Has run away from home overnight at least twice while living in the parental or pa- rental surrogate home, or once without returning for a lengthy period
- Is often truant from school, beginning before age 13 years

B. The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

NOTE:

With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).

Lack of remorse or guilt: Does not feel bad or guilty when he or she does some- thing wrong (exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules.

Callous lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.

Unconcerned about performance: Does not show concern about poor/problematic performance at school, at work, or in other important activities. The individual does not put

forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance.

Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off' quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).

4.3. PERSONALITY DISORDERS

Personality traits are stable patterns of understanding, reaction and thinking about one's surroundings and oneself, which are expressed in a wide range of contexts of a social and personal nature.

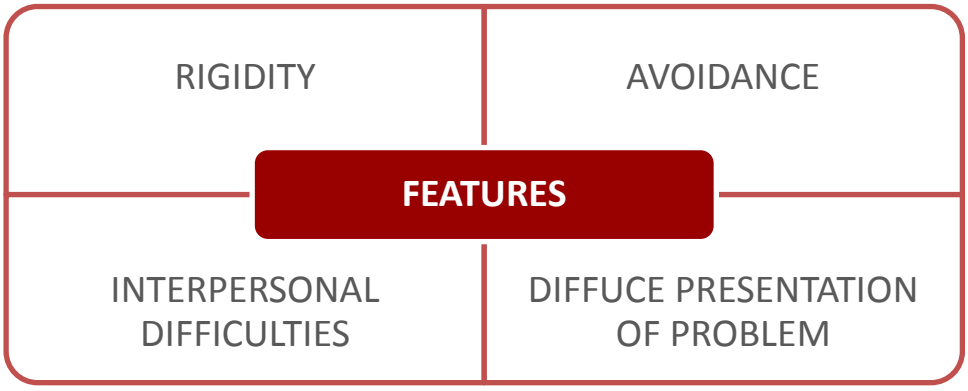
Only when personality traits are inflexible and maladaptive, causing significant functional deficit or subjective malaise, do they constitute Personality Disorders.

Characteristics of a Personality Disorder are usually recognizable during adolescence or early adulthood. Some types of personality disorder tend to be less evident or remit with age (antisocial and borderline) which seems to be less true for other disorders (obsessive-compulsive or schizotypic).

https://www.google.com/search?q=personality+disorders&tbm=isch&ved=2ahUKEwih0Li45JvsAhWI

PERSONALITY DISORDERS

- General name including several different typologies of psychopathological profiles
- They include pathological conditions marked by problems of emotional self-control and distinct behaviors
- These are egosyntonic traits, that is to say, people do not recognize that they have a problem. Most of the time they attribute the responsibility of events to others or the environment and never to themselves.



4.3.1. CLUES TO IDENTIFYING A PERSONALITY DISORDER

- The patient or significant other reports that the pattern of behavior is chronic
- Numerous therapeutic contacts already made
- Absence of an adaptive internal reference point
- Poor self-monitoring
- Self-monitoring of others also poor or distorted
- The therapy consists of a series of seizures
- The therapy seems to have come to a sudden and inexplicable impasse
- The behavior is egosyntonic
- Resistance to therapy
- Rigid and compulsive behavior
- Appreciation of the need for therapy but no observable change
- The therapist has to make a lot of effort to patient in therapy

4.3.2. PERSONALITY DISORDER - DIAGNOSTIC CRITERIA

CRITERIA

A. A lasting pattern of internal experience and behavior that markedly deviates from what is expected in an individual's culture. This pattern is manifested in 2 (or more) of the following areas:

1. Cognition (ie, forms of perception and interpretation of oneself, others and events)
2. Affectivity (ie, variety, intensity, lability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

B. The enduring pattern is inflexible and global in a wide variety of personal and social situations.

C. The enduring pattern results in clinically significant malaise or deficit in social, occupational, or other important areas of functioning

D. The pattern is stable, long-lasting and its onset occurs at the latest in adolescence or early adulthood

E. The enduring pattern is no longer best explained as a manifestation or consequence of another mental disorder

F. The lasting pattern is not due to direct physiological effects of a substance (eg drug abuse, medication) or other medical condition (eg head trauma)

4.3.3. DIAGNOSTIC GROUP

CLUSTER A - STRANGER / ECCENTRIC

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

CLUSTER B - THEATRICAL / EMOTIONAL / LABILE

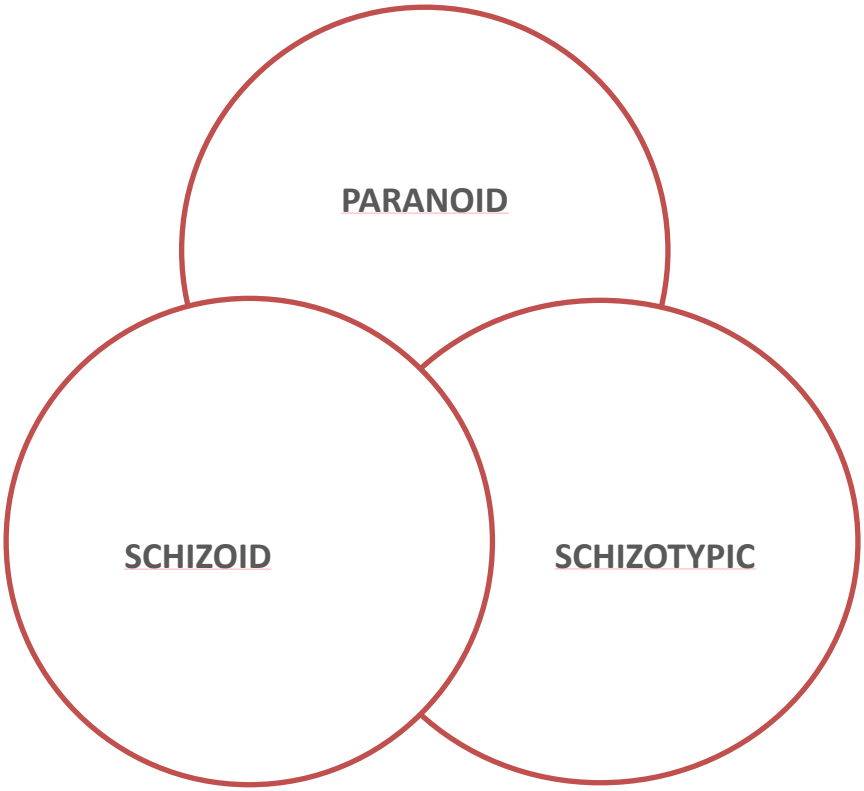
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder

CLUSTER C - ANXIOUS / FEARFUL

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

EXAMPLE

We often find comorbidity because the criteria of one pull out the criteria of the other. Comorbidity may occur without being within the same groups.



GROUP A - STRANGERS / ECCENTRIC

A. PARANOID

Distrust. Suspicious. The motives of others are interpreted as malevolent.

B. SCHIZOID

Indifference to relationships and restriction of emotional expression.

C. SCHIZOTYPIC

Null intimate personal relationships, cognitive and perceptive distortions, eccentric behaviors, belief in the supernatural, weird things.

GROUP B - THEATRICAL / EMOTIONAL / LABILE

A. ANTISOCIAL

Disrespect for the rules / laws and rights of others

B. BORDERLINE (LIMIT-STATE)

Instability in interpersonal relationships, self-image, with marked impulsivity

C. HISTRIONIC

Exaggerated emotionality and seeking attention from others

D. NARCISSISTIC

Greatness, need for admiration, lack of empathy

GROUP C - ANXIOUS/FEARFUL

A. AVOIDING

Social inhibition and negative evaluation of others

B. DEPENDENT

Dependent and submissive conduct, inability to make decisions, worry about being abandoned

C. OBSESSIVE-COMPULSIVE (ANANCASTIC

Concern with order, perfectionism and control, rules, organization and planning

4.3.4. CASE STUDY

Case Study: Bordeline Personality Disorder Ernest Hemingway

A. INTRODUCTION

For the purpose of this Case Study, we chose as public figure for the Borderline Personality Disorder, the Nobel Prize for Literature, Ernest Hemingway.

Ernest Hemingway was born on July 21, 1898 in Illinois, Oak Park. Ernest Hemingway belonged to a family of 6 siblings. He was preceded by his sister Marcelline and followed by his brothers Ursula, Madelaine, Carol and his brother Leicester. His father, Clarence Hemingway, a physician by profession, instilled in Ernest a taste for nature-related activities such as hunting, fishing, mountaineering, and other sporting activities. His mother, Grace Hemingway, with a background in music, including singing, promoted Hemingway's artistic taste.

Apparently, Ernest Hemingway would have everything to have a normal development, including having been born in a privileged environment from the financial as well as the cultural, scientific and religious point of view. However, the dynamics of the Hemingway family were dysfunctional, with serious implications for their children. Hemingway's family had a line of mental health problems from both his mother Grace and his father Clarence. Grace's brother Leicester also suffered from sudden mood swings, insomnia and headaches as well as Clarence's brother, Alfred.

In 1928, his father Clarence committed suicide with a gunshot to the head using a Civil War collection pistol. Hemingway receives the news of his father's death in Italy, where he was at the time, and blames his mother for his father's death, saying that she always dominated him and pushed him to suicide. This starts in Hemningway an escalation in alcohol consumption and "strange incidents" which in fact are no more than self-harm behaviors. He referred to his mother always as "that bitch" and kept for her and his father, whom he called a coward because he considered that he had committed suicide to escape his mother's control, anger and hatred. The brothers of Ernest, Ursula and Leicester will also commit suicide as well as Ernest Hemingway himself.

His academic life was quite good. Although he did not attend university, Ernest distinguished himself as a good student and an excellent athlete while attending college. His favorite activity, however, was to write for the school newspaper. During this time, he still tried to run away from home twice.

His opportunity to run away from home came when he was 18 years old at the time of World War I. Ernest volunteered to serve his country in the War in 1917 and thus had the opportunity to move away from the dysfunctional family environment in which he lived. Once he had vision problems he was not accepted for infantry but managed to enlist in the services of the Red Cross on the Italian front. He already lived the experience of a childhood in a violent and dysfunctional environment, and then one of the most remarkable experiences of his life happens when, in trying to save a wounded soldier, he was hit in the leg by a machine gun. The soldier died and Hemingway had to remove about 200 fragments of bullet from his leg. In addition to this experience, Hemingway, as the exponent of masculinity and manhood, courage and determination, a legend that Hemingway sought to cultivate throughout his life, also brings together another event. While hospitalized, Hemingway fell in love with a nurse, Agnes von Kurowsky, who later abandoned him by letter, with Hemingway already at home. Here Ernest suffers his first experience of abandonment and rejection of love.

Ernest Hemingway has been married 4 times. His love life, too, is a state of constant instability and impulsivity. In addition to his four women, he had numerous lovers and passions, he himself said that he needed to be always a little in love. His fame as a conqueror and man of many women was more than well-known.

Scott Fitzgerald is the author of the following statement “I have a theory that Ernest needs a new woman for each big book. There was one for The Sun Also Rises. Now there´s Pauline. A Farewell to Arms is a big book. If there is another big book I think we will find Ernest has another wife.(...) Sure enough, he married Martha Gellhorn for For Whom the Bell Tolls and Mary Welsh for Across the River.” (Metts, 2016, p. 19).

Even for all his charm, Ernest could not maintain a marriage because of his characteristics of mood instability, irritability, affective dysfunctionality and alcoholism. His first wife was Hadley Richardson in 1921, with whom he had his first son John. Hadley recounts an episode in which she found her husband "sky high, emotionally intense and ready to explode" (Martin, 2006,

p.354). At this point, Hadley advised him to go on a trip alone because his presence was too disturbing for her and her son John. His second wife was Pauline Pfeiffer, with whom he became involved while still married to Hadley. Hemingway married Pauline in 1927, just 4 months after divorcing Hadley, and with Pauline he had two children, Patrick and Gregory. While still married to Pauline, he began a romance with Martha Gellhorn, whom he married in 1940. Martha was going to Spain then Hemingway went with her to do journalistic coverage of the Civil War for the North American Newspaper Alliance. In Spain he was fond of bullfights, all the violent spectacle, the art of the matador, the glorification of blood and death are aspects that are transversal to his life and for which he was obsessed, practicing them in hunting, fishing and War. In 1944, Hemingway travels to England to write chronicles for Collier's Magazine about the work of British Royal AirForce. Still married to Martha Gelhorn, here he meets Mary Welsh, his next and last woman with whom he married in 1946.

After World War II, Hemingway decides to withdraw. Spend the time traveling between home in Cuba and his home in Key West Florida. He fishes fish three times as big as swordfish, just like the Old Man and the Sea, continues to hunt wild animals, drinks without standards, and trains the bombardment of enemy submarines by throwing grenades from his Pilar boat to sea turtles. He continues to have several "strange incidents" almost all of which put him at risk of life.

