

A Further Advance in Clinical Perspective: An Introduction to Neuro-Psycho-Education Model

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Abstract One thought creates an idea; an idea starts out a profession which begins to develop competing ideas; as: "In what way can contribute the production of a new model to change the life of mental people and to specify the scientific status of clinical psychology? I had this idea to develop my thesis of Master Diploma and later in my actual professional practice. This paper aims to present the importance of a new research model called 'neuro- psycho education' (N-P-E-M) as a clinical tool (complement of treatment with medications) to facilitate the recovery experience of Persons with Mental Dysfunctions (P.M.D) which are increasing in over the world. It is illustrated with a recent pilot study. The measuring instrument is the manual: Let us make recovery a reality, which is divided in three challenging issues: I- examines historical roots that can be traced by January 2010. Its scientific and ethical strengths will be noted, too. II- provides a view of basic brain research in operational system of presuppositions (neuropsychology and psycho education); the content related to the interaction between brain, psyche and education. III- is dedicated to the use of clinical techniques to improve cognitive functions. N-P-E-M shows an attempt to document measurable, physiological changes at P.M.D as a result of psycho educational efforts. It can manifest first movement of N-P-E-M'and an affirmation of its merits by adding knowledge that could potentially help people in theory and practice. However, its informal status and practical success will be re-examined, in order to assess future important organizing framework for clinical perspective.

Keywords: clinical perspective, neuro-psycho-education model, experience of recovery, persons with mental dysfunction

1. Introduction

One Moment Mental Activity

Imagine that you thinking. Try to remind your mental and emotional reaction to the thought. Think about: Which was the thought? What did become the process of thinking? What was the result? Be prepared to share it with your own mind.

I will start by saying that one thought creates an idea; an idea starts out a profession. A profession in turn begins to develop competing ideas as: "In what way can contribute the production of a new model to change the life of mentally ill people and to specify the scientific status of clinical psychology? Can the production of a new model facilitate the recovery experience of persons with disfunctions? Recovery is a very known term which is used in actual clinical practice. Nowadays it is becoming a risk to become a nonapplicable concept if there are not going to be qualitative reports to show that a given intervention based in recovery experience is effective and can be used at the same time with other intervention of rehabilitation.

Objectives:

- Elaboration of an intervention program as an instrument to facilitate the recovery experience to different persons with mental dysfunctions and
- Evaluation of the effectiveness of the neuro-psycho-educational model according to the results of participants.

Hypothesis

Can be used the Neuro-Psycho-education intervention (a complementary treatment with medications) as a regulator to facilitate recovery experience and to show clinical utility?

Identification of variables

Criterion variable (*dependent*) meta-cognition and cognitive functions: (*meta-cognition refers to emotions,*), (*cognitive functions which acknowledges the existence of internal mental states such as belief, desire, idea, knowledge and motivation*).

Predictive variable (*independent*): the experience of recovery

Moderating variable (*intrusive/adjustment*): neuro-psycho educational intervention

Background

- The researches support that many people with serious mental dysfunctions can learn to succeed at their inability so they can achieve great goals regarding with independent living. (Corrigan, 2006; Whitehorn et al,1998, Harding et al., 1987).There is a wide trunk of data that support that recovery takes place (Ridgeway, 2001; DeSisto et al., 1995), and can be described theoretically in the model and narrative (Ridgeway, 2001, Ralph, 2000; Davidson, 1995; Harding et al., 1987), that can be learned (Bullock, 2000), and can be practiced (Fres et al., 2001, Bullock et al., 2000; Copeland, 1997).Ralph and colleagues (2002) indicate that there has been several previous attempts to measure the recovery process, however, already, "Recovery from mental illness is not considered a" practice based on the data "because they are not chosen at random the clinical data with "certified" results.

Literature Review

The concept of clinical perspective - Based on my research, here I mean, I refer to *clinical psychology* as a perspective in itself.I refer to the clinical attitude and to the ways it contrasts with related approaches which are most obvious with respect to a given case.For example,in reading a description of the problems of a person admitted to a mental institution, the clinical psychologist would search for psychological or biological relationships that might explain the "disorder".So the *clinical perspective is a single discipline of research, assessment and understanding human behaviour and distress on an individual basis,that provides the substance of clinical psychology.*

