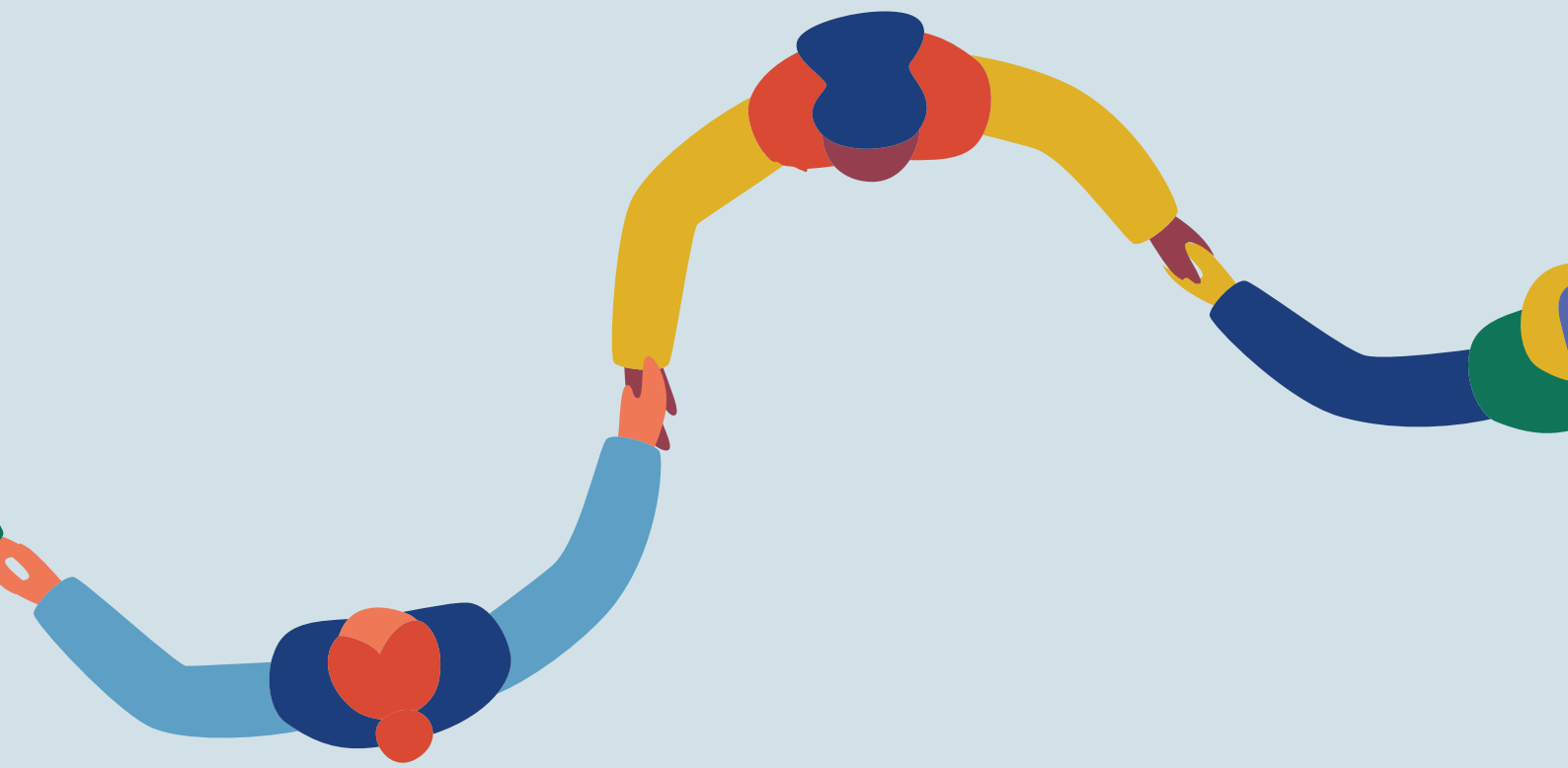




MANUAL FOR APPLYING MENTAL HEALTH CARE TOOLS FROM A HUMAN RIGHTS PERSPECTIVE

Futuro & Co.

Innovación
y comunidad
para la autonomía
de jóvenes
sin hogar





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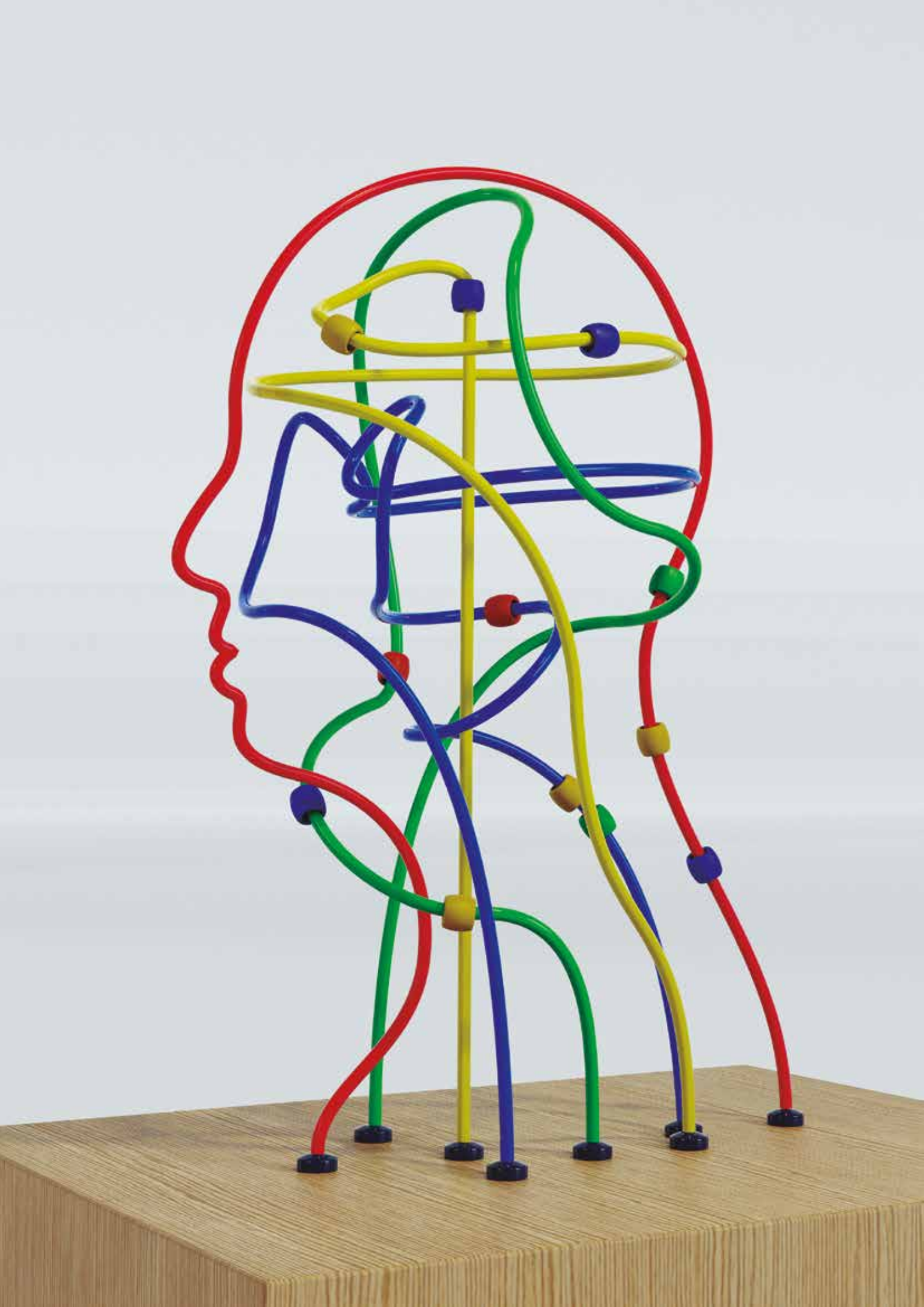
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1. Purpose of this handbook

In January 2022, FACIAM started a social innovation project which, with funding from the Ministry of Social Rights and Agenda 2030 at the expense of the EU Next Generation funds, aims to test a new mode of intervention with young people in social and residential exclusion. To this end, a set of tools has been designed to address people's demands at this stage of their lives, with the clear objective of favouring the (re)construction of their life projects in the community.

These tools are the result of a process of reflection and collaborative work based on the organisation of several discussion groups with young people in social and residential exclusion, with a wide variety of life stories and through discussion groups, where expectations, impact, limitations, dimensions and proposals for social intervention programmes were identified. A series of laboratories were developed around these proposals, and the technical teams of the Futuro & Co. executing entities took part with other

experts in Young People Experiencing Homelessness (YPSH) to define and design the dimensions of the intervention. Let us not forget that this intervention aims to facilitate the transition to adulthood for young people, giving them the capacity to make decisions that will allow them to develop their life projects.

The discussions held at both stages of defining the model were supported by the results obtained in the study "Social Exclusion and COVID-19: the Impact of the Pandemic on the Health, Well-being and Living Conditions of Homeless People" (de la Fuente et al., 2021). They pointed to the need to address the health of young homeless people comprehensively, with particular attention to mental health. Moreover, this should be done with a rights-based approach.