In 1952 is published the novel The Old Man and the Sea. In 1954 he is awarded the Nobel Prize for Literature. Hemingway's health was too deteriorated for him to go personally to receive. Hemingway already suffered from diabetes, hypertension, vision problems (which he has always had lifelong but refusing to wear glasses), multiple fractures in multiple organs due to the accidents he has had throughout his life, from a motorcycle accident in which he crashed with his head, two plane crashes in one of which he tried to open the door of the plane with two blows with his head until it began to drain cerebrospinal fluid through one ear, a fall in the Pilar where he also had a head injury, kidney failure and intense body aches.

Hemingway begins to enter into a phase of cognitive deterioration due to the mental and physical health problems we will explore in the Case Formulation, but also due to the various accidents, fractures, head injuries and alcohol abuse that have characterized his life and made him the icon of the masculinity, virility and bravery of his time. In this period, and in an episode

at home after severe hospitalization, he still writes A Moveable Feast, an ode to his youth spent in Paris with his first wife, when he began to acquire great literary notability.

On July 2, 1961, and after another two months of hospitalization and electroconvulsive shock therapy, Ernest Hemingway got up earlier than his wife, dressed in his best robe he liked to call "emperor's robe" and fires a shotgun at the head.

B. CASE FORMULATION

1. Ernest Hemingway´s characteristics that refer to a Personality Disorder, DSM 5 (APA, 2013)

Considering the whole history of Ernest Hemingway, we believe we are in a position to diagnose a Personality Disorder, in this case a Borderline Personality Disorder, but we will begin with the analysis for General Personality Disorder traits.

General Personality Disorder

CRITERIA

A. A lasting pattern of inner experience and behavior that deviates markedly from expected in the culture of the individual. This pattern is manifested in 2 (or more) of the following areas:

1. Cognition (that is, forms of perception and interpretation of oneself, of others and events).
2. Affectivity (i.e., variety, intensity, lability and adequacy of emotional response).
3. Interpersonal functioning.
4. Pulse control.

Ernest Hemingway fulfills criterion A in points 1, 2, 3 and 4. In our opinion, point 1, Cognition, Hemingway had a distorted image of himself, an image he built, an idealized image that he began to cultivate as Hemingway's real image. This image consists of heroic attributions, excessive masculinity, acts of bravery that in reality are acts of self-harm, including creating

what has been designated by scholars of his literature and life as "Hemingway Code Hero", an ideal of man, values and actions to which all would have to correspond, in particular the heroic characters of his literature. Concerning point 2, Affectivity, Hemingway characterized his entire life, particularly his love life, by total instability, marrying four times and having numerous lovers and passions. His friends report, themselves, as described above, this characteristic of Hemingway and use the expression “womanizer and egotistic” to describe it. Although a man who has several women may be considered, for the time, a relatively common conduct, the fact is that in Ernest Hemingway this acquired characteristics of exaggeration, identified by both society and his intimate environment that reveals that even by the standards of the time his behavior appeared to be out of order. Even with his friends, Hemingway was characterized as being both gentle and affectionate as irascible and intolerable. Concerning point 3, Interpersonal functioning, in spite of the idealized Ernest as hero of war and man of bravery and virility, in our opinion compensatory processes of a confused identity in terms of femininity and masculinity, Ernest also had reputation of being a man of difficult tract having problems in maintaining friends and wives, as stated above. An example that has been reported is his dispute, which came to physical terms, with the writer Max Eastman who made a chronicle of the following remark “Come out from behind that false hair on your chest, Ernest. We all know you “ referring to Ernest. Hemingway turned to him and smacked him in the face with his own book. Eastman later came to tell that he had tossed Ernest onto a desk to which Ernest replied: “If Mr. Eastman takes his prowess seriously – if he has not, as it seems, gone for fiction – then let him waive all medical rights and legal claims to damages, and I’ll put $ 1,000 for any charity he favors or for himself. Then we’ll go into a room (…) Well, the best man unlocks the door “(Bruccoli, 1986, p.16 in Dieguez, 2010, p.181). Hemingway had great difficulty in controlling his impulses, point 4, Impulse Control. Constantly drunk, he engaged in multiple fights, threw himself into bullfights, engulfed himself in violent situations, as well as being thrown into Normandy’s landing without permission. His own passions were driven on impulse, begging for marriage women on the first day he met them, in the case, Martha Gellhorn.

B. The enduring pattern is inflexible and global in a variety of personal and social situations

This pattern of behavior, as we can see from his life history, begins very early in Hemingway's adolescence and accompanies him throughout his life. We can also see that it is a pattern of stable and inflexible functioning and that is transversal to different situations of life, be it love relationships, friendships or professional relationships.

C. The durable pattern results in clinically significant malaise or deficits in social, occupational, or other important areas of functioning

Despite his posture of invincible Ernest Hemingway, Ernest has always had high levels of internal suffering. All his life since his childhood has been marked by events of extreme violence that he will reproduce excessively in its behavioral pattern. However, he often confided to some of his friends or, autobiographically in his books, phrases that revealed his suffering as "Families have many ways of being dangerous." (Hemingway, 1964, p 108 in Martin, 2006, p. 353) or, still relatively to his family, wrote to his friend Charles Scribner in 1961 about his mother "I hate her guts and she hates mine. She forced my father to suicide, " or, in a letter he wrote to his friend John dos Passos "I felt that gigantic bloody emptiness and nothingness. Like couldn't ever fuck, fight, write, and was all for death.". This whole pattern of functioning has caused great deficits in Hemingway's social functioning, creating enemies easily, exposing himself to risks, alienating his friends because of the often irascible behavior, often provoking the contempt of other intellectuals of the time, losing and gaining women, but without great emotional significance. It also creates a significant health deficit due to substance abuse, alcohol, and all the "strange incidents" he willingly exposed to, later brought severe sequelae to its cognitive functioning.

D. The pattern is stable, long lasting and its onset occurred at the latest in adolescence or early adulthood

According to what we have already seen, this pattern is stable, long-lasting, and manifested itself from an early age in Ernest, who by high school had tried twice to escape from home, idealized on how to kill his father and mother and at the age of 18 volunteered to serve in World War I. All this pattern, as already clarified above, will continue throughout his life until his suicide.

E. The durable pattern is no better explained as a manifestation or consequence of another mental disorder

Ernest Hemingway appears to have other mental disorders in comorbidity, which does not invalidate the diagnosis of Personality Disorder by fulfilling the above criteria and the justifications presented, as well as the characteristics of beginning and permanence of behavior, stiffness of traits and interpersonal difficulties.

F. The durable pattern is not due to the direct physiological effects of a substance (e.g. drug abuse, medication) or other medical condition (e.g. head trauma)

Hemingway's alcohol abuse and cranial trauma occur later in his lifeline when a behavioral pattern warranting a diagnosis of Personality Disorder was already identifiable.

1. Diagnostic Criteria for Borderline Personality Disorder according to DSM 5 (APA, 2013)

CRITERIA

A global pattern of instability in interpersonal relationships, self-image and affections, and marked impulsivity beginning in early adulthood and being present in a variety of contexts as indicated by 5 (or more) of the following:

A. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-deprecating behaviors described in Criterion 5.)

This being the most difficult criterion to observe in Hemingway's conduct, it is our interpretation that the abandonment of Agnes von Kurowsky had a profound impact on Ernest. Ernest Hemingway fell in love with the nurse Agnes von Kurowsky while hospitalized due to the injuries he contracted in the leg in I Great War. He never ceased to be in love with her and uttered swear words of love. Hemingway returned to the United States of America acclaimed hero by his act of bravery and still in love with Agnes. Already in the USA he receives a letter from Agnes saying she was going to marry another man. This was Hemingway's first love story and it resulted in abandonment and failure, with Hemingway being the abandoned lover. This event was so important that in the book, A Farewell to Arms, the story of a wounded soldier who falls in love with the nurse and she for him, at the end of the book the soldier and the nurse marry, have a daughter and the nurse dies while giving birth. We can see here the idealization of love with Agnes, but also an atrocious desire for revenge for the humiliation suffered that, in the book, culminates with the death of the nurse. Thus we risk proposing that Hemingway's romantic instability and impulsivity are due to the fear of being abandoned again, thus abandoning him first and not allowing his women and passions to do so. Knowing Ernest is a difficult man with irritable outbursts, even having his first wife to ask him to leave the house and travel alone because his presence was unbearable, and being an intelligent man is also to assume that his women would leave him sooner or later. For this reason, Hemingway always had a new wife before leaving the old one, always seeking to be the engine of separation. We consider that this pattern of only falling deeply superficially in love allowed him to be always abandoning himself, avoiding the humiliation of one more abandonment or failure.

B. A pattern of unstable and intense interpersonal relations, characterized by alternation between extremes of idealization and devaluation

Ernest Hemingway kept with friends, women, and others relatively close to him, or even acquainted, a life of immense instability and intensity of emotions, going from extremes of

idealized love like Martha Gelhorn, whom he asked to marry on the first day he met her to her total devaluation and, in this case, his own, by saying "She only likes me because I fuck her every night." to his friend Gustavo Duran (Meyers, 1999, in Metts, 2016, 24.) Let us not forget that he married 4 times and had numerous passions and lovers. Everything in his life was lived with immense intensity, outside the limits, an extreme of adoration or total devaluation. When married to Pauline, with whom he made successive safaris in the eagerness to feel alive, he wrote to a friend that Pauline was uninteresting, did not satisfy him, she was a boring woman. His friends were also not stable, his temperament kept many of his friends away, being few those of whom remained loyal to him until the end of his life. The relationship with his parents has been of intense anger since childhood. While idealizing ways to kill his father, he found him a victim of abuse of his mother, a disturbed woman whom he hated with immense intensity. His feelings of ambivalence toward his father are notorious at the time of his death in which Ernest shares with his friend Owen Wister, and refers to his father's death and its consequences. "My life was more or less shot out from under me and I was drinking much too much entirely through my own fault. "(Lynn, 1987, p.337 in Martin, 2006, p.357). Hemingway also utters the famous phrase "I drink to make other people more interesting." Such a phrase reveals not only his contempt for others which he considers inferior, a condition that is not standard throughout his life, but frequent in alternation, and, in addition, gives us an idea of a distorted identity, with some narcissistic traits.

C. Identity disruption: self-image or self-feeling marked and persistently unstable

Hemingway's identity issues begin in his childhood when his mother Grace, almost to Hemingway's eight years, dresses him, combs and calls him as a girl, trying to make him pass as the twin of his sister Marcelline, older than him, also insisting that they were both in the same class in school requesting for the retention of Marcelline. On the other hand, Grace encouraged Ernest's masculinity skills, particularly associated with hunting, fishing and sport. From the time he was little Ernest felt highly uncomfortable with this, showing a combative attitude, even crying to his mother "Damn it, I'm male" (Young, 1975, p 44 in Dieguez, 2010, p 178). The identity damage that this has caused in Hemingway is evident. All his life and since

young age, he has done the unthinkable, putting his life at risk to assert his manhood, becoming excellent, but not less dangerous, in all manner of activities from hunting, fishing to boxing. This compensation mechanism has acquired levels of clear excess, making for Hemingway a touchstone of his idealized being. Here is born what was later designated by his scholars as the "Hemingway Code Hero," the characteristics of his idealized self that Hemingway transposed to his literary works that were often so similar to his self that it made the distinction difficult. The "Hemingway Code Hero" is characterized by the principles of honor, courage and virility in the face of adversity. They also include no self-analysis, no regrets, no kind of sentimentality, no rationalizations or ways to escape the situation, no apologies to be asked, no cowardice, no falsehood or flourishing. This is Hemingway, at least whom he sought to be lifelong, the extreme of courage, masculinity and virility, the true "Male Macho Man", also often attributed nickname, trying to compensate for an identity disturbed by division with the female, abandonment and failure, and multiple bodily sequelae of the many "incidents" of which he was the protagonist. Scholars of his literature say that his heroes follow the code always, even in the most adverse circumstances, and end up almost always dying.

D. Impulsivity in at least 2 areas that are potentially self-injurious (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-deprecating behaviors described in Criterion 5.)

Ernest Hemingway fulfils criterion 4 being factual in its history the consumption of alcohol in an abusive and regular way as well as by its impulsiveness in the sexual component. At the end of his days, his finances would also be almost broken due to his comfortable life, with recurrent trips between Cuba and Florida, fishing, parties, hunting, but we do not have enough information to confirm this data since only one source of our research makes this reference. However, it is clear that Hemingway suffered from an Alcohol Use Disorder, meeting the criteria required for such in accordance with DSM-5 (2013). During his hospitalizations, bottles of whiskey and other alcoholic substances were constantly found under his bed. In one of his hospitalizations, when he already had features of cirrhotic functioning, diabetes and hypertension, his doctor and friend A. J. Monnier wrote to him "My

dearest Ernie, you MUST stop drinking alcohol. This is definitely of the utmost importance, and I shall never, never insist too much. "(Monnier, 1957 in Martin, 2006, p.355). Hemingway never stopped drinking. Regarding the sexual component it is also known that Hemingway always had several lovers and passions beyond the four formal wives. His need to boast about this fact, leads him to say "I have bedded every girl I wanted and some that I had not wanted". (Yalom and Yalom, 1971, pp. 493 in Dieguez, 2010, p.181).