The concept of persons with mental dysfunctions- The *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; *DSM-III-R*) operationally defines disorder essentially as "statistically unexpected distress or disability." This definition is an attempt to operationalize 2 basic principles: that a disorder is harmful and that a disorder is a dysfunction (i.e., an inability of some internal mechanism to perform its natural function).These problems with validity are traced to *DSM-III-R's* strategies for increasing reliability. (*PsycINFO Database Record* (c) 2011 APA, all rights reserved)

Another explanation of the concept comes from psychopathological perspective based on the fact that the *dysfunction is not related directly with the fact of being diverse from the others*; it is more a disorder of development: *so a dysfunction is not based totally only at deviations of behavior but should be taken into consideration also the subjective experience and types of these experiences*

The concept of recovery to persons with mental dysfunctions -The term "recovery" in mental health derived from first person narration and is designed by Patricia Deegan (1988) as "*the development of new meaning and purpose in life beyond the symptoms, disability and prejudice of mental illness.*" Recovery points out that a person can live beyond the limitations imposed by mental dysfunction and can define and meet goals that are meaningful to him. Antony (1993) defines recovery as "*a deeply personal process, unique to change attitudes, values, goals skills and/or roles*"

Experience as a structure-Our internal experiences are formed by inner representations of the five external senses. We can begin to explore this inner subjective world and learn how to change the structure of each experience.There are main components in our thought – pictures, sounds, and feelings All this constitutes the structure of thought or experience.If we make changes to the detail to induce the state we desire, we are in a better position to create varying states of mind. The change in meaning leads to a favourable change in our feelings towards the experience.

Clinical programs based on Recovery.-Criterion were selected by me based on research question "*What clinical programs exist for recovery in current practice based on psycho-mental health data?*"The literature review pointed out that there are few mental health clinical interventions and programs based on principles of recovery and recovery results.

Ridgeway (2001) notes that *an effective program of recovery builds applied knowledge that encourages the potential for recovery*. This allowed me to start with the research question:

a) **Psychoeducation as a way to facilitate the recovery experience?** -How to study and measure the recovery by helping people with mental dysfunction to achieve their needs, desires and goals is outlined in the literature field. Individuals who live continuous forms of the disease which participate actively in their health care are known to have better outcomes (Holman & Lorig, 2000; Wagner, et al., 1996). A way to participate actively in health care and treatment decisions is through increased knowledge about mental dysfunction, its effects and treatment options. Bullock and colleagues (2000) suggest that the wider issue of recovery for persons with psychiatric disabilities is a process that can be promoted successfully by psychoeducative intervention.

b) These searches did not give to me the right answer, because I was trying to find a way how to stimulate their nervous system through psychoeducation. The process of my thinking became a cornerstone because I could potentially create a new model to change the life of persons with mental dysfunctions; exactly neuro-psycho-education.

What is Neuro-Psycho-Education in Itself?

N-P-E- *it's a model not a theory. For this, I have used operational system presuppositions of two fields, neuropsychology and psychoeducation¹ which: cannot show what is right or what is wrong; it does not include a definitely reality but I think, it is acceptable to make an intervention in clinical perspective.*

It Contains Three Challenging Issues:

1. Historical roots of new Model based on Psychoeducation

"Every piece of your life means something to someone"

- Justification on this reflection is set by considering the result of my thought which became a kind of intervention, which I used as an entrance which leads directly to the window of my vision that motivated me to realize another step in clinical perspective. It is:

- **Firstly: Experiential:** As I did a lot of practices during the academic years of studying psychology and looking them closely in the everyday life of individuals with mental illness in Psychiatry, different Orphanages and Associations, because of the illness of a very close person to me, I was motivated to follow their life experiences associated with serious mental health problem.

- **Secondly: Challenging,** because it reminds me of both clinical situations and the everyday life in general. It remembers me how important it is to be endured, more courageous or even better listening.

- **Thirdly: Educational,** because life that the participants do describe in this study clearly convey what is the experience of recovery, what helps them to reconnect with life, with what is important in general

Taking this into consideration, I have tried always to develop some principles for their treatment to minimize their disorder. So, the main idea **can be traced by January 2010, including the consultations with my scientific advisor, when I was preparing for the master thesis** concerned with the maintenance of mental stability and hygiene of individuals with dysfunctions.

2. Ethical values of new Model based on Psychoeducation

Remember: *we are always in the same boat and sometimes in a nearly sea. Only a moment is just enough to change our life, especially our psychic stability and health.*

Keeping in mind that:

-Cannot obligate a person to participate or to make something against his/her values or moral

-In its content, does not have any mystical, magical or occult thing

-Internal recourses can be activated through the actual psychological mood

-Can make a person to feel comfortable and educate to say new things or to form positive images for him/herself.