With this goal in mind, the Experimentation for Health Group was set up, taking on the challenge of developing a series of tools based on respect for human ri-

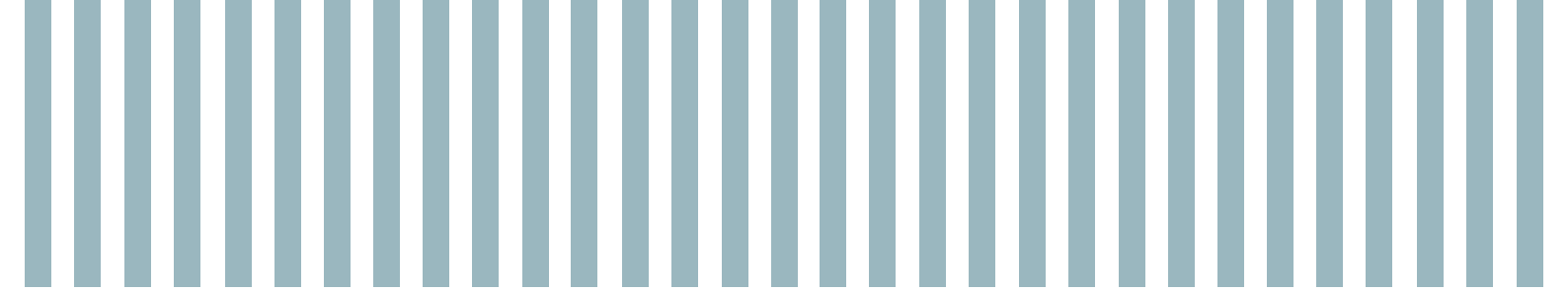
ghts and using different models with which:

- a. To Identify and consider the social determinants of health.
- b. To Identify and consider human rights violations in social and health work.
- c. To build rights-respecting alternatives.

As a result, the Experimentation for Health Group designed the following activities and tools for addressing mental health:

- Care covenants. Preliminary instructions. Downloadable booklet.
- Mutual care workshop.
- Maps of the Soul. Downloadable booklet.
- Body maps.









2. Some considerations on the rights-based approach to mental health

According to OHCHR, “the right to health is inclusive and encompasses a broad set of factors that can contribute to a healthy life, including safe drinking water, adequate sanitation, safe food and healthy working conditions.”

Human rights-based approaches to health focus on its underlying social determinants: accessibility, availability, acceptability, good quality, participation, accountability, freedoms and entitlements.

a. Social Determinants of Health (SDH)

The World Health Organisation defines the social determinants of health (SDH) as “the circumstances in which people are born, grow up, work, live, age and

grow old, including the broader set of forces and systems that influence the conditions of everyday life”.

Numerous scientific studies show that social and economic conditions have a decisive influence on our health and longevity. Gender, race, occupation, educational level, socio-economic status, affective-sexual and gender diversity and social support (social capital) are other determinants significantly related to the prevalence of specific diagnoses and life expectancy in general. It is, therefore, essential to identify these determinants and consider them when designing our work tools.

b. Trauma-aware services

Traumatic experiences are persis-

tent among young people in situations of socio-residential exclusion. Many of the problems they experience can be seen as a response to traumatic experiences.

A rights-based care framework must consider that the care process itself may contribute to rights violations or deepen existing difficulties. The Trauma Conscious Services proposals systematise this.

Within the framework of trauma-aware services, what we know about trauma is used as a guide for action and the organisation of care. Special attention is paid to avoid harming people who can be easily re-traumatised by their previous experiences.

Re-traumatisation in services occurs when a person experiences something in the present that reactivates a traumatic event in the past. The re-traumatisation often evokes the same emotional and physiological responses associated with the original event. One is not always aware that the current discomfort originates in past events.

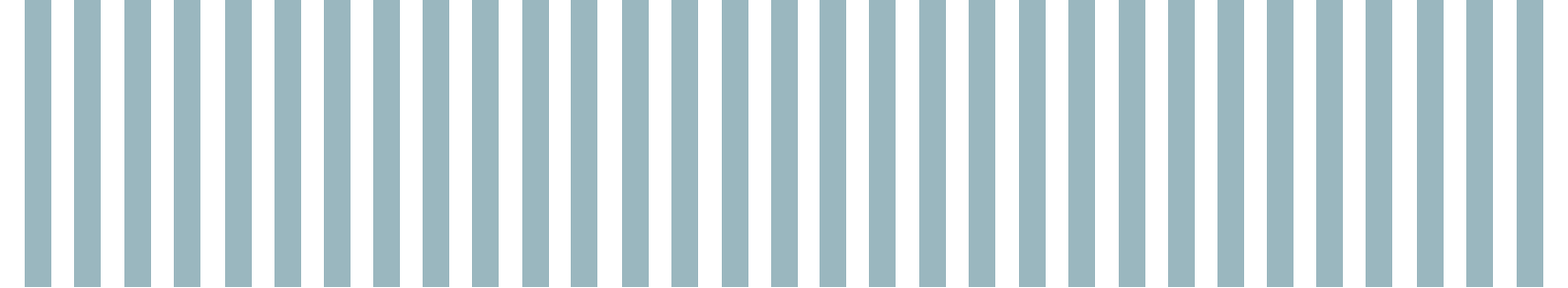
The trauma-aware approach involves moving from thinking: “What is wrong with you?” to considering: “What has happened to you?”

According to the framework of trauma-aware services, there are several everyday mental health practices with a particularly problematic character. Frequent crisis interventions such as involuntary admissions, forced medication and mechanical restraints and other interventions such as psychiatric diagnosis and over-medication are seen as potentially harmful and re-traumatising.

To avoid being a trauma-insensitive organisation, we suggest the following principles:

1. ACKNOWLEDGEMENT

- Recognise the prevalence, signs and impacts of trauma (have a trauma lens).



This should include a routine inquiry into trauma, with sensitive questions asked at the appropriate time. Acknowledging trauma can generate feelings of validation, safety, and hope for survivors.

2. AVOIDING RE-TRAUMATISATION

- Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can re-traumatise survivors (and staff). Take steps to eliminate re-traumatisation.

3. CULTURAL, HISTORICAL AND GENDER CONTEXTS

- Recognise community-specific trauma and its impacts. Ensure that services are culturally appropriate and gender sensitive.

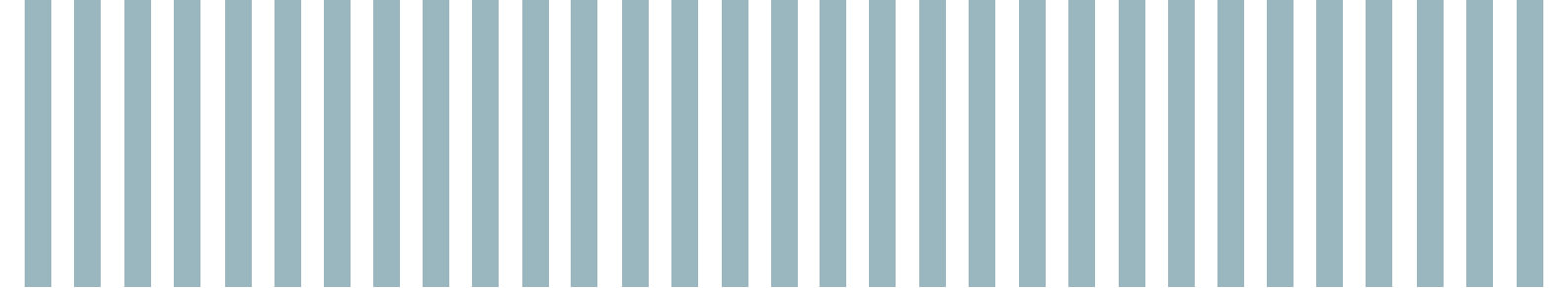
Recognise the impact of intersectionality and the healing potential of communities and relationships.

4. RELIABILITY AND TRANSPARENCY

- To build trust, services should ensure open and transparent organisational and individual decisions. This is essential for building relationships with trauma survivors who may have experienced secrecy and betrayal.

5. COLLABORATION AND MUTUALITY

- Understand the inherent power imbalance between staff and survivors and ensure that relationships are based on reciprocity, respect, trust, connection and hope. This is critical because the abuse of power is often at the heart of traumatic experiences.



Often, this leads to feelings of disconnection and hopelessness. However, healing can also occur through relationships.

6. EMPOWERMENT, FREEDOM OF CHOICE AND CONTROL

- Adopting strengths-based approaches and encouraging survivors to take control of their lives and develop self-advocacy is vital, as traumatic experiences are often characterised by a lack of control, with long-term feelings of long-term disempowerment.