E. Behaviors, gestures or recurrent threats of suicide, or self-defeating behavior

It is our conviction, and according to the literature we have consulted, that Hemingway spent much of his life trying to kill himself in an unexplained suicidal way. Looking back on all the "strange incidents" he suffered, we find that almost all are near-death experiences and mostly involve blows to the head. Thus, one of the first accidents that he had was in Paris, when he lived with his second wife Paulinne. Hemingway got up from the bed and went to the bathroom. According to his narrative, he confused the lantern of the lamp with the lanyard of the flushing toilet, pulling it violently, so that the lamp, glass and quite heavy, fell on his head, needing 9 stitches. In 1944 he had a car accident, when he came from a party with several literary geniuses of the time, and he was already drunk. Hemingway ripped part of his scalp with his skull on the windshield, needing 57 points. Three months after the car accident, he had a motorcycle accident while trying to flee Germany. Hemingway was violently projected from the motorcycle banging his head. He suffered from headaches, diplopia and slow speech for several months. In Cuba he crashed the car on a sandbar doing another head injury by banging his head in the rearview mirror. There are countless Hemingway accidents that put him to the brink of death, beyond his sporting options, such as hunting wild animals and fish as swordfish, two or three times his size, activities that also put him in danger. Incidentally, Hemingway described this feeling "Now, truly, in actual danger, I felt a clean feeling as in a shower" (Lynn, 1987, p. 415 in Martin, 2006, p.368). It is only pertinent here to report one more episode to reinforce that Hemingway tried to die, but did not intended to commit explicit suicide until he had no alternative. In Africa, in 1954, on a safari, his plane crashed. There was no major damage and a second rescue plane was called to transport the passengers. Ironically, but this second plane begins to fall and catch fire. Hemingway decides

to try to leave through the door of the airplane uttering against the same two violent blows of head, pulling scalp, fracturing the skull and with cerebrospinal fluid running through an ear. He was hospitalized with multiple fractures in several organs. It is a phrase of Hemingway, in 1936, as follows: "I like life very much. So much it will be a big disgust when I have to shoot myself. Maybe pretty soon I guess although will arrange to be shot in order not to have bad effect on kids.". This phrase was written to his friend Archibald MacLeish almost 25 years before Hemingway committed suicide.

F. Affective instability due to marked mood reactivity (e.g., intense bouts of dysphoria, irritability or anxiety, usually lasting a few hours and only rarely more than a few days)

This feature is one of the most reported by his closest. From his women, friends, and others who were very close to Hemingway, all referred to his sudden mood swings. He could as well be a gentle, courteous, and polite man and suddenly he was about to explode with rage, being rude and unpolite to his friends and significant. "His mood swung so fast from low to high and back again that one could almost say he was simultaneously exhilarated and depressed." (Lynn, 197, p.261 in Martin, 2006, p.354). His first wife Hadley, as previously described, shared an episode in which Hemingway was "sky high, emotionally intense and ready to explode" (Martin, 2006, p.354). Ernest swiftly went from good-natured to irascible, made conflicts with friends, his mood swings made him a difficult company, hence the instability of his friendships, some even he suddenly dispensed with no understandable reason, as his women. The narratives indicate that he needed very little to irritate himself, it could be practically harmless stimuli (Martin, 2006, Metts, 2016). In Baker's words "Hemingway was a man of many contradictions who was capable of alternately appearing shy or conceited, sensitive or aggressive, warms and generous or ruthless and overbearing" (Baker, 1969 in Martin, 2006, p. 357).

4. Chronic feelings of emptiness

The data we have to confirm this criterion would need more robustness. However, in the literature we find some indicators lead us to consider, including narratives by Ernest's friends, that Ernest tried to remain always extremely busy and in activities of great excitement, as well as constantly drunk, precisely not to focus on the sensation of emptiness and melancholy that plagued him. "He had difficulties in being alone and constantly sought to fill his life with excitement and travels (Yalom and Yalom, 1971, p 487, Brian, 1988 in Dieguez, 2010, p.179), to the point of complaining after the 2nd World War "of the emptiness and meaninglessness of his life without war.". Again Ernest wrote "I felt that gigantic bloody emptiness and nothingness". It is not clear that this particular sensation is due to the feelings of emptiness and loneliness of the Bordeline Personality Disorder or whether Hemingway also suffered from Major Depressive Disorder.

5. Intense and inappropriate anger or difficulties in controlling anger (e.g., frequent demonstrations of temper, constant anger, recurring physical struggles)

Hemingway all his life had great difficulty in controlling his anger, being known by his next and friends his facility in exploding in anger with situations, histories or events apparently empty of meaning. His felt and manifest anger was almost always disproportionate to the facts that triggered it, as the episode recounted in his life synopsis, with the writer Max Eastman in which because of the challenge written by the first Ernest responded by beating him with a book in the face and not contented gave sequence to the events defying it for a physical fight. Nothing pleased Ernest more than a good fight coming to say "My writing is nothing, my boxing is everything." His nicknames, attributed by his family and friends, with the exception of the nickname "Papa", which we will focus on in the analysis of the case against the EMP, were all heroic nicknames like "Champ", this being an explicit reference to his boxing in which he was considered one of the best amateur boxers of his time, another nickname was "Ernestoic", alluding to his stoicism, one of the best known being "Ernest Hemingway - Male Macho Man.". Clara Spiegel, a friend of Ernest's, about the nickname and its relation to the

man: "His image had some relationship to him, he was big, he was burley, he did drink, he was a boxer, he was an outdoorsman, he was about as well rounded a man as I've ever known.". Other evidence of this point was Hemingway's constant and persistent anger toward his parents, particularly intense anger and hatred toward his mother. Hemingway hated both of them for their ill-treatment. Had been subjected to his mother as a manipulative, controlling woman that subjected him to the violence of dressing him as a girl until the age of 8 and to his father by the physical and psychological mistreatment and later by the cowardice that revealed in killing himself. From Hemingway´s point of view, his father Clarence committed suicide to escape the domain of its mother Grace, which would go against all his principles, as Hemingway Code Hero, that does not admit any act of cowardice, like escape situations.

6. Transient paranoid ideation reactive to stress or severe dissociative symptoms

We could not verify this criterion. Although, at the end of his days, Ernest Hemingway demonstrates paranoid ideation, one shall not exclude other factors that allow classification as attributable to Borderline Personality Disorder. Ernest Hemingway appeared to suffer from multiple mental health disorders in comorbidity, was undergoing treatment with electroconvulsive shocks, made medication for diabetes, hypertension and a whole series of other health problems, with obvious side effects, one of which was reported in literature as the accentuation of the depressive symptomatology, had already suffered multiple cranial traumatisms, reason why we can´t attribute exactly what triggered the episodes of paranoid ideation that characterized his end of life.

C. CONCLUSION

The present work was based on biographical information and analyzes of both the literature and the person and psychological profile of Ernest Hemingway. It will be subject to biases underlying the obvious fact that the collection of information is not carried out on the basis of our own reports, but on inferences made from the multiple readings we have made.

One conclusion to be drawn is the complexity of the case we chose, which suffered from multiple psychopathological comorbidities leading to atrocious internal suffering. It is a good lesson in human complexity and the difficulty of producing good Diagnoses and Good Case Formulations, but more important of the difficulty and, at the same time, absolute urgency of managing all this symptomatology and reducing the suffering of the subject, under penalty of aggravation of the severity of the difficulties.

The effort to situate data collection in the light of Scheme Focus Theory was also an excellent exercise in the analysis and selection of relevant information. The multiple Compensatory Processes, giving rise to Early Maladaptive Schemes contrary to the primary Schemes, are absolutely fascinating. We had some difficulty in identifying Emotional Deprivation as nuclear so we chose not to consider it as such, yet all the analysis led to this Schema as source of great and long lasting suffering. Lastly, we sought in the Therapeutic Protocol to make an effort to adapt to the (inferred) characteristics of the subject, which was also a demanding and very useful experience.

As for Ernest Hemingway, he lived up to both his psychopathological complexity and his genius. He was a man of great achievement, courageous, participating in the two Great Wars and making journalistic coverage of various war scenarios, including the Spanish Civil War. His idealized self was idolized by his generation, by all the enchantment associated with his manhood, hunting, boxing, fishing, his predisposition to adventure and danger, and also to his many love achievements. However, behind all this scenario lived a man in great and continuous suffering, plagued by multiple psychopathologies that inspired several literary works, giving rise to nothing less than the award of the Nobel Prize for Literature.

4.4. PSYCHOSIS

What is Psychosis?

Psychosis is an umbrella term.

Psychosis means that an individual has sensory experiences of things that do not exist and/or beliefs with no basis in reality.

During a psychotic episode, an individual may experience delusions and/or hallucinations.

They may see, hear or feel things that do not exist. Psychosis can be incredibly frightening for the individual and, sometimes, the symptoms can cause them to lash out and hurt themselves or others.

Psychosis is classically associated with schizophrenia spectrum disorders, and, although there are other symptoms, one of the defining criteria for schizophrenia is the presence of psychosis.

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4.4.1. TYPES OF PSYCHOSIS

SCHIZOPHRENIA - a serious mental health disorder affecting the way someone feels, thinks, and acts. Individuals find it difficult to distinguish between what is real and what is imaginary.

SCHIZOAFFECTIVE DISORDER - a condition similar to schizophrenia that includes periods of mood disturbances.

BRIEF PSYCHOTIC DISORDER - psychotic symptoms last at least 1 day but no longer than 1 month. Often occurring in response to a stressful life event. Once symptoms have gone, they may never return.

DELUSIONAL DISORDER - the individual has a strong belief in something irrational and often bizarre with no factual basis. Symptoms last for 1 month or longer.

BIPOLAR PSYCHOSIS - individuals have the symptoms of bipolar disorder (intense highs and lows in mood) and also experience episodes of psychosis. The psychosis more commonly occurs during manic phases.

PSYCHOTIC DEPRESSION - also known as major depressive disorder with psychotic features.

POSTPARTUM (also called postnatal) psychosis - a severe form of postnatal depression.

SUBSTANCE-INDUCED PSYCHOSIS - including alcohol, certain illegal drugs, and some prescription drugs, including steroids and stimulants.

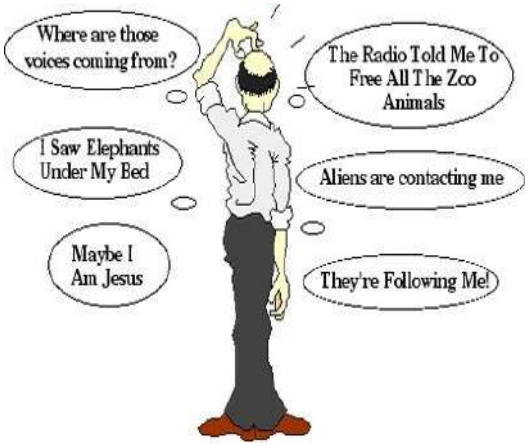
4.4.2. SYMPTOMS OF PSYCHOSIS

The classic signs and symptoms of psychosis are:

- Delusions - false beliefs, especially based on fear or suspicion of things that are not real
- Hallucinations - hearing, seeing, or feeling things that do not exist
- Disorganization - in thought, speech, or behavior
- Disordered thinking - jumping between unrelated topics, making strange connections between thoughts
- Catatonia - unresponsiveness
- Difficulty concentrating

4.4.3. MANIFESTATIONS OF PSYCHOSIS

Usually present with 1 or more of the following:



4.4.4. DELUSIONS

- False beliefs a person holds that are not congruent with reality
- It is difficult to change the belief, even with evidence presented against it
- Common delusions| Persecutory; Grandiose; Erotomanic; Somatic

PERSECUTORY DELUSION

- Most common
- Fear of being stalked, spied upon, obstructed, poisoned, conspired against or harassed by other individuals or an organization
- As a result, the sufferer may retaliate violently against the persecution and/or turn to the law and other government agencies for support

DELUSION OF GRANDEUR

- The person believes they are much greater or more influential than they really are
- For example, they may be convinced they have an exceptional talent, or they are extremely rich or have a special relationship with a prominent person

EROTOMANIA OR DELUSION OF LOVE

- The person is often firmly convinced that a person he or she is fixated upon is in love with them
- This obsession leads to stalking, unnatural jealousy and rage when the object of their affection is seen with their spouse or partners
- Erotomanis often concern a famous person or someone who is in a superior status and usually there is no contact between the patient and the victim, who has never encouraged the patient

SOMATIC DELUSIONAL DISORDER

- The person is convinced something is wrong with them
- This type of delusion may often lead to multiple consultations with physicians, surgical procedures, depression and even suicide
- Some individuals may also develop tactile hallucinations and feel the sensation of insects or parasites crawling over their skin. This is called monosymptomatic hypochondriacal psychosis and forms part of somatic delusional disorder

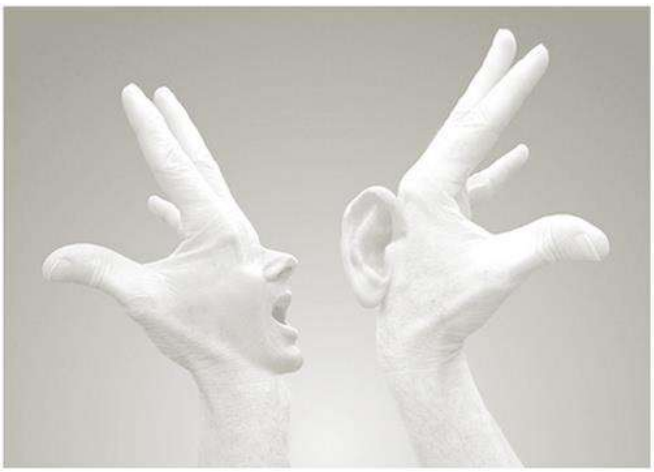
4.4.5. HALLUCINATIONS

- Sensory perceptions in the absence of external stimuli.
- Differ from illusions, or perceptual distortions, which are the misinterpretation of external stimuli
- Auditory hallucinations are one of the most common features of psychosis.