¹Psychoeducation is defined as "systematic, structured and didactic information on the disease and its treatment and which includes integrated emotional aspects in order to enable participants / patients and their families to cope with the disease.

-Goes beyond obstacles and mechanism of defenses and opens their minds for new ideas, positive thinking regarding their mental illness or behavioral disturbances

3. Scientific Value of Model based on Psychoeducation

Theoretical:

-The programme marks a starting because commits the nervous system, the way he/she thinks, the feelings changing some components in him/ herself providing immediately a positive effect in behavior. The person with these dysfunctions begins to feel under control.

-The results can provide an educative curriculum full of qualitative information regarding specific elements of impact of neuro-psycho educational model at facilitation of recovery for the individuals with mental dysfunctions.

Practical:

- Can be developed in a natyral environment, not in laboratory

- Can be used individually and in group too.

- Some of the techinques to improve the cognitive disfunctions can be exercised by themselves regarding to their need without creating dependence from the clinical psychologist.

- Persons with mental dysfunctions can not only take knowledge about the recovery but to live it indeed.

Pressupositions of neuropsychology and psycho education

Research in operational system of presuppositions in neuropsychology

Here **neuropsychology**, as effect of intervention refers to *the mind, the way how does a person think, refers to the nervous system and how the disfuncioned brain elaborates the guides*. It is divided in two branches:

Operational system of presupposition

Presupposed beliefs-A belief describes a basic structure in model of the world that is seen as a reality. Here the beliefs are called basic beliefs and they act as filters that determine how we perceive external reality. Beliefs of a person (*what he/she sees as important or not*) in a powerful way do form its perceptions.

Presupositions of mental processing²

Representative system-All our experiences are *the result of what we hear, see, feel, touch and smell, for this through the five senses which is called the representation system*. Although that human beings share the five senses and their neurology basis, their unique experience changes as our five fingers. And this is a big difference between persons.

Maps and Filters: When a person describes his/her world, he/she uses it on two levels: an objective, external reality and internal reality subjective. At this new model the *"map is not the territory"*. Territory is the reality and the map describes what exists in the mind of the person's mental understanding of the territory..When a person wants to give the sense to the experience, it builds its internal representations. The maps consist of *beliefs, values, attitudes, language and other psychological filters and these are perceived as thoughts*. Maps of the internal representation interact with a person's physiology and thus are able to be generated. The reason why people see the world differently lies not in the world, but due to different filters (*healthy or damaged*) by which each person sees him/her world. The new model *wants to change the map but not the reality*.

Research in operational system of presuppositions in psycho-education

Psychological operational system of presupposition³ based in work of:

2-the performance of some composite cognitive activity; an operation that affects mental contents; "the process of thinking"; "the cognitive operation of remembering"

3- a **presupposition** is background belief, relating to an utterance, that: Will generally remain a necessary assumption whether the utterance is placed in the form of an assertion, denial, or question,

Fritz Perls- Reading *An Introduction to Clinical Psychology* among others Gestaltist therapy, I took into consideration with techniques of Perls and found that can be used his Perls therapeutic procedures and to experiment with them. Techniques are as following: Here and now, Contact, Learning through experience and Internal dialogues.

Virginia Satir- reading the electronical book, *Family therapy* I found that theory of Margaret Satir is modeled correctly. Techniques are as following: *Erasures –Reframing, Anchoring and Gentleness*.

Eric Ericson- reminding the Lectons of Developmental Psychology, I remember some known techniques as following: Sources, Report, Rhythm

Educational operational system of presupposition based in work of:

Milton Model-This model can be used while talking with art somewhat undefined in order to move the person toward the desire to give the relevant opinion.

Logical levels, Dilts created a model of personal change. From a psychological perspective, the person can be educated in these six levels: Spiritual - What is my purpose?, Identity - Who am I? This is the basic sense of self, the core value and mission in life, Beliefs and values-Why am i doing certain things?, Skill - How am making some aspects? Behavior - What am I doing? Environment - Where and when?-The way a person reacts to other people

System and techniques of Neuro-Psycho-education

Modeling –that according to Bandura; the modeling can be described as *the brain (neurons) and it works and how materializes expressing it through verbal communication and behavior or nonverbal*. Result is a strategy or model to teach to the others how to achieve improvements in mental health, what indicates that beliefs of a person, behavior, feelings, and thinking up form a certain skill in a specific moment. According psychopathological perspective: *a skill is then an inner experience or sequence of experimental events in mind*

Management of mental status - mental condition has to do with thoughts and emotions, specifically with the unconscious thoughts. The mood is neither good nor bad but is a result that may be appropriate, not appropriate, and able to, limited and no source. Changing the situation changes all the time and this can be done by **anchoring** that may refer to a stimulus to change a position to recreate a condition. Emotional mood is a way of being in any given moment. (McDermott & Jago 2001).