7. SECURITY

- Trauma engenders feelings of danger. Priority should be given to ensuring that everyone in a service feels and is emotionally and physically safe. This includes the feelings of safety engendered by choice, control, and cultural and gen-

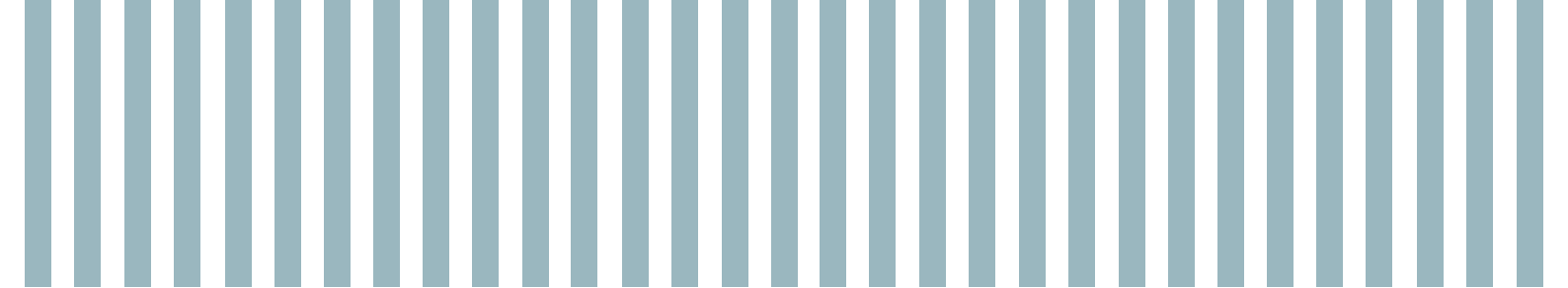
der awareness. Environments must be physically, psychologically, socially, morally and culturally safe.

8. SURVIVORS' ASSOCIATIONS

- Understand that peer support and co-production of services are integral to trauma-informed organisations.
- This is because the relationships involved in peer support and co-production are based on mutuality and collaboration.

9. PATHWAYS TO TRAUMA-SPECIFIC CARE

- Survivors should be supported to access trauma-specific care when they wish to do so. Such mental health services should be provided with the necessary resources.



This is why we will propose alternative tools to these potentially harmful and re-traumatising practices so that we will avoid resorting to them under any circumstances.

c. Drug-based prescribing as an alternative to over-medicalisation

Another element denounced by the United Nations and studied by the trauma-aware services framework has to do with the use and abuse of psychotropic drugs.

Drugs of various kinds are the mainstay of modern psychiatric treatment. The relationship between mental health professionals and service users often revolves around medication. Patients' problems are usually attributed to not taking medication or to taking it in reduced doses, although other explanations are perfectly plausible. In many cases, no clear evidence exists that people improve more with medication than without it (Moncrieff, 2013).

By assuming that psychiatric problems are diseases, we also assume that most drugs used in psychiatry work by reversing all or part of the underlying disease process. The names of psychiatric drugs reflect this assumption. We will call this view of the nature of psychiatric drugs the "disease-centred model" (Moncrieff, 2013).

It has been argued that pharmacological treatment is the best evidence for the biochemical origin of psychiatric conditions, arguing that since drugs have biochemical effects and appear to improve people with psychiatric symptoms, the disorders must be caused by a biochemical state opposite to that produced by the drugs.

However, this argument is only valid if one assumes that drugs always act according to the disease-centred model. However, another way of explaining the effects of psychiatric drugs is what we call the "drug-centred model" (Moncrieff, 2013).

The following table illustrates the main and conflicting characteristics of the two models.

DISEASE-CENTRED MODEL

- The drugs correct an abnormal state of the brain.
- The beneficial effects of drugs are derived from their effects on a presumed disease process.
- Example:
Insulin in diabetes.

DRUG-CENTRED MODEL

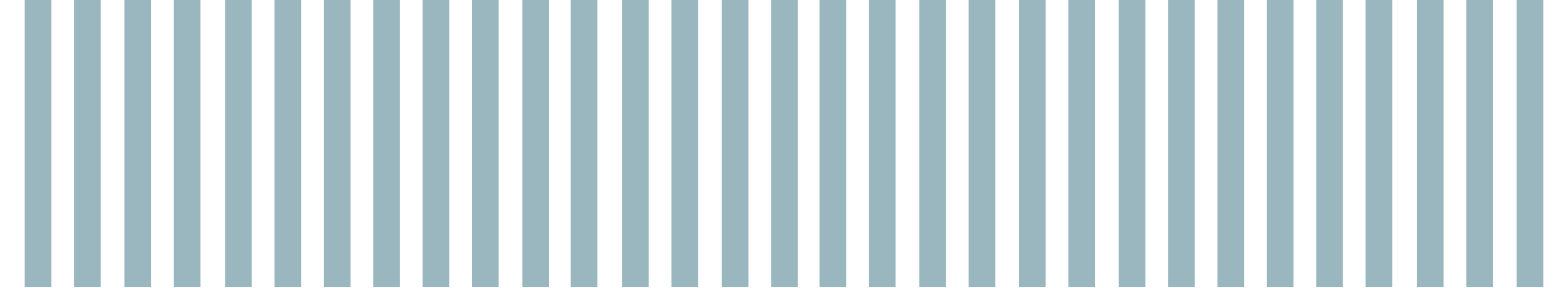
- The drugs create an altered state in the brain.
- Drug-induced effects overlap with and alter the expression of psychiatric problems.
- Example:
Alcohol for social anxiety.

d. Alternatives to Diagnosis

Mental health care systems are currently undergoing a major crisis. Undoubtedly, one of the critical elements of this crisis concerns diagnostic systems. The major systems that have attracted the attention of the professional community over the past decades have yet to define conditions whose recognition would serve to provide increasingly specific remedies. The harm that the application of these systems can cause is increasingly well documented –not only in terms of their possible stigmatising role.

Above all, to apply these diagnostic systems, it is necessary to assume that the experiences, whether emotional or cognitive, of the person seeking help are meaningless and can only be understood as a symptom, a consequence of a particular disorder.

Contrary to these assumptions, various alternatives have been developed based on the assumption that experiences, which manifest themselves in the behaviours, thoughts, and emotions of those we are trying to help, have meaning.



They can be understood as experiences and ways of responding to questions related to their personal history and the context in which they have developed their lives.

They can be understood as ways of responding to questions related to their personal history and the context in which they have developed their lives.

In other words, if we consider the biographies and psychosocial situations of the people we care for, understanding their difficulties or responses as resulting from psychopathology or an alteration in their neurotransmitters and not as normal responses to challenging contexts and experiences can be very harmful.

Crazy Maps

The movement of psychiatric patients has developed a tool to focus on the violence and oppression they have received. Or, in other words, on the invisible thread of the hook in Menninger's metaphor. It

proposes that people look at the multiple axes of oppression that continue to run through us. Instead of focusing on the chemical processes in the brain, it focuses on the social causes and how these are expressed and interfere with their everyday lives.

This tool, known as Crazy Maps, is a direct response to diagnostic manuals' failure to consider the political, social, and biographical context of suffering.

Power, Threat and Meaning Framework

The Power, Threat and Meaning (PAS in Spanish) Framework is a meta-framework that also tries to integrate other knowledge to construct an alternative to diagnosis that can be manageable in public mental health systems. It draws on diverse models, practices and philosophical traditions, although it is broader and does not depend on any particular theoretical orientation. Instead, it aims to account for and extend existing approaches by offering a fundamentally different perspective on the origins, experience and expression of emotional distress and disturbed or disruptive behaviour.

ASPECTS OF THE POWER, THREAT AND MEANING FRAMEWORK

The exercise of POWER (biological, corporeal, coercive, legal, material economic, ideological, social, cultural and interpersonal) that acts on people.

The THREAT that the harmful exercise of power can pose to the individual, the group, and the community, with a focus on emotional suffering and how this is mediated by biology.

The central role of MEANING (product of social and cultural discourses), which activates evolutionary and acquired bodily responses in shaping action, experience and expression of power, threat and our response to them.

Reacting to all the above are the ANSWERS TO THREAT, learned and developmental, which a person, family, group or community may need to use to ensure emotional, physical, relational and social survival. These responses range from physiological reactions (primarily automated) to language-based and deliberately chosen responses.

e. Transcultural perspective

It should also be noted that models that attempt to account for the causes, naming and treatment of problems vary significantly from one culture to another. This forces us to work with loose models that regard cultural context as a starting point. The cross-cultural perspective shows that if there is no bridge between the explanatory model of the person and that of the professional, the problem can hardly be treated. Therefore, the meaning or explanation given to the illness will guide the search to restore lost health; thus, both concepts are intimately linked.

From this perspective, it is proposed to include healing agents consistent with the person's original explanatory model in the medical process and to consider and respect all products and treatments recognised in the patient's original explanatory model.

f. Bodywork

Different psychotherapeutic models probe thoughts, emotions, behaviours,

psychic conflicts or defence mechanisms. However, there are many difficulties in working directly with the patient's embodied experience (bodily experiences), and this work is relegated to a marginal place in the traditional treatment plan and therapeutic interventions.

Psychomotor psychotherapy and, increasingly, other approaches address the body as a central element.

In the specific case of traumatic responses, we know that trauma has profound effects on the body and the nervous system and that many of the symptoms of traumatised people have a somatic basis.

People suffering from unresolved trauma almost always experience dysregulated bodily experiences. At the bodily level, they endlessly reproduce an uncontrollable cascade of intense emotions and physical sensations triggered by memories of the traumatic experience.

This chronic physiological activation is often at the root of recurrent post-traumatic symptoms for which people seek support.