- Sensory perceptions in the absence of external stimuli.
- Hallucinations can affect any of the senses (sight, sound, smell, taste, and touch) in the person with psychosis, but in about two-thirds (2/3) of patients with schizophrenia, hallucinations are auditory - hearing things and believing them to be real when they do not exist.

The following auditory hallucinations are common:

- Hearing several voices talking, often negatively, about the patient
- A voice giving a commentary on what the patient is doing
- A voice repeating what the patient is thinking



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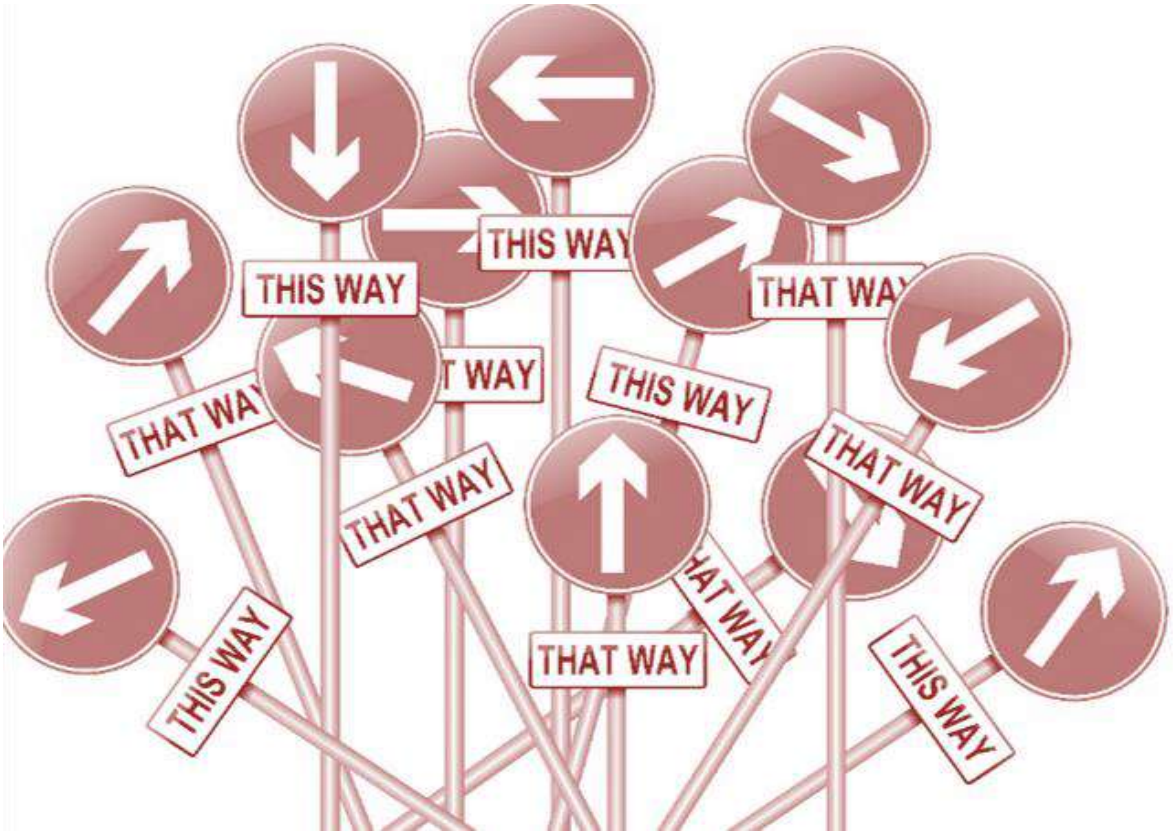
Difference between delusion and hallucination

- A delusion is a false idea, typically a misinterpretation of a situation, a perception error
- A hallucination is the perception of something that isn't really there – which can manifest as something that is seen, heard, tasted, or felt
- The hallucination creates the object that does not exist in reality
- In delusion "thinking" is distorted
- In hallucination "feeling" is distorted

4.4.6. DISORGANIZED THOUGHTS/BEHAVIORS

- Decline in overall daily functioning
- Unpredictable or inappropriate emotional responses
- Behaviors that appear bizarre and have no purpose
- Lack of inhibition and impulse control
- Speech Abnormalities: clanging, loose associations, preservation, neologisms, tangentially, illogical statements, derailment



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POSSIBLE CAUSES

Biopsychosocial Formulation = Biology + Psychology + Social

	BIOLOGY (BRAIN-BODY)	PSYCHOLOGY (MIND)	SOCIAL (ENVIRONMENT)
PROBLEM	Sleep, appetite, hallucinations, delusions	Thought process, self-image	Isolation, avoidance
PREDISPOSING FACTORS	Genes, family history	Personality, cognitive function, coping skills	Relationships, finances, living environment
PRECIPITATING FACTORS	Acute physical illness, medications, substances	Acute psychological trauma	Divorce, unemployment, loss of loved one
PERPETUATING FACTORS	Chronic illness	Poor adaptive responses	Inability to establish social network
TREATMENT	Pharmacologic	Psychotherapy	Social Support

4.4.7. CASE STUDY

CASE STUDY 1

A woman threatens with a knife the cashier at a supermarket refusing to pay for a bag of carrots saying these have been replaced with poisoned ones at the order of her husband who is spying on her all the time. She is pointing at the surveillance camera. She is asking the police to arrest the cashier and her husband as they are plotting against her.

CASE STUDY 2

A man is trying to enter at a piano concert without a ticket. He says he is a famous pianist himself, the grandson of Mozart and cousin of the King and owner of the concert hall. In case he is not permitted to enter and sit in the first row he will fire all staff and close the concert hall for good.

CASE STUDY 3

After going to see a play with his friends a man goes with them to have dinner at a restaurant. Twenty minutes later the leading actress enters the restaurant and is looking for someone. The man tells his friends that she is his lover and that she is looking for him. He goes to her, talks to her quietly, she looks embarrassed and leaves in a hurry. He returns to his friends and tells them that she is expecting him at her house, that she is crazy about him and that he has to go as she will be upset if not.

CASE STUDY 4

A woman shouts at the cashier of a supermarket saying she is not going to pay for the potatoes because they smell like chloride. She has nothing in her basket.

CASE STUDY 5

A man said that 6 weeks ago he was sleeping on a railway platform waiting for a train. He woke up with a foreign body sensation in his right ear. He also saw many cockroaches moving around in the vicinity and believed that the foreign body sensation was due to the entry of a cockroach into his right ear. He tried to remove the cockroach from the ear but failed. After a day or two, he started experiencing peculiar sensations in the head, which he believed to be due to movement of the cockroach. He believed that the cockroach was growing in size and would not be able to come out through the small ear orifice through which it had entered. He got worried and approached people for help. As days passed by, he believed that the cockroaches had increased in number and were moving all around his brain, particularly when he combed his hair.

CASE STUDY 6

In the middle of a piano concert a man stood up, run to the stage, pushed the pianist from his chair and started playing himself. He continues the Mozart piece that the pianist was playing without reading the notes as if someone is dictating to him. He stops from time to time like waiting for some more instructions, alternating the Mozart piece with jazz parts. He plays beautifully.

4.5. DEPRESSION AND BIPOLAR DISORDERS

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4.5.1. WHAT CAUSES DEPRESSION

FAMILY HISTORY

- Having family members who have depression may increase a person's risk
- Deficiencies of certain chemicals in the brain may lead to depression

MAJOR LIFE CHANGES

- Negative or particularly stressful events can trigger depression. Examples include the death of a loved one or a job change
- Major Illnesses such as heart attack, stroke or cancer may trigger depression
- Certain medications used alone or in combination can cause side effects much like the symptoms of depression
- Use of Alcohol or other Drugs can lead to or worsen depression.
- Depression can also occur for no apparent reason at all!

4.5.2. SYMPTOMS OF DEPRESSION

ADDITIONAL SIGNS INCLUDE

- Feeling empty
- Inability to enjoy anything
- Hopelessness
- Loss of sexual desire
- Loss of warm feelings for family or friends
- Feelings of self blame or guilt
- Loss of self esteem
- Inexplicable crying spells, sadness or irritability

CHANGES IN BEHAVIOR AND ATTITUDE

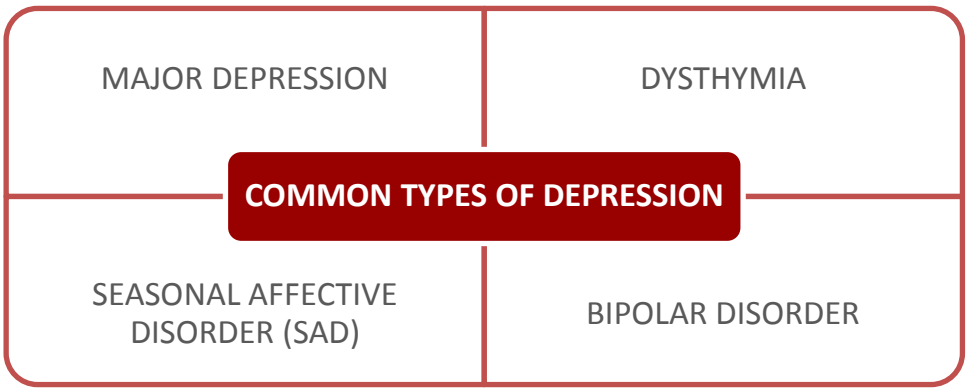
- General slowing down
- Neglect of responsibilities and appearance
- Poor memory
- Inability to concentrate
- Suicidal thoughts and feelings
- Difficulty making decisions

PHYSICAL COMPLAINTS

Sleep disturbances such as insomnia, early morning waking, or sleeping too much

- Lack of energy
- Loss of appetite
- Weight loss or gain
- Unexplained headaches or backaches
- Stomachaches, indigestion or changes in bowl habits

4.5.3. COMMON TYPES OF DEPRESSION



MAJOR DEPRESSION

This type causes symptoms that may:

- Begin suddenly, possibly triggered by a loss, crisis or stressful change
- Interfere with normal functioning
- Continue for months or years
- It is possible for a person to have only one episode of major depression. However, It is more common for episodes to be long lasting or to recur several times during a person's life

DYSTHYMIA

- People with this illness may be consistently and mildly depressed for years.
- They function fairly well on a daily basis, but their relationships and self-esteem suffer over time.

BIPOLAR DISORDER (ALSO KNOWN AS MANIC-DEPRESSION)

- People with this type of illness change back and forth between periods of depression and periods of mania (an extreme high, sometimes with agitation or irritability).
- Symptoms of mania may include:
  - Less need for sleep
  - Overconfidence
  - Racing thoughts
  - Reckless behavior
  - Increased energy
  - Mood changes are often gradual, but can be sudden

SEASON AFFECTIVE DISORDER

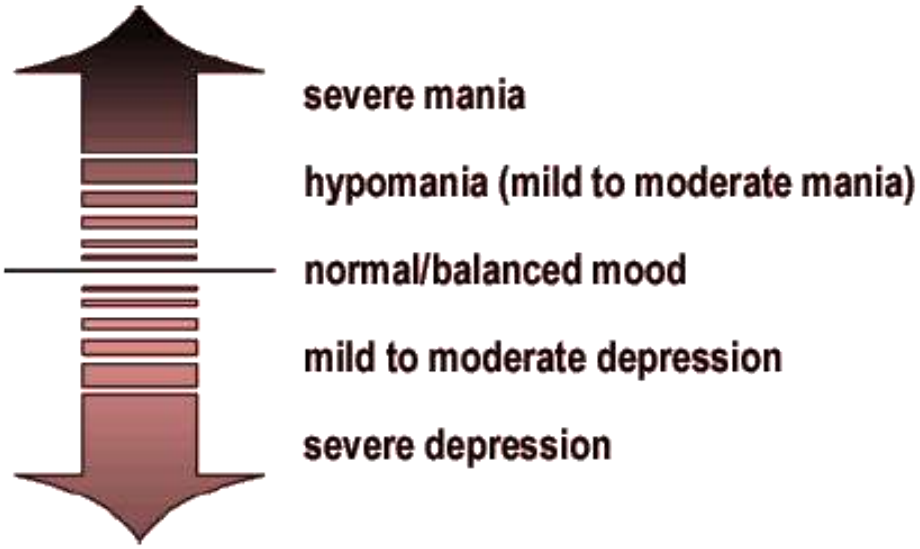
- This is depression that coincides with changes in the season. Most cases begin in the fall or winter, when there is a decrease in sunlight (more common in regions farther north)
- Less often, depression can occur in late Spring or Summer

4.5.4. BIPOLAR DISORDER

WHAT IS BIPOLAR DISORDER?