Setting goals -Present state and desired state - Establishment of purpose in neuro-psycho-education model wants to look to the desired state more than the state of present problems. Abaraham. Maslow states that a goal gives purpose and direction and is the first step towards his/her achievement arritjes. Sipas, following objectives are important to set goals (*The main goals needed to be*)

Research Methodology

Outline of research-This reasearch was under a prospective with selected control trial. It is used the technique with no-probability which do not allow to generalize the findings to the whole population.

Selection of sample -Selected sample is made from the Project Hope at the Diurnal Center of Occupational Therapy and Socialisation during 24 weeks (*February-June 2011*). The sample in this research included 10 persons with mental disfunctions, (6 girls and 4 boys) among which 4 *with mental retardation*, 3 *with moderate intellectual deficits*, 2 *mentally ill* and 1 *with behavior disorder*. To meet the criteria for selection of participants I studied diagnose and made the mini-examination mental status. Also I have reviewed the relevant files with clinical data regarding inclusive and exclusionary criteria.

4 -(Similar to the work of I. Pavlov - classical conditioning Discovered by Russian physiologist Ivan Pavlov, classical conditioning is a learning process that occurs through associations between an environmental stimulus and a naturally occurring stimulus.).

Criteria for inclusion:	- Criteria of exclusion:
<p>- Participants shall be included if:</p> <ol style="list-style-type: none"> 1. Receive support from Project Hope 2. Meet diagnostic classification of mental retardation, intellectual deficit, mentally ill 3. In any case, are acceptable those with behavioral disorders 3. Is between ages 17- 30 years and 4. Has no organic disorders or substance abuse, deemed as a major cause of the symptoms. 	<p>Participants shall be excluded from the research if :</p> <ol style="list-style-type: none"> 1. Is unable to shape the give an approval 2. Taken to hospital for clinical diagnosis at the time of the research 3. Has a significant head injury or other damage resulting in significant cognitive impairment 4. Has a mental retardation (premorbid KI <65), 5. Stands to any other home at the time selected for the research

Experimental group- Experimental treatment included 24 weekly sessions according to neuro-psycho educational model with 7-10 participants. Each session was 50-70 minutes and is held by me as the main investigative and supported from a multidisciplinary team.

Instruments- The instrument used in this study was application of neuro-psycho-education model through the Handbook of Recovery: *Let's make the recovery a reality* divided into 9 sections that can be met within a period of research. No content has not been excluded from manual and practical exercises and topics covered. Each session was designed to include a combination of learning, discussion, design, animation, group and individual work time to complete practical and therapeutical exercises. Each session included a variety of educational techniques drawn by titles of authors Spaniol & colleagues to enhance learning and to gain attention.

Specific goals of Recovery Handbook: this contains the part of techniques with topics as: 1.To become aware of the recovery process, 2. To increase the knowledge and controll 3.To become aware of the importance and natyre of stress 4. To to increase personal understanding and values, 5. To build personal support, 6. To develop goals and action plan, 7. To manage anxiety and confidence, 8. To manage the mental preparation 9. To controll the flow of the mental status

The effectivity of its utility is measured by:

1. **Self-reported recovery experience;** which assess their perceptions: visual, auditory, kinesthetic, olphatory, tactile, and motoric preferences in life circle (*knowing,doing, getting,relating and being*)
2. **Descriptive reporting of educators;**which assess the process of life circle in everyday activities, so in *knowing,doing, getting,relating and being*
3. **Clinical reporting protocol;** which assess, the processes in life circle according the stimulation of internal mental states such as belief, desire, idea, knowledge and motivation in *knowing,doing, getting,relating and bein*

Gathering Of Qualitative Data

The main themes emerging from self-reports of recovery experience were: Comparisons, Confidence,Hope, *in knowing,doing and being* during the development of life circle in Home-Families.

The main themes emerging from the reports of educators were: Turning return, - Understanding, Relationships in *getting, knowing and doing* the things during the development of life circle in Home-Families.