The ability to assimilate traumatic experiences within the context of a life narrative is not yet within reach for many people who have suffered trauma, both

because traumatic memories are not encoded within autobiographical memory and because recurrent physiological activation of traumatic origin continues to generate a somatic sense of threat: “a mute terror”.

Hence, working from the bottom (body) to the top (mind) is essential.



The training module “Health with a Human Rights-Based Approach” explains the rights-based approach to mental health in more detail..

.....
“Trauma-aware services”, available
at www.campus.faciam.org







3. Tools for addressing mental health with young people in social and residential exclusion from a rights-based approach

This section is designed to guide the use of a rights-based approach by offering various tools and activities to accompany young people in socio-residential exclusion.

a. Care covenants. Advance directives

Many of the more explicit violations, such as those cited in the previous pages, occur at times of crisis, with tense emotional expressions, when people are deemed unable to make decisions for themselves, or when people have difficulty expressing what care they need and how they would like to organise it. It is at such times that it is easier to harm the people we serve.

People in crises, even with less disruptive expressions of distress, such as shutting themselves in the room without talking for days, spending nights crying, withdrawing into themselves, or silently self-harming, will also have difficulties expressing the care they would like to receive at that moment. Therefore, professionals are much more at risk of harming and re-traumatising them in these moments of vulnerability.

This tool comes from the world of law and is recognised at the autonomic level in Spain to help people express the care they would like to receive (or not) in the event of illness or injury preventing them from doing so, following their ideas, beliefs and values. What kind of care do

they need, and from whom they would like to receive it?

The reasoning is simple: if I am in a state in which I cannot express my opinion nor decide what treatment I receive, I can express my preferences in advance so that the people who will take care of me can respond accordingly. The movement of psychiatric patients thought that this tool would be perfectly applied to times when mental suffering prevents patients from saying what treatment and care they would like to receive. Thus, it has been adapted.

However, not all care requests can be accepted by the environment and the caregivers. Sometimes, agreements must be reached.

METHODOLOGY SHEET

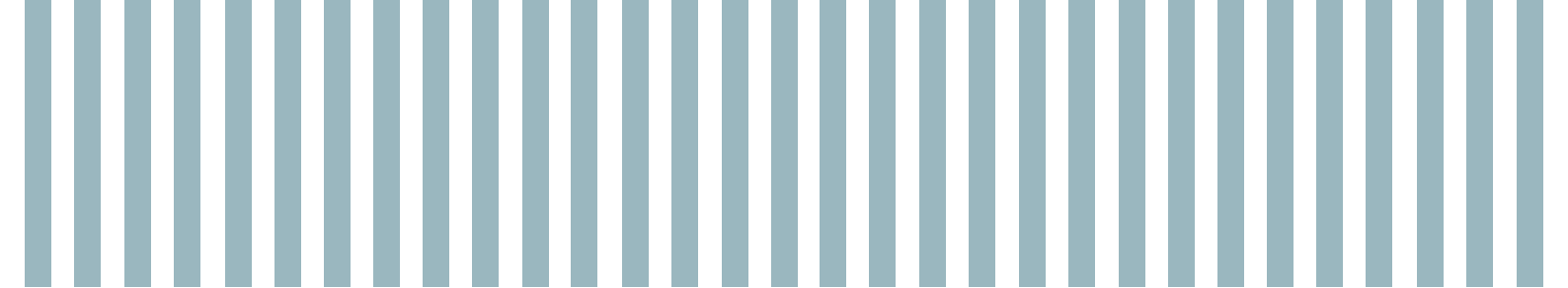
Justification

This tool requires considering the intersectional identities and power dynamics established in therapeutic relationships.

It focuses on the individual as the protagonist of their life, who decides based on their criteria, preferences and values. In other words, it gives the individual the right to self-determination and largely avoids the violation of human rights.

The aim is to reach care agreements with the participants and to draw up a joint safety plan.

BASED ON INFORMATION FROM:
Mental Well-Being and Sexuality (Nikkei Haffu) and Transmutual Support Training Schemes (T-MAPS).



Both documents emphasise Mutual Support as a tool for fostering new ways of living, where people create systems of care and generosity capable of alleviating harm and promoting well-being.

Objectives

- Prevent the violation of rights in mental health.
- Avoid re-traumatisation.
- Establish consensual care covenants.
- Encourage the possibility of building mutual support networks.
- Improve general self-awareness.
- Improve self-awareness when suffering.
- Improve self-management of problems or conflicts.

- Reduce the impact of future crises.
- Strengthen the therapeutic alliance and communication.

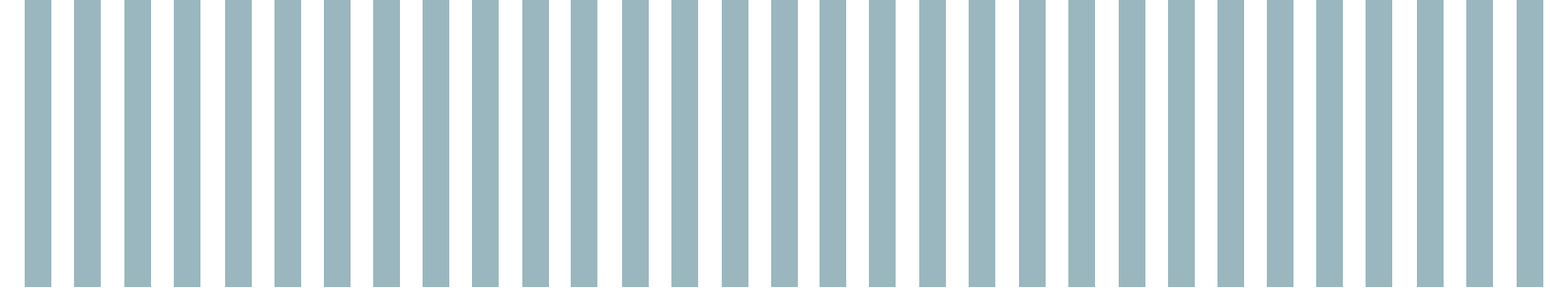
Participants

The document can be drawn up by the person concerned alone or with the support of professionals, relatives, friends, flatmates...

If joint elaboration is chosen, avoid exerting pressure or conditioning the expression of preferences.

Methodology and development

The activity is supported by a notebook on which each participant can write their preferences regarding the treatment and care



they want to receive when they are in a state in which it is more challenging to make decisions about their care.

The time to fill in the questionnaire will depend on the person and their circumstances, and their situation will always be considered. A good time would be after the previous crisis experience and always in calm moments, where good communication facilitates reflection.

This is a voluntary tool whose main objective is to facilitate dialogue and reflection.

The person concerned must have the opportunity to read the final booklet carefully and make any changes they consider necessary.

The individual has the right to amend the booklet or update it

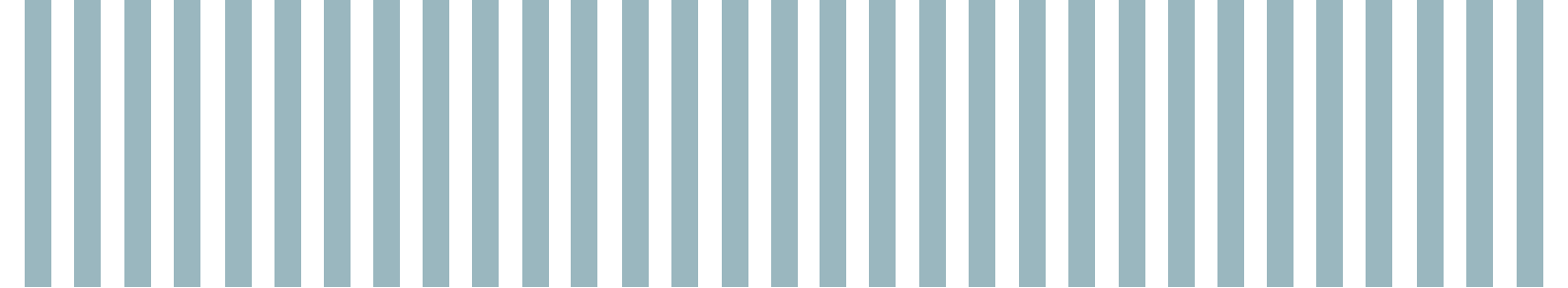
or cancel it whenever deemed appropriate.

We recommend that the person reviews the document after essential events such as:

- Changes in family structure.
- Breaking up with a partner.
- After significant health changes (diagnoses, crises...).
- If the ability to make decisions or live independently is lost.

The person who fills in the questionnaire must decide whether they want to share it and, if so, with whom.

It would be a good idea for the person concerned to give a hard copy of the document to whome-



ver they consider appropriate. It is essential for the person concerned to record in the document those situations or times when they wish their preferences and care arrangements to be considered.

The expectations of the persons being cared for may conflict with legal regulations, rules of cohabitation or healthy habits. If this happens, this incompatibility should be reported, and alternatives should be sought.

This is not a tool to be completed in a single day; it requires time to listen to and understand the person. The development of this document is an ongoing process of information, counselling and decision-making.

It is also a tool for the practitioner who carries out the accompaniment, especially if, at a critical

moment for the young person, we feel that we have not provided the kind of help they seemed to need. Through the questions in the booklet, we encourage the young person to reflect, and their answers are also instructions for the professionals who accompany them.