A mood disorder that alters:

- Feelings
- Thoughts
- Behaviors
- Perceptions



WHAT CAUSES BIPOLAR DISORDER?

No single cause may ever be found for bipolar disorder. Among the biological factors observed in bipolar disorder, as detected by using imaging scans and other tests, are the following:

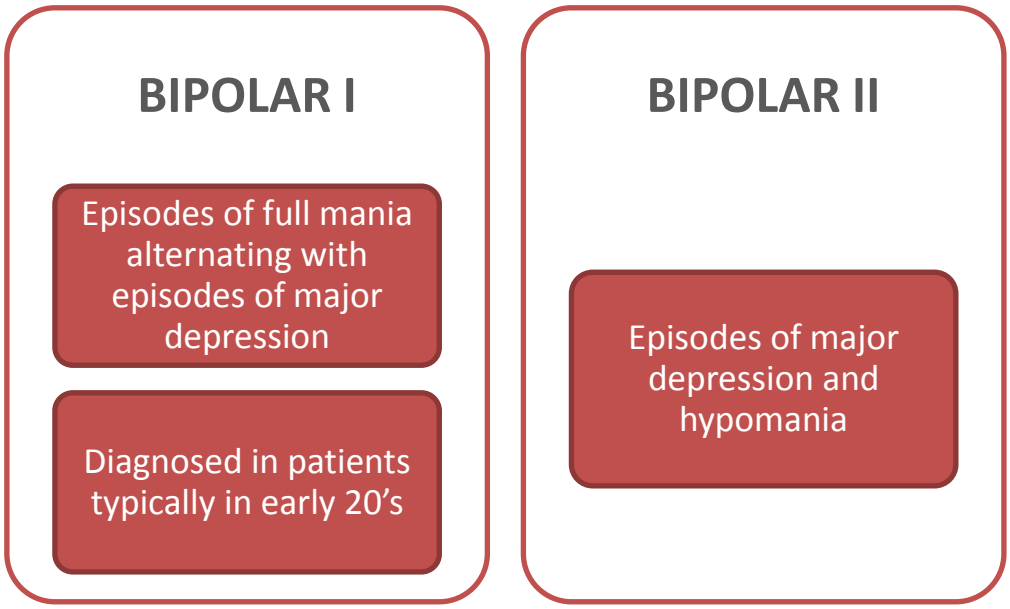
- Over secretion of cortisol, a stress hormone
- Excessive influx of calcium into brain cells
- Abnormal hyperactivity in parts of the brain associated with emotion and movement coordination and low activity in parts of the brain associated with concentration, attention, inhibition, and judgment. (Well Connected, 2002)

HOW SERIOUS IS BIPOLAR DISORDER?

Risk for Suicide | An estimated 15-20% of patients who suffer from bipolar disorder and do not receive medical attention commit suicide.

- In a 2001 study of Bipolar I disorder, more than 50% of patients attempted suicide; the risk was highest during depressive episodes
- Patients with mixed mania, and possible when it is marked by irritability and paranoia, are also at particular risk
- Many young children with bipolar disorder are more severely ill than are adults with the disorder
- According to a study in 2001, 25% of children with the disorder are seriously suicidal

4.5.5. THE TWO SIDES OF BIPOLAR DISORDER



CHARACTERISTICS OF MANIA (THREE OR MORE SYMPTOMS MUST BE PRESENT)

- Feeling of being able to do anything
- Little sleep is needed
- Feeling filled with energy
- Not caring about financial situations
- Delusions
- Substance abuse

CHARACTERISTICS OF HYPOMANIA (SIMILAR TO MANIA EXCEPT HYPOMANIA IS OF LESSER INTENSITY)

- Feeling of creativity
- Don't worry about problems seriously
- Feeling as if nothing can bring you down
- Have confidence in yourself

MANIC SYMPTOMS
SYMPTOM/DEFINITION
Euphoria: Elevated (too happy, silly, giddy) and expansive (about everything) mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time.
Irritability: Energized, angry, raging, or intensely irritable mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time
Inflated Self-Esteem or Grandiosity: Believing, talking or acting as if he is considerably better at something or has special powers or abilities despite clear evidence to the contrary
Decreased Need for Sleep: Unable to fall or stay asleep or waking up too early because of increased energy, leading to a significant reduction in sleep yet feeling well rested.
Increased Speech: Dramatically amplified volume, uninterruptible rate, or pressure to keep talking.
Flight of Ideas or Racing Thoughts: Report or observation (via speech/writing) of speeded-up, tangential or circumstantial thoughts

DEPRESSIVE SYMPTOMS
SYMPTOM/DEFINITION
Depressed Mood: Feels or looks sad or irritable (low energy) for an extended period of time.
Markedly Diminished Interest or Pleasure in All Activities: Complains of feeling bored or finding nothing fun anymore.
Significant Weight Lost/Gain or Appetite Increase/Decrease: Weight change of >5% in one month or significant change in appetite.

Insomnia or Hypersomnia: Difficulty falling asleep, staying asleep, waking up too early or sleeping longer and still feeling tired.

Psychomotor Agitation/Retardation: Looks restless or slowed down.

Fatigue or Loss of Energy: Complains of feeling tired all the time

Low Self-Esteem, Feelings of Worthlessness or Excessive Guilt: Thinking and saying more negative than positive things about self or feeling extremely bad about things one has done or not done.

Diminished Ability to Think or Concentrate, or Indecisiveness: Increase inattentiveness, beyond person's baseline attentional capacity; difficulty stringing thoughts together or making choices.

Hopelessness: Negative thoughts or statements about the future

Recurrent Thoughts of Death or Suicidality: Obsession with morbid thoughts or events, or suicidal ideation, planning, or attempts to kill self

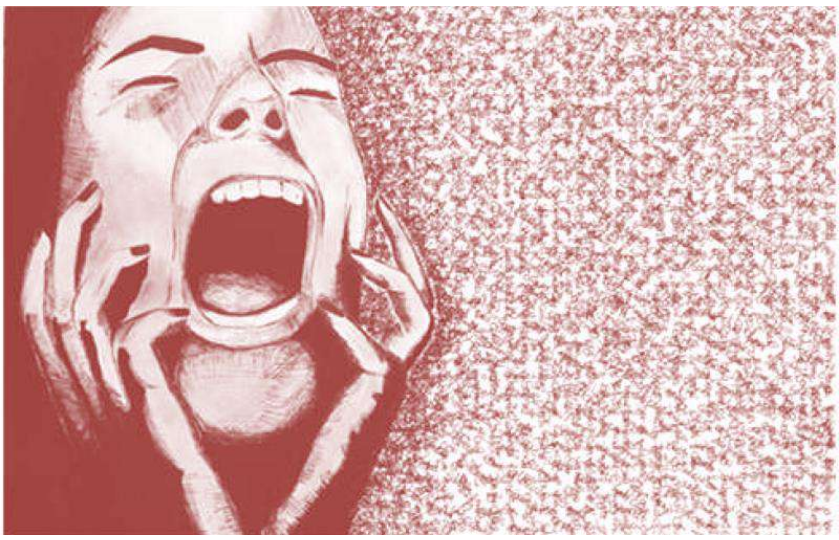
PATIENT STATEMENT

"I'm terrible. Everything is horrible. I can't do anything. I'm a bad, evil person, even when I don't do anything bad. I can't sleep. I can't get up. Even little things take forever to do. Nobody loves me. Everything's my fault. Nothing feels good."

4.6. POST-TRAUMATIC STRESS DISORDER (PTSD)

WHAT IS PTSD?

Post-traumatic stress disorder (PTSD) is an anxiety disorder that a person may develop after experiencing or witnessing an extreme, overwhelming traumatic event during which they felt intense fear, helplessness, or horror.



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DOMINANT FEATURES OF PTSD

- Emotional numbing (i.e., emotional no responsiveness)
- Hyperarousal (e.g., irritability, on constant alert for danger)
- Reexperiencing of the trauma (e.g., flashbacks, intrusive emotions)

4.6.1. CRITERIA AND SYMPTOM

CRITERIA FOR PTSD

The person has been exposed to a traumatic event in which both of the following have been present:

- The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others
- The person's response involved intense fear, helplessness, or horror.

CRITERIA FOR A DIAGNOSIS OF PTSD

- Exposed to a traumatic event
- Distressing re-experiencing of symptoms
- Avoidance of reminders of the event
- Arousal or numbing symptoms

RE-EXPERIENCING SYMPTOM

- Recurrent and intrusive distressing recollections of the event
- Recurrent dreams of the event
- Sudden acting or feeling as if the traumatic event were recurring
- Intense psychological distress at exposure to things that symbolizes or resembles an aspect of the trauma, including anniversaries thereof
- Physiological reactivity when exposed to internal or external cues of the event
- At least one of these symptoms to be diagnosed with Post Traumatic Stress Disorder

AVOIDANCE SYMPTOMS

- Efforts to avoid the thought or feelings associated with the trauma
- Efforts to avoid activities, places, people or situations that arouse recollection of the trauma.
- Inability to recall an important aspect of the trauma (psychological amnesia)
- Markedly diminish interest in significant activities
- Feelings of detachment or estrangement from others
- Restricted range of affect-unable to have loving feelings
- Sense of foreshortened future- does not expect to have career, marriage, children or normal life span.
- One or more of these symptoms to be diagnosed with PTSD

AROUSAL SYMPTOMS (NOT PRESENT BEFORE TRAUMA)

- Difficulty falling asleep or staying asleep
- Irritability or outburst of anger-irritability can progress to rage
- Difficulty concentrating
- Hypervigilance - resembles frank paranoia
- Exaggerated startled response
- At least two of these symptoms to be diagnosed with PTSD

4.6.2. TYPES OF PTSD

TYPES OF PTSD

- Acute PTSD - symptoms less than three months
- Chronic PTSD - symptoms more than three months
- Although symptoms usually begin within 3 months of exposure, a delayed onset is possible months or even years after the event has occurred

4.6.3. POSSIBLE CAUSES AND TRAUMATIC EVENTS

POSSIBLE CAUSES

A person develops PTSD in response to exposure to an extreme traumatic stressor involving direct personal experience of an event.

This includes:

- Actual or threatened death or serious injury
- Threat to one's physical integrity
- Witnessing an event that involves death, injury, or a threat to the physical integrity of another person
- Learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close person

SECONDARY PROBLEMS OF PTSD

- Substance use disorders
- Depression including the risk of suicide
- Other anxiety disorders e.g. panic attacks

THE RESULT OF A SINGLE TRAUMATIC EVENT

EXAMPLES OF TRAUMATIC EVENTS EXPERIENCED DIRECTLY

TRAUMATIC EVENTS

- Military combat
- Violent personal assault (sexual assault, physical attack, robbery, mugging
- Being kidnapped
- Terrorist attack
- Torture
- Incarceration as a prisoner of war or in a concentration camp
- Natural or manmade disasters
- Severe automobile accidents
- Being diagnosed with a life-threatening illness

ESTIMATED RISK FOR DEVELOPING PTSD BASED ON EVENT

ESTIMATED RISK FOR DEVELOPING PTSD

- Rape (49%)
- Severe beating or physical assault (31.9%)
- Other sexual assault (23.7%)
- Serious accident or injury (i.e. car or train accident) (16.8%)
- Shooting or stabbing (15.4%)
- Sudden, unexpected death of family member or friend (14.3%)
- Child's life-threatening illness (10.4%)
- Witness to killing of serious injury (7.3%)
- Natural Disaster (3.8%)

WHY PTSD VICTIMS MIGHT BE RESISTANT TO GETTING HELP

- Sometimes hard because people expect to be able to handle a traumatic even on their own
- People may blame themselves
- Traumatic experience might be too painful to discuss
- Some people avoid the event all together
- PTSD can make some people feel isolated making it hard for them to get help
- People don't always make the connection between the traumatic event and the symptoms; anxiety, anger, and possible physical symptoms
- People often have more than one anxiety disorder or may suffer from depression or substance abuse

4.6.4. PTSD MYTHS

PTSD is a complex disorder that often is misunderstood. Not everyone who experiences a traumatic event will develop PTSD, but many people do.

MYTH

PTSD only affects war veterans.

FACT

Although PTSD does affect war veterans, PTSD can affect anyone.

Victims of trauma related to physical and sexual assault face the greatest risk of developing PTSD.

Women are about twice as likely to develop PTSD as men, perhaps because women are more likely to experience trauma that involves these types of interpersonal violence, including rape and severe beatings.