The main themes emerging from clinical protocols were: *knowing*, (concept formation, knowledge acceptance), *doing*,(action, motivation. self-belief) *getting*,(attention,idea advice), *relating* (association, desire interconnectness), *being* (perception,mental imagery.belief, existence) during the development of life circle in Home-Families.

The Final Survey

It is concluded that the participants have undergone significant changes as follows:

- a) **Feeling understood:** *the construction of confidence* - a point in treatment when participants felt understood and began to believe by showing willingness to engage in the treatment of
- b) **Efforts to improve:** *the role of medication* - underlines the confidence of participants in their healthcare team and the willingness to take medicine as a way to simplify matters for symtoms, Also experienced battles that result from issues

related to the effects of medications (*psychotropic drugs*); that means this is conform what honoured Dr. Gezim BOÇARI has explained to us in subject of psychopharmacology.

c) **Efforts to improve:** *beyond mechanism of defences*-during this period of stability of symptoms they began to use non-medicated strategies such as making changes in lifestyle, being engaged, supporting the others, challenging their views and taking part on personal interests as ways to manage their symptoms and increase their knowledge that they are much more than the suffering of mental dysfunction.

d) **Start to feel better** -a complex period where participants noted changes in itself indicative of improvement and provided various data related to daily life as waking up on a set schedule, cleaning the house, washing clothes, looking on tv of a preferred program together, going to church or outside home-family, etc. that they had started to feel really good. Participants also recognized the feelings of sadness and began to complain to me if I had the opportunity to repeat it again in a longer stretch of time.

Conclusion

As to follow up with my conclusions, as **Ivanov Smolenski writes** "*non e facile stabilire fin dove arriva il fisiologico e dove incominca il patologico, quando entrano in azione i meccanismi di difesa: nella misura in cui impediscono la normale attività sono patologici, nella misura in cui proteggono la cellula sono normali*". Starting by this clear explanation, I understood that to wash the *punto malato* (pathological point) was necessary to stimulate or to use a positive induction during the intervention program. Here the results showed an interesting finding because through this program it is arrived to stimulate a *punto alla periferia* (peripheral point) of pathological seat, following it under a provocative stimulation only for some short moments to keep its effect, not adding local inhibition. So the question was to create artificially a second pathological seat of inhibition to enter in concurrence with the first one in order to change their experience in a positively way. Taking these into consideration, it does exist a connection between the nervous activity, mind and education, because the recovery experience was facilitated through this intervention, through the positive stimulation of internal mental states such as belief, desire, idea, knowledge and motivation in knowing, doing, getting, relating and being regardless of the medication effects. So the N-P-E-M shows an attempt to document measurable, positive physiological changes at P.M.D as a result of psycho educational efforts because as Hebb writes: **the education consists in a lasting change of facilitations between the activities of specific neural structures.** The finding gives an acceptable answer, because the participants have had **simple psychic reactions** and not the **locking of cortical circle**. The last one can happen after a lot of purposeless mental and hygiene activities. It can be said that the domain of clinical research is also significant and is evidence of the first controlled selection that examines the effects of neuro-psycho educational intervention, based entirely on principles of positive stimulation of nervous system preparing the persons with mental dysfunction to think and to let the mind flow freely and experiencing excited emotions. Hence, it can manifest first movement of N-P-E-M and an affirmation of its merits by adding knowledge that could potentially help people in theory and practice. However, its informal status and practical success will be re-examined, in order to assess future important organizing framework for clinical perspective.

Limitations

The first limitation was that it used a modified version of the original baseless and Recovery Handbook. It is not covered all the content because of the study aims, but time is recommended to cover the material is reduced from 30 weeks to 24 weeks.

The second limitation was a lack of standardised reporting observations. They are elaborated only purposely Logistics of the study did not allow collection of additional data other than the period of 24 weeks.

The last limitation was the lack of a control group

Possible confounding of this study include: a-Effect of Group Leader and b) Time of Day

Recommendations for Research, Training and Practice

Research- For further researches held within this focus on persons with mental dysfunctions to be added to the findings of this intervention with other samples like at orphanages or psychiatries

Training- For existing labor force of mental health including clinical psychologist to get training for "recovery" and possess knowledge and understanding of different models of recovery experience

Practice -That clinical psychologist in conjunction with mental health team promotes understanding and to facilitate

positive sense and effective ability to solve the problem for the recovery of persons with mental dysfunction implementing the successful and practical intervention called Neuro-Psycho-education.

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