Materials

- “Care Covenants” booklet. Instructions.

b. Care covenants. Mutual care workshop

This tool opens honest, straightforward and transparent spaces of dialogue between the people who express the care they would like to receive and those who will be their carers (friends, flatmates, family, professionals...) to agree on how to organise it all.

The idea is also to consider the caregivers' reality and put it on the table so that, if it cannot or will not be adjusted to the request of the person to be cared for, other agreements can be reached. Thus, the advance directives will not be a Christmas letter but a proposal to be discussed with their caregivers.

A care pathway will result from agreements reached after expressing freely and transparently what and how to do in the event of reaching a situation where it is not possible to talk about it.

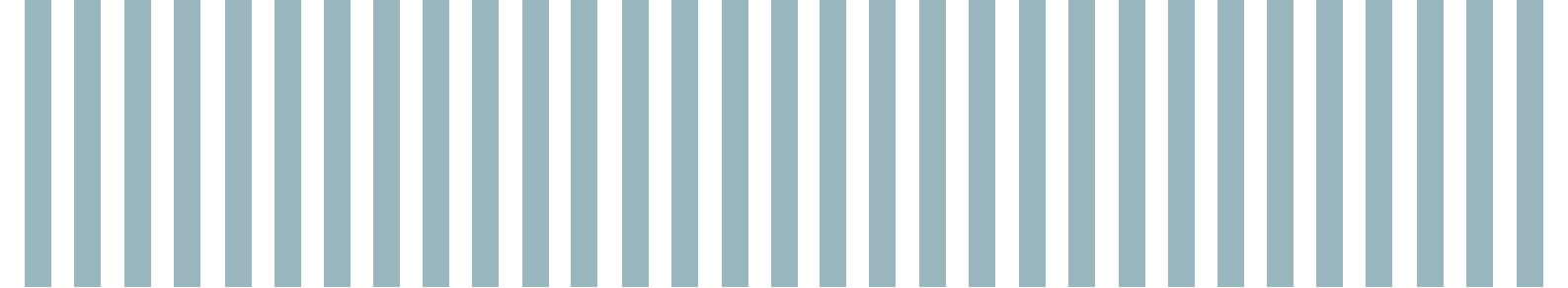
METHODOLOGY SHEET

Justification

This tool is suitable for those moments when someone is suffering because their mental health is deteriorating, regardless of the reason (family, finances, work, addictions, etc.). When someone close to us, such as a flatmate, is going through a rough time like this, it can alter their mood.

In these circumstances, insecurities and fears may arise regarding what they are going through and our ability to help them (or mitigate their suffering).

Some problems can put much pressure on friends and family; anticipating these problems is advisable to avoid burnout. Hence, people need to express their emotions (positive or negative) and share them with their closest circle.



This activity is designed in a workshop format to facilitate joint reflection and agreement on what to do when someone close to us is suffering.

BASED ON INFORMATION FROM:
Saldremos de esta - Guía de salud mental para el entorno de la persona en crisis (Erro, 2016).

Objectives

- Establish consensual care covenants.
- Encourage mutual support networks.
- Improve self-awareness.
- Improve self-awareness when suffering.
- Improve self-management of problems or conflicts.
- Reduce the impact of future crises.

- Strengthen therapeutic alliance and communication.
- Prevent the violation of rights in mental health.
- Avoid re-traumatisation.

Participants

This workshop should be attended by the people who live with the patient, always of their own free will.

Participants are encouraged to express their doubts and experiences in the way and manner they feel most comfortable.

Methodology and development

The workshop takes place in a space where everyone feels safe and calm. Guided by the therapist, the participants share any

major psychological issues that may require attention.

The aim is to raise essential awareness within the patient's close circle, just enough to enable them to react.

To address these issues, we must engage in discussions on the floor regarding:


- What did you do when you saw your friend/relative acting in such a manner?
- How did it make you feel?

Materials

Supporting graphic presentation:



CREENCIAS NO COMPARTIDAS



¿QUÉ ES?

- La persona puede expresar la expresión física de lo que siente. Hay creencias, aunque desde nuestro punto de vista sean ideas muy arraigadas e no están basadas en una realidad compartida.

¿CÓMO AYUDAR?

- **NO ALARMARSE**, escuchar lo común.
- **No tratar de convencer** a la persona, según su grado de conciencia.
- Hay que intentar ir con una serie de **emociones**, probablemente más desagradables e incómodas. Lo único que podemos intentar, cuanto más pronto en lo más silencioso.
- Siempre de frase a utilizar son: **«Te veo muy preocupado/a con lo que me dices de que lo médico quiere más...»** que **«¿qué me dices una cosa por el papeo y me lo conviertes...»**

Importancia de la comunicación



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Consejos básicos:



- **Charlar personalmente.**
- Escuchar atentamente. Dar el tiempo que haga falta para que la persona se exprese y lo comprendamos. Hacer preguntas abiertas, que no se contesten con un simple Si/No.
- **No juzgar sus emociones, vivencias y acciones.**
- No decirle lo que debe hacer en primera instancia, a no ser que nos pida consejo. Las propuestas deben hacerse muy poco a poco y contando siempre con lo que la propia persona proponga.

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Algunos ejemplos



- **No decirle lo que debe hacer** en primera instancia, a no ser que nos pida consejo. Las propuestas deben hacerse muy poco a poco y contando siempre con lo que la propia persona proponga.
- Ofrecer un apoyo realista, **expresar sus limitaciones**. Dejar claro los límites de su intimidad y tiempo.
- Expresar **cómo te sientas** si lo consideras oportuno. Utilizar frases que empiecen por «Yo me siento...» y no por «Tu haces...».

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- Si ha hecho o dicho algo fuera de lugar, o que te haya sentado mal, **evitar rechistarlo** con frases que empiecen por «eres» o «estás».
- Podemos criticar su conducta, pero **no invalidarlo como persona**. Así pues, primero asegúrate de que es un buen momento para comentarlo, y después céntrate en lo que te hizo sentir a ti, más que en lo que hizo y en si lo hizo mal.
- **Tener paciencia**: si se repiten una y otra vez los mismos temas.



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- Al realizar algún tipo de contacto físico, **preguntar primero** («¿Te puedo dar un abrazo?», «¿Te puedo acariciar?»).
- Averiguar qué es lo que la otra persona necesita en términos concretos.
- No poner todas las esperanzas en una primera charla, no trates de solucionar todo en una hora, **o poco a poco**, las prisas pueden **o b i r**.



FuturaSCA

Comunicarse en el entorno sin la persona

- Para temas en que está involucrada la persona, hay que comunicarse con ella.
- Las reuniones formales también pueden estar indicadas para tomar decisiones, pero siempre que **no se escuche nada a la persona**.

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Algunos consejos:

- No se trata de hablar continuamente sobre la persona, sino también sobre nosotros, **¿cómo se sienten más personas?** a nosotros, lo que sentimos, etcétera etc.
- **no planificar**, ni tomar decisiones por ella.
- No es una reunión rutinario de trabajo, **no es una reunión**. Es un **entorno compartido** y dispuesto a apoyar de la mejor manera posible. Si nos reunimos es para mejorar nuestro apoyo.
- **Reservar una sesión**, decir lo que necesitas para ser ayudado, escuchar lo que otra necesita para tratar de ayudar.
- No interpretar por qué le sucede lo que le sucede, **o más habitual es equivocarse**. (Ejemplo: «esto le pasa por, esto es debido a...»)

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Comunicarse el entorno con la persona

- ✓ No se trata de comunicar a la persona que queremos ayudar que está habiendo «reuniones» sobre ella porque se sentiría invadida y atacada.
- ✓ Si se considera necesaria, puede ir alguien a hablar con ella y expresarle la preocupación que su entorno está experimentando.



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¿QUÉ?

Será recomendable que fuesen a hablar solamente las que tengan **relaciones** con la persona. Cuantos menos mejor, menos invasivo será. Preferiblemente **una persona a la vez**.

¿CÓMO?

Se pueden utilizar frases parecidas a: «Te notamos un poco diferente últimamente, ¿cómo estás?»
También, puedes expresarle lo que estás sintiendo, utilizando el **«yo»** en lugar de «ella», como: «Yo me siento mucho más que el «tu hogar»».

Un pequeño detalle puede ser tomada como un insulto.

¿PARA QUÉ?

El objetivo puede ser preguntarle a la persona **«¿cómo estás?»**, si necesita ayuda o no y, si la necesita, **¿cómo es?**

Que sepa que **estás ahí** para cuando es necesario.

¿CUÁNDO Y DÓNDE?

Lo mejor es preguntar en lugar de tratar de adivinarlo, hace que sea un **«acto»** voluntario, según sea necesario. Úbalo después que no es vola a encontrar a gente conocida.

En caso de que la persona no quiera hablar **«no»** demasiado, si la persona niega que le está pasando mal no hay que sentirse frustrado.

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Reunirse con el entorno de la persona

- Esta modalidad puede servir si la persona quiere expresar una necesidad, pedir algo o comunicar alguna decisión o reflexión.
- Lo ideal sería que esta reunión **«propone»** ella misma, pero también se le puede sugerir o animar a que lo haga si se considera apropiado.
- Tenéis que estar muy seguros de que la persona va a considerarlo adecuado y **no como una burla**.