Victims of domestic violence and childhood abuse also are at tremendous risk for PTSD.

MYTH

People should be able to move on with their lives after a traumatic event. Those who can't cope are weak.

FACT

Many people who experience an extremely traumatic event go through an adjustment period following the experience.

Most of these people are able to return to leading a normal life.

However, the stress caused by trauma can affect all aspects of a person's life, including mental, emotional and physical well-being. Research suggests that prolonged trauma may disrupt and alter brain chemistry.

For some people, a traumatic event changes their views about themselves and the world around them. This may lead to the development of PTSD.

MYTH

People suffer from PTSD right after they experience a traumatic event.

FACT

PTSD symptoms usually develop within the first three months after trauma but may not appear until months or years have passed.

These symptoms may continue for years following the trauma or, in some cases, symptoms may subside and reoccur later in life, which often is the case with victims of childhood abuse.

Some people don't recognize that they have PTSD because they may not associate their current symptoms with past trauma.

In domestic violence situations, the victim may not realize that their prolonged, constant exposure to abuse puts them at risk.

PART V | TOWARDS AN INTEGRATIVE APROACH

5.1. DE-ESCALATING TECHIQUES

WHAT IS DE-ESCALATION?

De-escalation refers to behavior that is intended to escape escalation of conflicts. It may also refer to approaches in conflict resolution. De-escalation is aimed at calmly communicating with an agitated person in order to understand, manage and resolve their concerns. Ultimately, these actions should help reduce the person's agitation and potential for future aggression or violence. The idea is that you can prevent escalation of disruptive behavior with your own verbal and nonverbal behaviors. The ability to organize your thinking and calmly respond are effective de-escalation techniques that can help you avoid a potential crisis.

5.1.1. COMMUNICATION IS THE KEY TO CRISIS DE-ESCALATION

A difficult and potentially dangerous situation for officers involves being called to a scene and engaging with a person who may be mentally ill. Most individuals with mental illness are not dangerous, but a special set of skills is required to bring a mutually successful end to the encounter.

Although an officer's inclination may be to intervene immediately, that may not always be the best response. As long as the individual isn't an immediate danger to self or others, there's time to make a quick assessment. CPI (Crisis Prevention Institute), an international training company specializing in violence prevention and crisis intervention, recommends evaluating the person's behavior before acting, if at all possible.

How does an officer make the decision about how to treat that individual? Of course the answer is communication: talking to the person and evaluating the responses. But what if the person is unable or unwilling to speak? Again, as long as the person is not a danger to self or others, there is time. Use it to listen to what the person is saying – not only with words, but also with body language and tone of voice.

We must stress the importance of listening with empathy, trying to understand where the person is coming from. Like other skills, empathic listening can be learned. The five keys are: give the person undivided attention; be non-judgmental; focus on the person's feelings, not just the facts; allow silence; and use restatement to clarify messages.

UNDIVIDED ATTENTION

When people are paid attention to they feel validated; they feel important. The converse is also true: people feel less important and sometimes feel they need to up the ante if they feel like they need attention. Paying attention doesn't just mean saying, "I'm listening." It means looking at the person, making eye contact if it's culturally appropriate, and virtually listening with the entire body. By really listening, and conveying that through body language as well as words, an officer can take away the person's reason for escalating the situation.

BE NON-JUDGMENTAL

If someone says, "The sewers are talking to me," an officer's immediate reaction might be to think that the person is crazy. That reaction, especially if verbalized, will probably upset the individual even more. Even if not said aloud, that attitude may be conveyed through the officer's body language. If someone is psychotic, she may tune into the nonverbal communication much more than words. So besides paying attention to what is said, ensure that body language and tone are non-judgmental as well. This will go a lot further in calming the individual.

FOCUS ON FEELINGS

Going back to the previous example, if an individual says, "The sewers are talking to me," a feeling response might be, "That must be pretty scary," or even, "Tell me what that feels like." This isn't getting into a therapist's bailiwick, but it is using a handy therapeutic tool. Most likely it will elicit a response that is positive, since the individual will know that the officer understands what's happening.

ALLOW SILENCE

As people devoted to protecting and serving, officers are quite comfortable using silence during interrogations, but may not be quite so comfortable using it on the street. Officers want to make sure the incident is handled quickly and peacefully. However, sometimes allowing that moment of silence can be the best choice.

If the individual doesn't immediately answer a question, it doesn't mean he didn't hear you. It may mean he's thinking about his answer, or even that he wants to make sure he's saying the right thing.

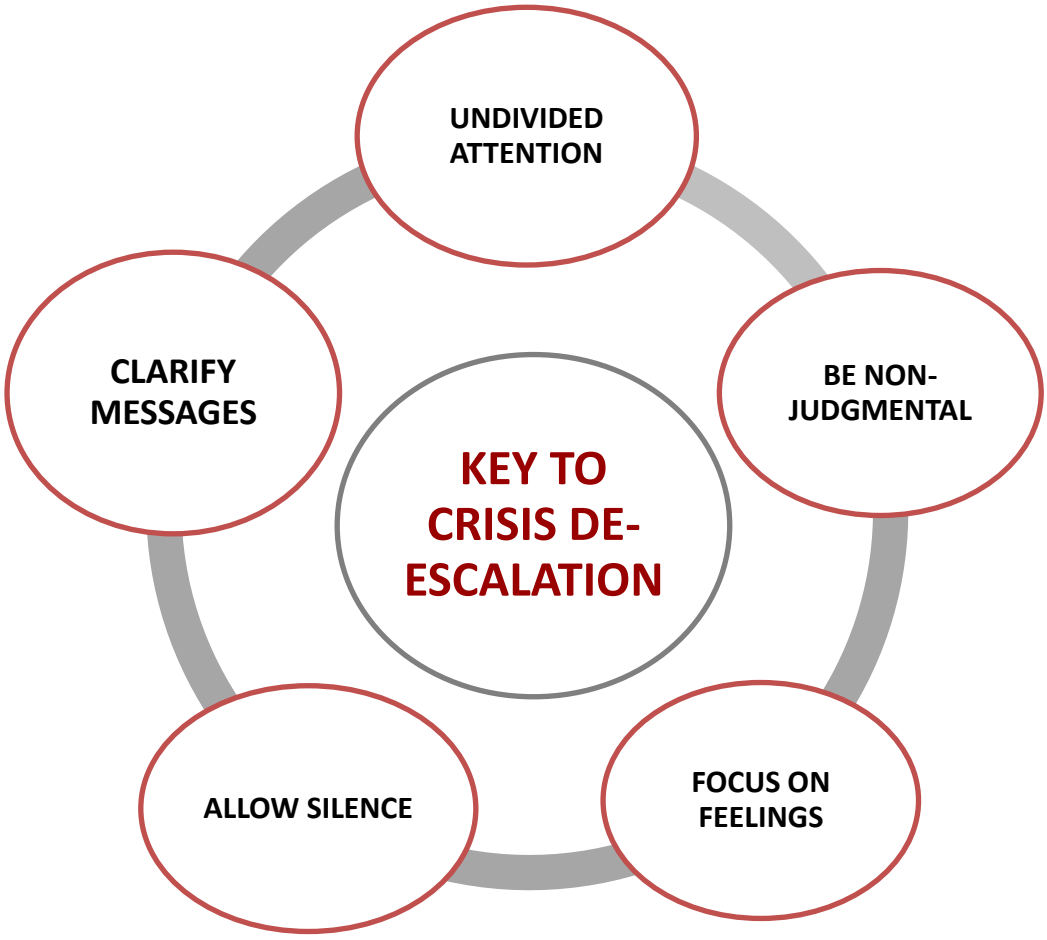
Allow a moment of silence. If the person's face registers confusion, then repeat the question and let the silence happen again. Just as officers are taught in basic training, another good reason for silence is that no one likes it and people tend to start talking when silence lengthens.

CLARIFY MESSAGES

When a subject makes a statement, an officer may think he knows what the person means. The only way to be sure is to ask. Sometimes a question may be perceived as challenging and can make the subject defensive, restatement is used instead.

For example, someone living on the street might say, "I don't want to sleep here anymore." The officer might think he knows what the person is saying, but instead of just making an assumption the officer could restate, "Oh, you're ready to go to the shelter?"

The homeless person could say, "Yes." Or perhaps, "No, I don't want to sleep here anymore. I'm going to move over to Main Street where it's safer." In either case, the officer has shown an interest in the individual and has kept the lines of communication open.


UNDIVIDED ATTENTION
BE NON-JUDGMENTAL
FOCUS ON FEELINGS
ALLOW SILENCE
CLARIFY MESSAGES
KEY TO CRISIS DE-ESCALATION

5.1.2. RATIONAL DETACHMENT

One of the most important actions in any crisis is for the officer to remain in control of himself. This factor, which CPI calls rational detachment, will be the key to whether the officer helps de-escalate or escalate the situation. To rationally detach: develop a plan; use a team approach whenever possible; use positive self-talk; recognize personal limits; and debrief.

DEVELOP A PLAN

Devise a plan before one is needed. Decisions made before a crisis occurs are more likely to be more rational than those made when on the receiving end of emotional outbursts. Think about those things that are upsetting and practice dealing with those issues ahead of time. This is called strategic visualization and is effective in helping officers get through some stressful and even dangerous moments. Just as with other professional training officers receive, this training will kick in when needed.

USE A TEAM APPROACH

It's easier to maintain professionalism when assistance is nearby. Support and back up are both crucial pieces when trying to rationally detach.

USE POSITIVE SELF-TALK

Positive self-talk has been the butt of many jokes and some of those can be funny, but positive self-talk really can work wonders. Just as saying, "I can't deal with this" might cause an officer to behave in one fashion, saying to oneself, "I'm trained, I know what to do" will cause another response.

RECOGNIZE PERSONAL LIMITS

Being a professional doesn't mean that a police officer must be able to excel at everything. That's an unrealistic expectation. Know what your limits are. Know that sometimes it's not easy to leave problems alone. Sometimes the most professional decision is to let someone else take over, if that's an option.

DEBRIEF

Be sure to debrief with co-workers, team members, or a supervisor after a major incident. Talking about it can relieve some of the stress and is also a good time to start planning for next time: what was done correctly, what could have been handled better, how could the response be improved the next time a similar situation occurs. This serves to assist in being able to rationally detach in the future.

5.1.3. COMPLEMENTARY TIPS/STRATEGIES/OPTIONS

- **First, calm yourself before interacting with the person**
  - If you're upset, it's only going to escalate the situation. Calm down and then begin to look at the situation and how you can intervene safely
  - Take a deep breath
  - Use a low, dull tone of voice and don't get defensive even if the insults are directed at you

- **Becoming aware of your situation is also critically important. This can include**
  - Other people in the room
  - Objects, such as chairs, tables, items on a table
  - The space around you, like exits or openings, and if you are blocking the person so that they are made to feel trapped

- **Try to look as non-threatening as possible**
    - Appear calm and self-assured even if you don't feel it
    - Maintain limited eye contact and be at the same eye level. Encourage the customer to be seated, but if he/she needs to stand, stand up also
    - Maintain a neutral facial expression
    - Place your hands in front of your body in an open and relaxed position
    - Don't shrug your shoulders
    - Don't point your fingers at the person
    - Avoid excessive gesturing, pacing, fidgeting, or weight shifting
    - Maintain a public space distance, which is 12 feet or more

- **Make a personal connection. Something as simple as asking, "What's your name?" can diffuse a situation quickly**
    - People respond positively to their own name and can make the dialogue more personal

- **Listening to the persons concerns. - Acknowledge the other person's feelings without passing judgment on them.**
    - Empathy needs to be shown during conflict situations. Even if you do not agree with the person's position, expressing an understanding why that person feels a particular way will help resolve the conflict
    - Clarifying, paraphrasing and open-ended questions all help to ensure that the person is aware you have understood their frustrations completely
    - Ask to take notes

- Ask for their ideas or solutions
- Help them talk out angry feelings rather than act on them

- **Shift the conversation to the future, create hope, and you make yourself less threatening**
  - Using “what” and “we” helps include the person in those future plans
- **Get them to say yes**
  - It is very hard for someone to stay angry towards you if they are agreeing with you

5.1.4. KEY STRATEGIES

1) BE EMPATHIC AND NON-JUDGMENTAL

When you encounter a person in crisis, be willing to make an earnest effort not to judge or discount their feelings even if you don’t necessarily understand them or feel comfortable with them. Showing somebody else the grace and compassion you would want to be shown can go a long way toward helping them avoid escalating further. It also keeps the environment around you and the people working and living within it safe, by reducing the likelihood of violence.

Remember that behavior impacts behavior. The empathy you show to a person in crisis can not only transform the immediate situation, but can demonstrate a useful skill that others may someday use when they find themselves on the other side of an escalating individual or situation. The choice to be empathetic may seem simple, but can be really powerful.

2) RESPECT PERSONAL SPACE

Use extreme caution with touch. Even if some touching is generally culturally appropriate and usual in your setting. Cognitive disorders in agitated people allow for easy misinterpretation of physical contact as hostile and threatening.