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Apuntes sobre la ayuda profesional

- Muchas veces no sabemos si la situación que se nos presenta requiere de **ayuda profesional**. Esta es una decisión que conviene tomar a la persona que está sufriendo.
- En algunas ocasiones puede ser la única forma de que la problemática mejore, mientras que en otras no será un absoluto necesario.
- También habrán situaciones en que será necesario pedir ayuda y en otras una poco más. Cada situación debe valorarse independientemente.
- En cualquier caso, lo más lógico es acudir en función de la cantidad de información que la problemática tenga en la vida de la persona y de las herramientas que disponga en su entorno. No es lo mismo escuchar voces que sufrir una depresión.



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RECURSOS A UTILIZAR



PACTOS DE CUIDADO



GRUPOS DE AYUDA MUTUA



FÁRMACOS

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- Generalmente no hay urgencia a la hora de buscar **ayuda profesional**. Esta opción se puede esperar y **valorar con calma**.
- Una buena idea es buscar diferentes opciones, informarse acerca del enfoque de cada terapeuta y hacer una buena **lista de pros y contras** de cada opción.
- En caso de que la problemática esté produciendo una gran cantidad de sufrimiento a la persona y/o al entorno, quizás sea necesario recurrir a la **ayuda profesional** cuanto antes.
- Un aspecto que hay que tener en cuenta es que los profesionales **«ayudan»**. Dan recursos, herramientas, información y pueden acompañar a la hora de expresar emociones.



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Algunas reflexiones finales

- Las **«reuniones»** familiares o con amigos, no son reuniones de la persona que está sufriendo, sino que se trata de una **«reunión»** para **«ayudar»**.
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c. Maps of the Soul

We are grateful for the inspiration from “The Icarus Project,” and based on their work, “Crazy Maps Guide,” we have found it helpful to analyse the impact of oppression or abuse of power of one group of people over others based on socially, politically, or culturally pre-established systems. We aim to make us aware of the situations that have harmed us beyond medical diagnoses to find ways of recovering our well-being through writing.

The first step in transforming an oppressive system and fighting against the feeling of oppression is individual and collective consciousness. As we understand our experiences of vulnerability and share with our peers the oppression we have experienced, we feel more empowered to overcome the inequalities and injustices present in our society at large. Taking positive action on our behalf is the most potent cure for both internalised and external discrimination and oppression.

The Soul Maps guide has been developed based on what many other people

have shared from their experiences of oppression and feelings of vulnerability, which can help us recognise our own experiences of oppression and wounds to heal them, discovering a language to express ourselves and tell our own story.

METHODOLOGY SHEET

Justification

Self-mapping is a psychotherapeutic tool for remembering goals, difficulties, and well-being strategies. It helps one recognise and heal one’s experiences of oppression and woundedness and discover a language to express oneself and tell one’s story.

Objectives

- Awareness of the im-

pact of oppression and abuse of power.

- Raise awareness of situations of vulnerability derived from oppression and find ways of recovery through writing.
- Facilitate individual and collective awareness through peer recognition.

Participants

Individually and with the support of a professional. The content can be shared with the rest of the participants.

It also raises the possibility of getting to know the experience of third parties (possible mentors) who have a consolidated discourse based on their experiences of surviving systems of oppression before writing the book.

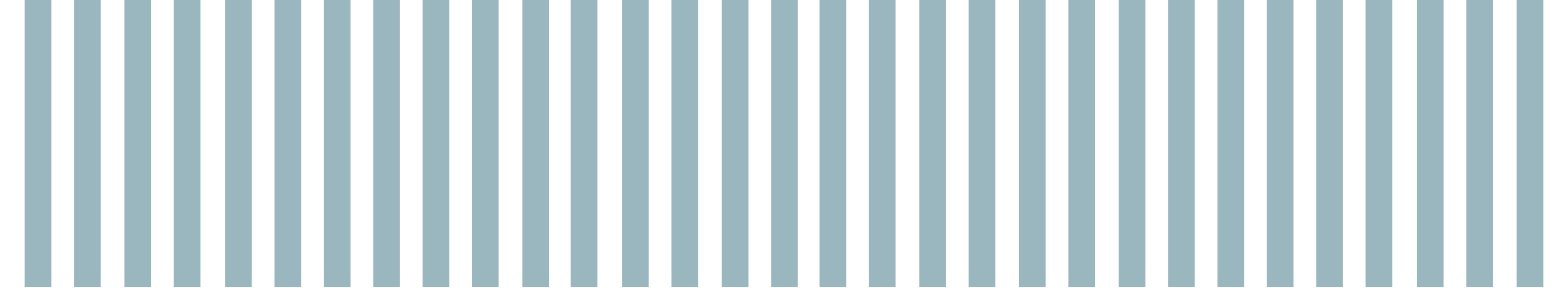
Methodology and development

This activity may take several sessions to develop. Participants may need to space out the sessions to facilitate personal reflection and awareness.

The questionnaire can be completed individually or with the help of a technician. It is also possible that several people decide to complete it as a group (this will always be a personal decision).

The patient must be committed; no one can force anyone to journey through the memory of painful and traumatic episodes if they do not feel up to it. The soul map can be compared with that of others for mutual inspiration.

Before starting, you must ensure you have a safe space to stay for as long as necessary without interruption. Somewhere comfortable and relaxed.



The booklet is mainly organised in two blocks with the following questions:

HOW DO YOU EXPERIENCE OPPRESSION?

Identifying the type of oppression: classism, racism, patriarchy, chauvinism, ableism, fundamentalism, discrimination against non-normative bodies, ageism, etc.

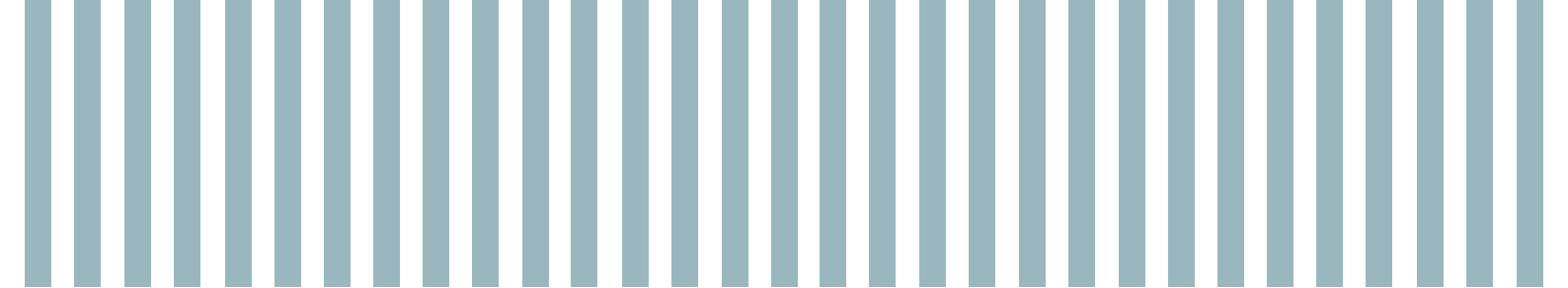
- How has it affected you? What did it make you feel?
- How does it make you see yourself? What are the social consequences of your relationships with others?
- How does it affect your ability to work and your daily life? How does it make you see the world?

- What meaning have you given to these experiences, what does it mean to you, and what does it mean to accept all these experiences?

CONSCIOUS RESPONSE TO THREAT

Creación d Creating healthy and conscientious alternative responses to preserve well-being and establishing warning signals as a protective weapon to continue achieving goals.

- How would you express the oppression you experience?
- What do you do to survive all these experiences?
- What practices do you think you could use for your care? In what other ways



can you cope with the impact of oppression?

- How can other people help you? How can people who suffer from the same kind of oppression help each other?
- How can we jointly address oppression in our communities?

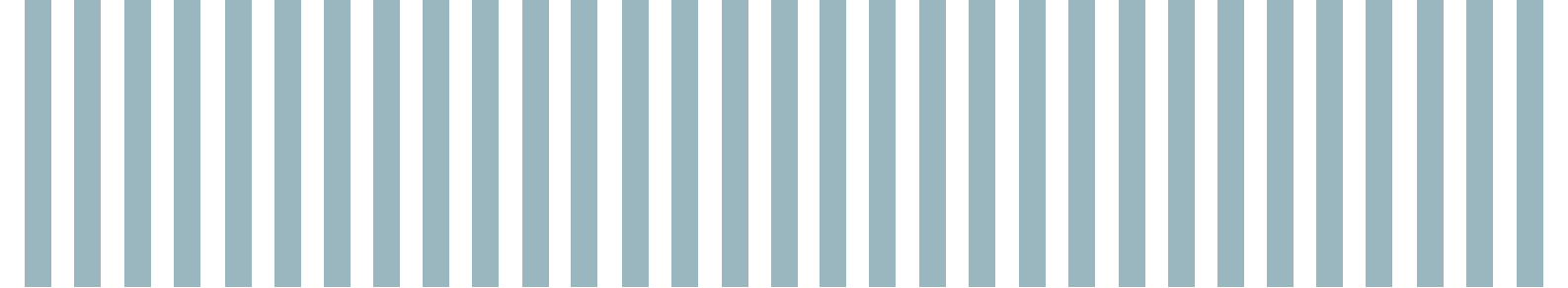
The creative activity proposed in the final part of Maps of the Soul involves artistic media, but it is essential to be clear that these are a means and not an end. Exploring and developing creative capacity are highly effective tools for blossoming new forms of expression and self-awareness.

This involves communicating by different means and, as such, allows us to expand the resources of human communication beyond the verbal, broaden the means of

expression, and eliminate some of the barriers that may occur with oral and written language. In short, it consists of using all the possible means at our disposal.

The therapist will focus on providing the ideal conditions for the participants to develop their artistic manifestation. As far as physical resources are concerned, they must have a physical space in which they feel comfortable, an environment they can choose, a communal or private space. It should be added that certain materials such as oil, water, some types of glue, etc., should be used in well-ventilated rooms.

It is also essential to consider time as a factor, whether the activity is to be done in one or several sessions, the duration of the sessions, and, above all, to ensure that there is “enough time for it.” This process requires be-



ing in a suitable frame of mind for successful execution, and having time set aside for it dramatically facilitates the experience.

It must be clear that our tastes, opinions, concepts and ideas must be kept within the framework of their creation. We intend to help them express themselves; they will express their inner world, which will be impossible if we impose our aesthetic codes. All available materials, shapes, colours, techniques... must be explained to them in the most unbiased way possible; we cannot condition or help them develop their creativity if we try to impose our own.

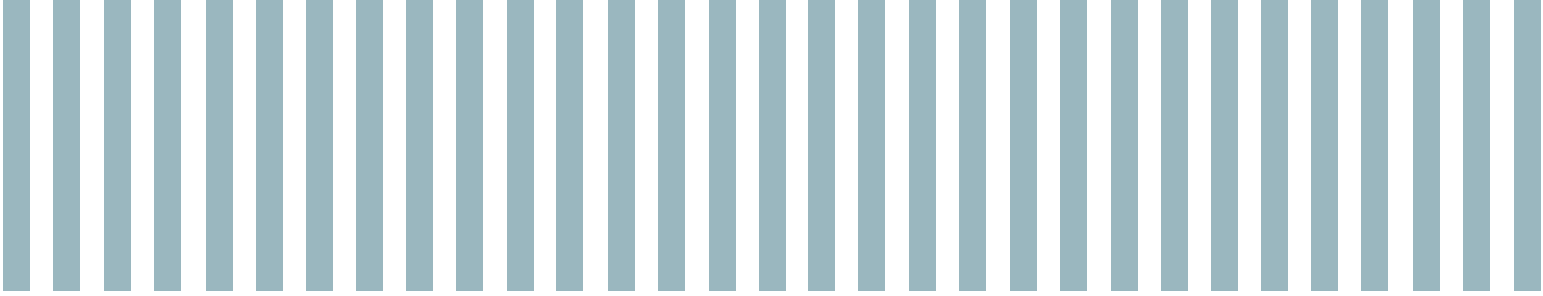
Our role is to stimulate them, encourage their self-esteem and ability to make decisions, help them overcome their fears, and make it clear to them that the artistic space is precisely a space of absolute freedom.

If they feel uninspired and ask for help at some point, we can show them images, but as varied as possible and without our predictions conditioning them. Millions of icons exist, from prehistoric paintings to contemporary art, including the purest abstraction. If what they need is for us to help them draw the first lines or colours, we will do so on another canvas, not on theirs.

We will be careful not to intimidate them with our artistic skills. Our attitude will always encourage them to enjoy themselves and give free rein to everything they have inside them.

Materials

- Booklet “Maps of Soul”.



d. Body Maps

Body Mapping is a methodological model used in biographical research. In this model, the body is studied as a place where the psychic experiences of each subject converge and are regulated, trying to interpret the corporeal instead of psychological symptomatology as most approaches do, "privileging the valuation of the cognitive".

One thing that sets this model apart from others is its origin, popularised in theories of the human and social sciences, which focus on the body.

The Body Map Model emphasises the relationship and interaction between the narrator and the subject who interprets it, as two actors differentiated by their histories and subjectivities come into play. In autobiographical applications, the subject decides what to remember, how to evoke it and how to narrate or interpret it.

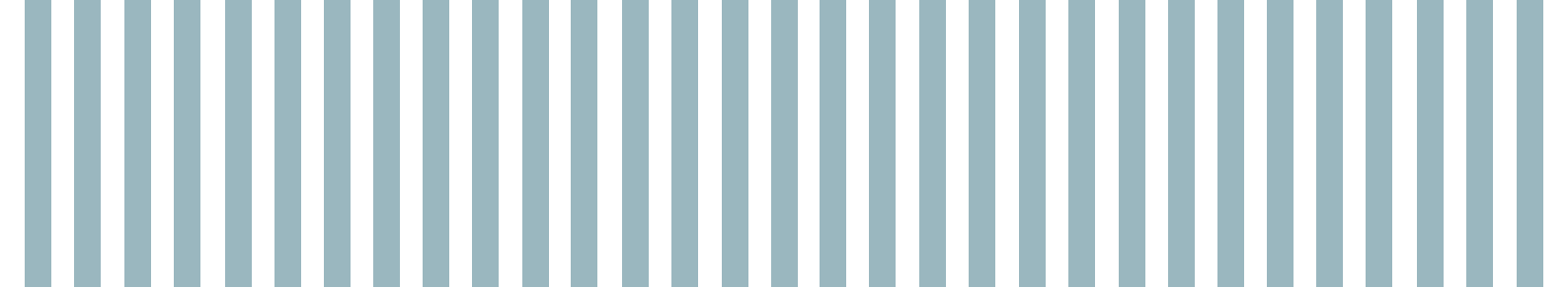
The method's authors reaffirm that the body is a stage in which different oppressions and influences have occurred.

They are a direct result of the social and cultural context in which they took place (as well as their independence or autonomy from said systems). BASED ON: Modelo de los mapas corporales (Silva, Barrientos and Espinoza-Tapia, 2013).

METHODOLOGY SHEET

Justification

This tool seeks not to interpret symptoms or diagnose but to stimulate "the emergence of embodied meanings and discourses". Once these have been expressed, the aim is to co-construct an oral and visual autobiographical account. The idea is to be able to draw up a mapping of bodily experiences based on specific personal and relational experiences in different socio-cultural settings. Having a knowledge-based approach is



critical for carrying out qualitative work with all the shared experiences.

Objectives

- Facilitate greater awareness of the relationship between the intimate and personal and the socio-cultural context.
- Promote self-discovery, reflection, expression and personal understanding by listening to the body's language.
- Enhance the well-being of every human being.

Participants

The group should be composed of participants voluntarily agreeing to carry out this autobiographical and personal work.

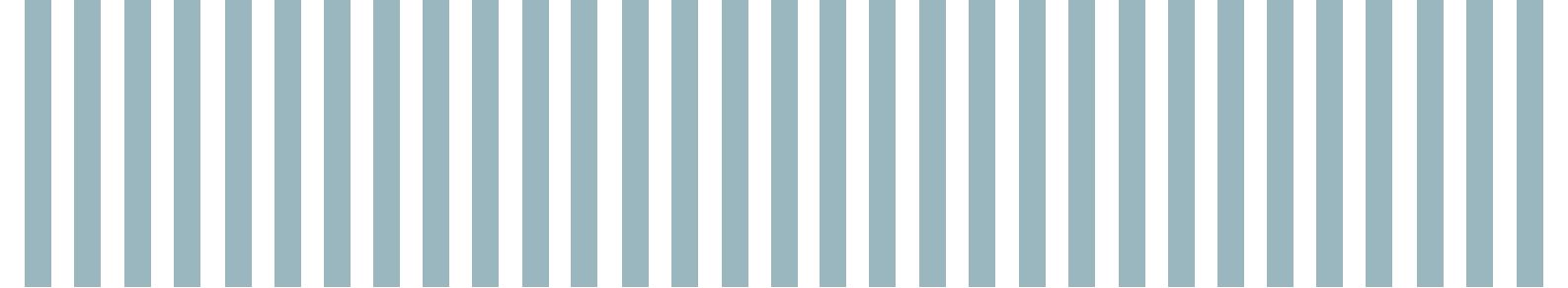
A commitment to their continued attendance at all sessions is essential.

If it is intended to use such stories, the participants must be informed, and their consent must be obtained.

Methodology and development

The persons accompanying the activity must ensure that all participants develop their involvement freely, autonomously, and comfortably.

Participants should be made aware of the sensitive, intimate



and personal nature of many of the experiences and performances that will take place during the session, advocating respect and listening to each other.

If a conflict occurs or emerges, it is advisable to deal with it immediately, trying to mediate and accompany the people affected.

Introducing the participants to this tool's theoretical and methodological motivation is essential for the activity to run smoothly and positively.

Introducing the socio-cultural aspects and the powers, systems and oppressions that influence each person will be helpful. A short discussion can be held beforehand.