3) USE NONTHREATENING NONVERBALS

The more a person escalates into distress, the less they can process your choice of words. So how you speak becomes far more important than what you say. When we speak to somebody we care about and respect, our tone and body language become relaxed, receptive, and nonthreatening. There is a special degree of patience and attention we show to those people. And those same qualities are exactly what a person in crisis needs to see so that they can safely de-escalate.

What you do influences the reaction of a person in crisis far more than what you say. Keeping your nonverbals as neutral as possible begins to defuse the situation at a subconscious level by making the situation feel less combative. The trick, of course, is being mindful in those moments of adjusting your nonverbal messaging, consciously taking a nonthreatening physical posture, and controlling your tone. Training can help you and your staff engage with a compassionate voice and see beyond the challenging behavior so that you can connect to the person in crisis. Picturing that you're talking to somebody who inspires your most compassionate and thoughtful behavior is a fantastic holistic approach to your nonverbal behavior—not just for a crisis, but for our interactions in everyday life as well.

4) AVOID OVERREACTING

"I notice that when people are very upset at (a) particular time, the more limits you put on them, the more they want to act out. So I let them act out. I would rather you verbally act out and release all that ugliness than me have to put my hands on you because you're trying to physically attack me. I've got all day as far as I'm concerned. When it comes to intervention, I can talk my way out of any situation because I've got all day. But when you make the decision to put your hands on someone, you take it to a whole other level that you have no control over."

5) FOCUS ON FEELINGS

When a crisis happens, our reactions aren't always logical. Floods of adrenaline or cortisol, physical pain, panic, fear—any number of intense emotions and chemical reactions seize our brains and our bodies. They redirect our rational thoughts into responses that can feel out of

control, appear outlandish, or jar us from a more reasonable perspective. But those feelings are real, and rational or not, we must feel them and work through them if we want to get to the other side of a crisis. The more I tried to tamp down my tears, the stronger the tidal wave became. Only by letting the feelings work through my system could I move through to the next phase of coping with the situation.

Anxiety expresses itself differently in people, and can be triggered by any number of Precipitating Factors. So sometimes, the easiest way to de-escalate a person in distress is to simply acknowledge the fact that what they are feeling, while perhaps irrational to the outside world, is profoundly real to them. Being present, offering support and compassion, and simply reflecting that you hear them and see them you might find that these simple efforts are all it takes to help a person successfully de-escalate.


BE EMPATHIC AND NON-JUDGMENTAL
RESPECT PERSONAL SPACE
USE NONTHREATENING NONVERBALS
AVOID OVERREACTING
FOCUS ON FEELINGS
REMEMBER

EXERCISES

Activity no. 1

Description: Show movies, clips, documentaries about de-escalation techniques and intervention in a violence crisis and have a discussion around it.

Examples:

- https://www.youtube.com/watch?v=4SbVP-JvxPk
- https://www.youtube.com/watch?v=fflQf-T155o
- https://www.youtube.com/watch?v=ux1Dtd58dyU
- Mindhunter – Netflix Series – Season One, First Episode – Opening Scene

Activity no. 2

Role playing scenarios based around the participants own experiences.

5.2. BETTER PRACTICE IN COMPULORY HOSPITALIZATION

WHAT IS COMPULSORY HOSPITALIZATION?

It is an internment by judicial decision of the bearer of severe psychic anomaly.

5.2.1. COMPULSORY INTERNMENT UNDER PORTUGUESE LAW

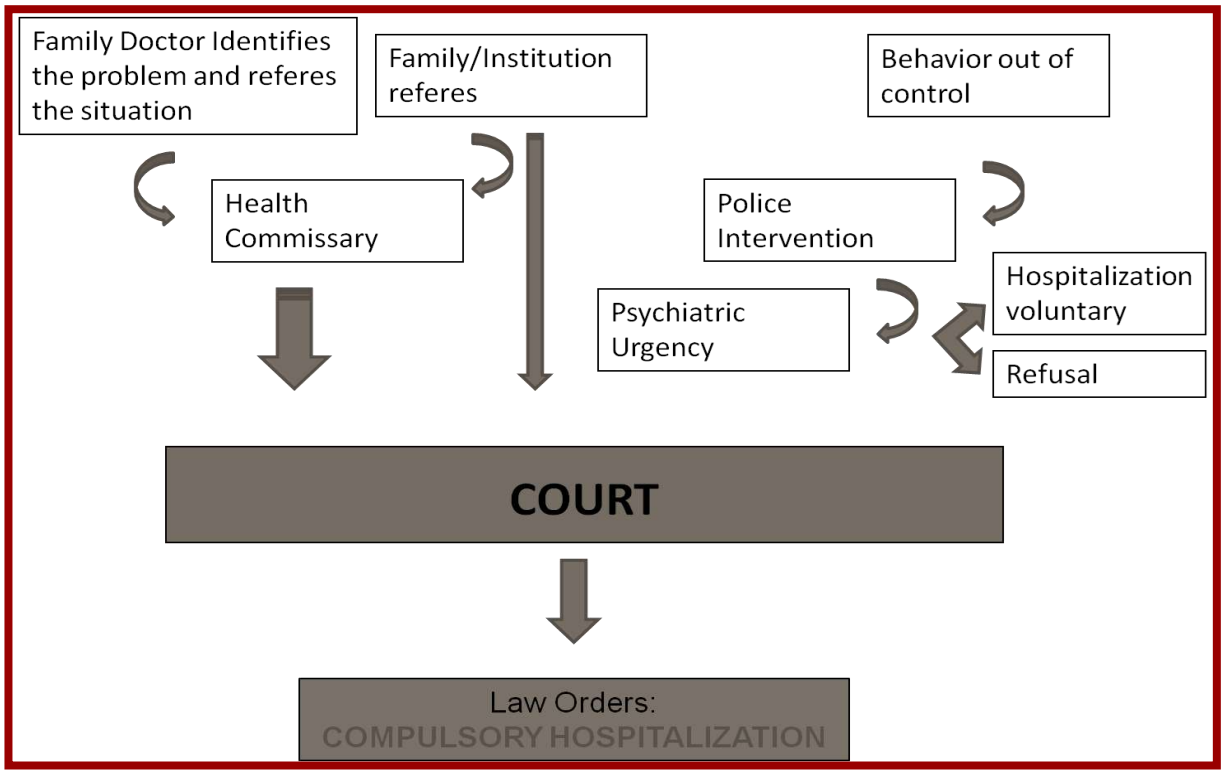
WHEN CAN IT BE APPLIED?

- A person with a severe psychiatric disorder that creates a danger to legal property of significant value, whether of his own or others, of a personal or property nature, and refuses to undergo the necessary medical treatment may be admitted to an appropriate establishment.
- Patients with severe psychic abnormalities who lack the necessary discernment to assess the meaning and scope of consent may also be admitted when the absence of treatment significantly deteriorates their condition.

WHEN CAN THERE BE POLICE INTERVENTION?

Police can intervene in two situations:

- Law orders
- Out-of-control behavior



Questions and complaints about procedures in this area can be sent to the following email:

comissaointernamentocompulsivo@dgs.pt

5.2.2. GOOD PRACTICES

Compulsory hospitalization of mentally disturbed people and unwilling treatment are viewed as legal and ethical issues that require specific application criteria. Compulsive measures raise multiple questions, and various constraints are felt by practitioners in everyday practice. Patients with severe mental disorders may experience periods in which their ability to make decisions about their treatment is severely compromised and may put themselves and others at risk, where effective and timely treatment is imperative.

Through the analysis of international documents, the importance of recommendations related to the duty to provide information on patients' rights and knowledge of available legislation, but also for health professionals to see their training needs.

WHO (2005) warns of the importance of mental health legislation in order to protect people's rights and maintain a balance between freedom and dignity, as well as the need to protect society. That is, account must be taken of justice, the right to treatment, the protection of the rights of the people with mental illness, and the general well-being.

5.2.3. SUPPORTING (PORTUGUESE) LEGISLATION

- Lei n.º 36/98, de 24 de julho, alterada pela Lei n.º 101/99, de 26 de julho (Lei de Saúde Mental)
- Lei n.º 48/90, de 24 de agosto, alterada pela Lei n.º 27/2002, de 8 de novembro (Lei de Bases da Saúde)
- Decreto-Lei n.º 82/2009, de 2 de abril, alterado pelo Decreto-Lei n.º 135/2013, de 4 de outubro (Designação, Competência e Funcionamento das Entidades que exercem o poder de Autoridades de Saúde)
- Lei n.º 81/2013, de 21 de agosto (Sistema de Vigilância em Saúde Pública)
- Decreto-Lei n.º 547/76, de 10 de julho (relativo à Doença de Hansen)

- Despacho conjunto n.º 13363/2014, da Ministra da Justiça e do Ministro da Saúde, publicado no DR, 2.ª série, n.º 213, de 4 de novembro de 2014, que cria a Comissão para Acompanhamento da Execução do Regime Jurídico do Internamento Compulsivo, prevista no capítulo II, da Lei da Saúde Mental

EXERCISES

Activity no. 1

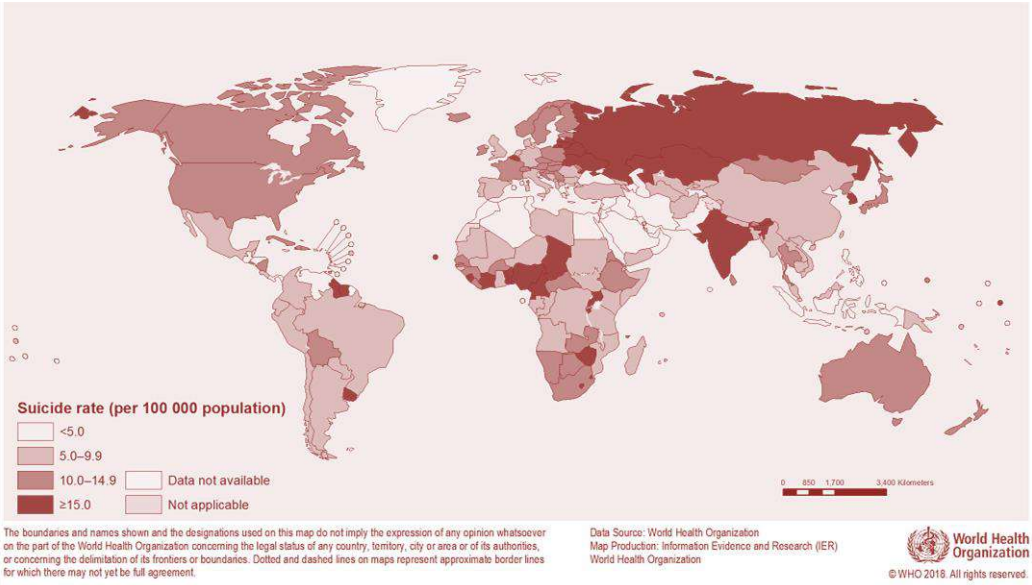
Brainstorming based around the participants own experiences.

5.3. INTERVENTITON IN A SUICIDE-RELATED EVENT APPROACH

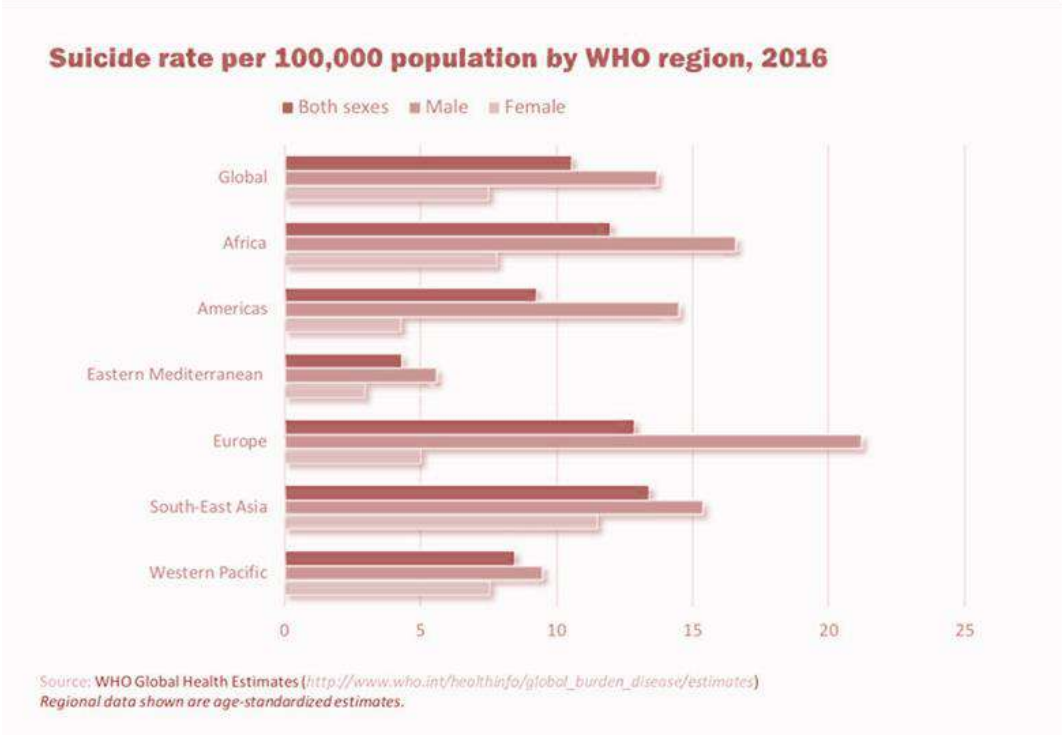
According to the WHO (2018), around 800 000 people, every year, take their own life. This represents one death every minute, almost 3000 deaths every day. The number of people who attempt suicide is much greater (approximately one suicide attempt in every 3 seconds). It's a tragic phenomenon that affects families, communities and countries, resulting from a profound suffering in those who act on it, and resulting in a profound suffering in those who are left behind.

5.3.1. STATISTICAL DATA

It's a global public health problem and Europe is among those with highest rates of suicide, with the highest percentage of men taking their own life.



Age-standardized suicide rates (per 100 000 population), both sexes, 2016



It can also occur at any age and was considered, in 2016, the second leading cause of death among 15-29-year-olds, only surpassed by road injuries.

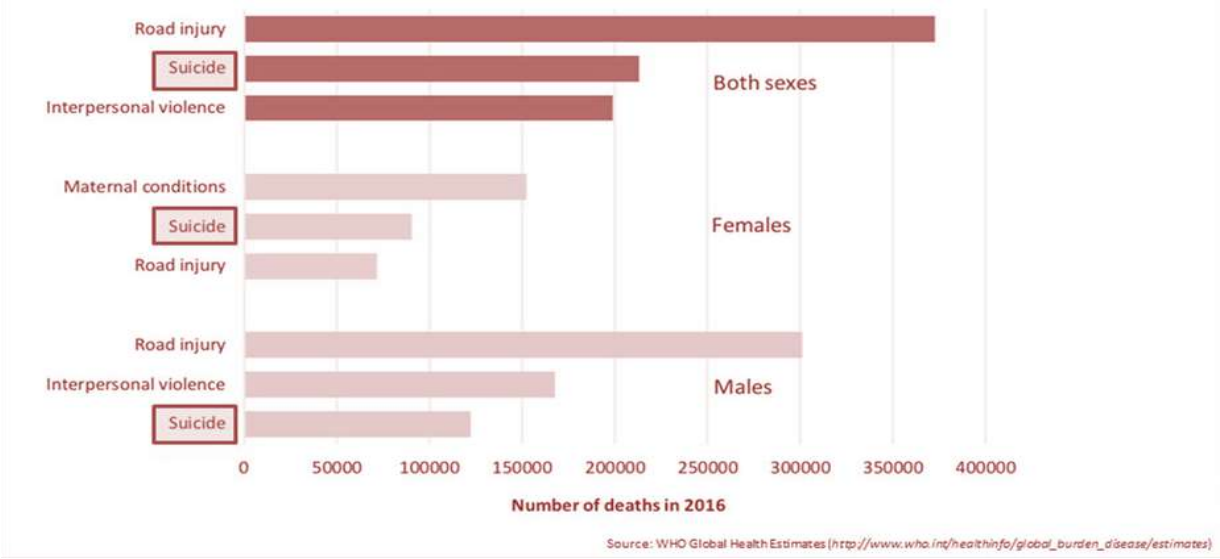


Figure 1. Suicide rate per 100,000 population by WHO region, 2016

Then, we can ask ourselves: what drives people do take their own life? Are there some who are at higher risk? What could we do to prevent this tragic ending? What can we do when confronted with someone who's attempting on their life?

5.3.2. DEFINITION OF CONCEPTS

First of all, it's important to understand some suicide-related concepts, so we can better understand the phenomenon.

SUICIDE

The act of deliberately killing oneself.

SUICIDE ATTEMPT

Any non-fatal suicidal behaviour. Refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome. It is important to understand that suicide intent can be difficult to assess because there can be ambivalence or concealment.

SUICIDAL BEHAVIOUR

A range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself.

SUICIDAL IDEATION

Any self-reported thoughts of engaging in suicide-elated behaviours.

SUICIDAL INTENT

It is to have one conscious aim, purpose or goal to deliberately take one's own life.

SUICIDAL MOTIVATION

It is the driving force behind ideation or intent that does not need to be conscious.

AMBIVALENCE

It corresponds to the coexistence of opposing attitudes or feelings, toward a person, object, or idea. It can also be uncertainty or indecisiveness as to which course to follow.

5.3.3. WHO IS AT RISK OF ATTEMPTING/COMMITTING SUICIDE?

An act of suicide or its attempt results of a complex interchange of factors. There are a number of them that can put people at risk and be real predictors of suicidal behaviours, if no preventive or intervention measures are taken. However, it doesn't necessarily mean that people under those situations will commit or attempt suicide. Here (Table 1) follows some of the risk factors involved in this issue.

RISK FACTORS ASSOCIATED WITH SUICIDE/SUICIDE ATTEMPTS	
Risk factors associated with the health system and society	▪ Difficulties in accessing and receiving health care. ▪ Easy availability of the means for suicide (e.g. access to firearms, pesticides, medication). ▪ Inappropriate media reporting that sensationalizes suicides (and increases the risk of 'copycat' suicides). ▪ Stigma against people who seek help for suicidal behaviours, for mental health or substance use problems.
Risk factors associated with the community and relationships	▪ War and disaster ▪ Stresses of acculturation ▪ Discrimination ▪ Sense of isolation/alienation ▪ Abuse ▪ Violence ▪ Conflictual relationships
Risk factors at the individual level	▪ Previous suicide attempts ▪ **Mental disorders** (e.g. depression, substance use, schizophrenia, personality disorders) ▪ Harmful use of alcohol ▪ Psychosocial stressors : o Loss of a close relationship through death or divorce o Loss of employment/unemployment o Chronic illness/disability o Chronic pain o Legal proceedings o Interpersonal conflicts o Financial loss ▪ Family history of suicide ▪ Intention to die ▪ Age (the young (15-24 years) and the elderly (over 75 years)

5.3.4. SUICIDE PREVENTION

In order to create protective factors, that counterbalance the effects of the risk factors, suicide prevention actions should be put into action. The WHO (2014) distinguishes the following 3 kinds of suicide prevention strategies:

Universal prevention strategies – they are meant to reach an entire population, by:

- Increasing access to health care;
- Promoting mental health;
- Reducing harmful use of alcohol;
- Limiting access to the means of suicide;
- Promoting responsible media reporting.

Selective prevention strategies – they are meant to target vulnerable groups, e.g. people who have suffered trauma or abuse, or people affected by conflict or disaster, by:

- Training "gatekeepers" who assist the vulnerable;
- Offering help services (e.g. suicide hotlines).

Indicated strategies – they are meant for specific vulnerable individuals, by:

- Offering community support;
- Keeping follow-up for those leaving health-care facilities;
- Educating and training health workers;
- Improving identification and management of mental and substance use disorders.

On September 10th, it's celebrated the World Suicide Prevention Day. Currently, to the best of our knowledge, 28 countries have national suicide prevention strategies. These strategies

include measures such as surveillance, means restriction, media guidelines, stigma reduction, raising public awareness, and training health workers, educators and police.

Among others, police officers are first line responders, which means that they are often the first ones involved in crisis situations, including mental health emergencies (such as suicidal behaviours). For that reason, they play an important role in community-based suicide prevention strategies, for example, by ensuring that persons with mental disorders receive appropriate mental health treatment, or by removing access to lethal means from people at high risk suicide.

Possible warning signs for a suicide attempt (behavioural or verbal cues):

- Being withdrawn and unable to relate to friends and co-workers;
- Talking about feeling isolated and lonely;
- Expressing feelings of failure, uselessness, lack of hope, or loss of self-esteem;
- Constantly dwelling on problems for which there seem to be no solutions;
- Expressing a lack of support or belief in the system;
- Speaking about tidying up affairs;
- Giving some other indication of a suicide plan.

Naturally, the ultimate aim of suicide prevention is to reduce the number of deaths by suicide. However, it figures equally important to reduce the frequency and severity of suicide attempts, since it constitutes a significant risk factor

5.3.5. INTERVENTION IN A SUICIDE ATTEMPT SITUATION

There is no recipe for a successful intervention. Sometimes we do the best we can, but still it doesn't work the best way – people still have their self-determination.

What is suggested is to reflect about this issue, to unveil some of the stigma around it and to remind of some interpersonal behaviours that can promote the connection with other human being and his/her suffering.

For that purpose, the following suggestions of activities may facilitate points of self-reflection and group discussion.

EXERCISES

Activity no. 1

Self-Reflection Game

Materials necessary: 3 types of cards: "I agree", "I don't agree" and "I'm not sure".

Description: The 3 types of cards are distributed to the police officers and they need to raise one of them when confronted with each of the sentences presented. Then, reflections are made, according with the responses and the clarification from WHO can be presented.

SENTENCES (MYTHS)	CLARIFICATION FROM WHO (2014)
People who talk about suicide do not mean to do it.	People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option.
Most suicides happen suddenly without warning.	The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and look out for them.
Someone who is suicidal is determined to die.	On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively by drinking pesticides, for instance, and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.
Once someone is suicidal, he/she will always remain suicidal.	Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previous suicidal thoughts and attempts can go on to live a long life.
Only people with mental disorders are suicidal.	Suicidal behaviours indicate deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.
Talking about suicide is a bad idea and can be interpreted as encouragement.	Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

Activity no. 2

Sharing personal experiences

Examples of possible questions (there may be other possibilities):

In professional life…

- Have you ever been involved in a suicide attempt situation?
- How did you feel?
- What was done?
- How did it work out?
- Do you think something could have been done differently?

In personal life…

- Do you know someone who has attempted/committed suicide?
- Do you feel there were warning signs (which ones)?
- How did you feel about it?
- Do you feel like something could have been done to prevent it?

Activity no. 3

Movie time

Description: Show movies, clips, documentaries about suicide and have a discussion around it.

Examples:

- https://www.youtube.com/watch?v=63WQo5ca63w
- https://www.youtube.com/watch?v=h-gkACVd5Hg
- https://www.youtube.com/watch?v=WcSUs9iZv-g
- https://www.youtube.com/watch?v=Lpo65ciblA4
- https://www.youtube.com/watch?v=LytKNC405oI
- https://www.youtube.com/watch?v=7CIq4mtiamY

Activity no. 4

Brainstorming exercise: I'm in a suicide attempt situation…What now?

Description*:* collect all possible ideas of actions that could be taken in a suicide attempt situation.

Discuss the pros and cons of each action and select those with major acceptability.

In the end, show the proposal from WHO's Manual "Preventing Suicide: A Resource for Police, Firefighters and other First Responders" (2009).

(Possible) Actions in a suicide attempt situation:

- Approach all situations involving someone who is suicidal as a psychiatric emergency and act accordingly. Never assume that suicidal ideas or gestures are harmless bids for attention or an attempt to manipulate others.
- Clear the scene and keep yourself and others who may be present safe.
- Give physical space. Don't get too close to the person too soon. Sudden movements, attempts to touch the person, or the introduction of others into the scene, may be misunderstood.
- Express acceptance and concern. Avoid sermonizing, arguing, problem-solving, giving advice, or telling someone to "forget about it". It is important to convey an attitude of concern and understanding.
- Engage the individual. Encourage the person to talk. Most suicidal people are ambivalent about dying. Asking someone if they are suicidal or otherwise talking about suicide will not tip them over the edge, but will provide a sense of relief and a starting point for a solution. To assess intent, ask if the individual has a plan, access to lethal means, or has decided when to act.
- Remove access to all lethal means of self-harm, particularly firearms, and toxic substances (such as large supplies of psychotropic medications, or pesticides).
- Suicide may be averted if people receive immediate and appropriate mental health care. If the individual fulfils mental health act criteria, take immediate action to ensure that the individual is committed to a hospital for psychiatric assessment and treatment. If the individual does not appear to meet mental health act criteria, it is still important to ensure that they have prompt access to mental health and substance abuse treatments. As most individuals are ambivalent about suicide, they will agree to receive treatment. Pre-arranged agreements with local hospitals, community mental health and addictions agencies will facilitate this process.
- Never leave a potentially suicidal individual alone based on their promise to visit their mental health worker or the hospital. Ensure that family members or significant others are on the scene and accept responsibility for help seeking.

Activity no. 5

Role Playing: What if it was me?

Description: Ask the participants to turn their attention to themselves and to a sad episode or moment of their lives. They don't have to describe the moment, only remember how they were feeling (e.g. sad, desperate, angry, downbeat, demoralized, demotivated). Ask them to think about (and write, if they prefer) what they wish someone had told them (which words could have brought them comfort) and how it should have been done.

Then, ask them to turn to a partner and tell him/her those words.

Bring the discussion to the table about the effect of the words, and the way they were told, as well as their usefulness for different people in different situations.

Conclude the exercise by bringing focus to interpersonal competencies in a crisis situation and reinforcing the idea that there are no recipes of what would work best in a suicide attempt situation.

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