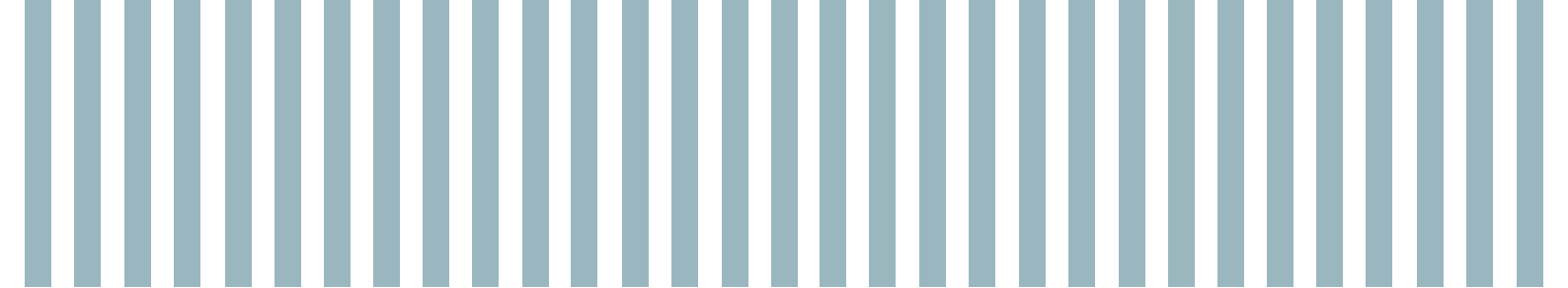
Try to get someone in the group to clarify what they understood from the exercise and give some valuable examples.

The idea is for the participants to see the exercise as an original practice, changing the focus of analysis and experiencing their body as a stage on which certain events, people, relationships and experiences have had an impact.

The procedure's analysis will be a constant and simultaneous real-time exercise, and it will be developed into an interpretation and representation that benefits all involved.

The authors allude to intertextuality as the epistemological basis for interpreting and signifying the stories and performances. However, their text offers a plurality of authors and theories for evaluating each aspect.

If the person wishes or requests feedback, it would be prudent to do so in private after an assessment of their exercise and ex-



pressions. They should be consulted beforehand if you want to use their exercise to contribute to your work with that person.

PART ONE:

This first phase of the activity, which can be carried out on an individual or group level, constitutes the narrative dimension. Its objective is to recover memory fragments and their interpretations by organising these memory spaces into significant biographical points.

A. Lifeline

The lifeline can be the first step in chronologically organising events and happenings. The person makes a first exposition of the theme or stage of his or her

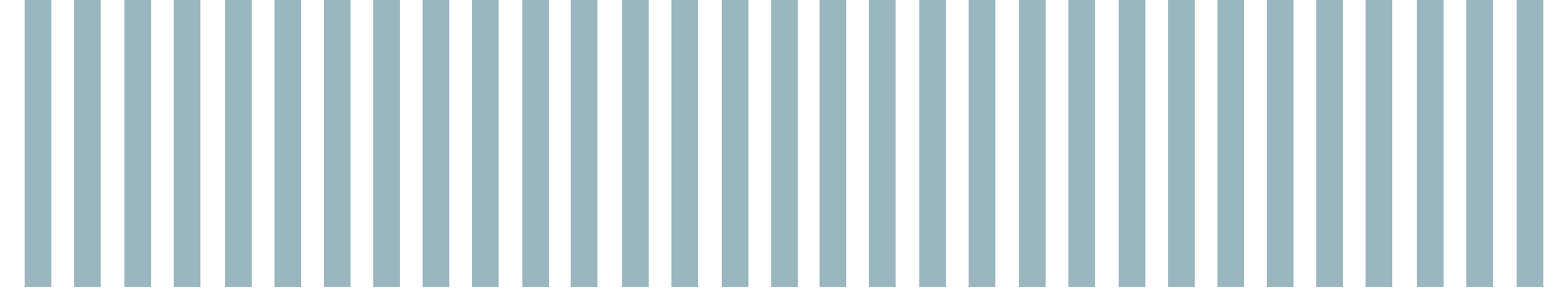
life on which he or she wants to work and allows the organisation of events and the different episodes that each participant wants to develop.

This lifeline will be represented by a graphic line on which relevant events and experiences will be reflected as marked knots or dots (representing “traces of biographical events”).

B. Autobiographical writing

With the lifeline as a working basis, reflective questions will be asked to stimulate the participants to share these biographical nodes, adding description and social, cultural, political, etc. contextualisation.

Focusing on family, affective, and sexual figures and relationships and the socio-cultural set-



things in which they occurred will give each experience greater meaning.

The following is an essential tool for the interpretation.

We could help the participants with questions such as:

Where was I? Was I indoors or outdoors? Was it light or dark? What was around me? What was I feeling? Did I feel calm, relaxed, or tense? Do I remember a specific body posture? What happened?

What did I see? How did I see it? What did I smell? What did I feel in my body? Who was there? What did others do or say? What did I feel? What did I think? How did I experience it, how do I see it now, etc.?

Such narratives can be written or oral. They can be recorded

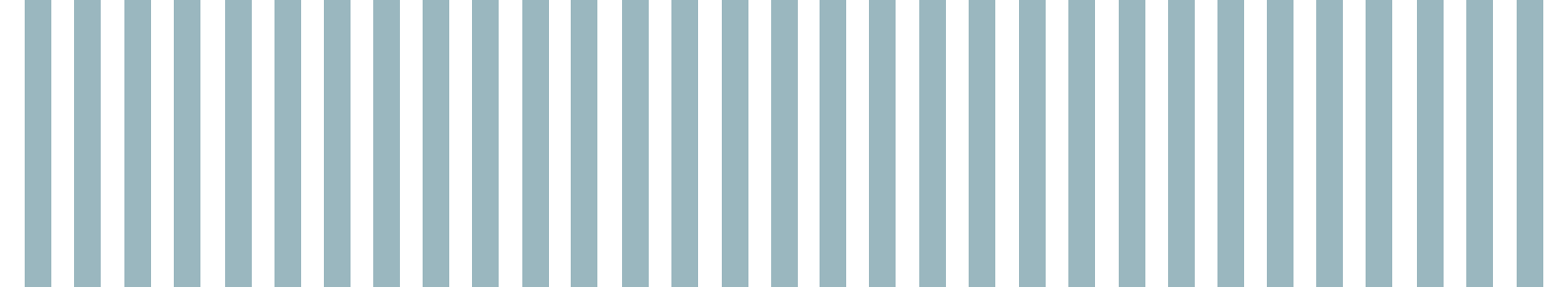
to facilitate literacy or language management problems.

C. Reading the story

Speaking from an emotional dimension can help bring in human and experiential reality, promoting empowerment, self-interpretation, and reflection.

The therapist's and other participants' attitudes must be of maximum respect, without judgement, and actively listen to express each person's life experiences.

In this first part, whose methodology is related to self-narrative techniques, we have the "lifeline," the "autobiographical writing," and the "story" written by each participant. Using these, we activate the person's memory and help them organise their testimony in oral and written form.



We have also added the body as another element of evocation in memory.

PART TWO:

All the elements of the first part are now compiled to feed the body map.

This is a plastic representation of the personal experiences recorded in the “first space inhabited by a human being”: their own body. Therefore, the most crucial iconographic element will be the figure of a human being, an alter ego in which each participant can graphically record his or her remembered experiences.

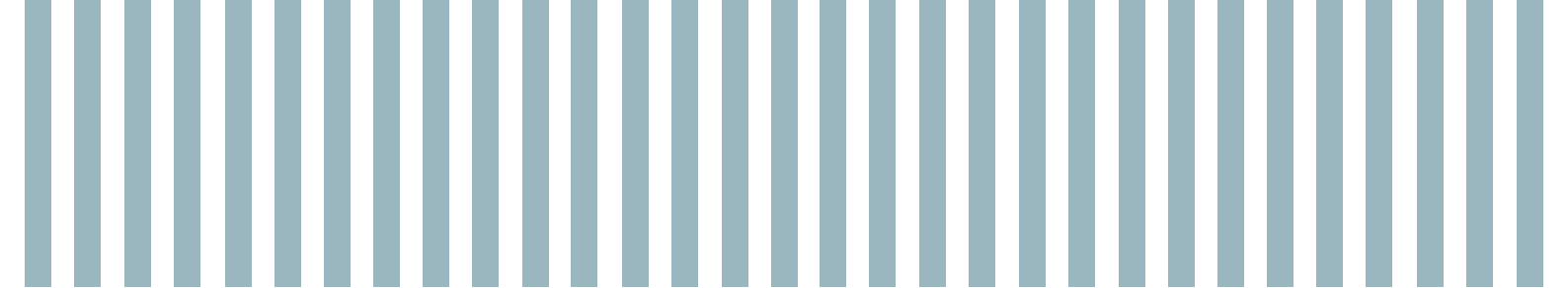
D. Body maps

Therapists can draw on various supports, depending on the re-

sources available and the participants’ choices.

They can also work in any format, from a sheet of DINA4 paper to large dimensions, depending on the workshops where the activity occurs. The support material can vary from soft and flexible, such as canvas, sheets, and all kinds of fabrics, to rigid, such as cardboard, boards, cork sheets, expanded polystyrene, cardboard foam, fine stone slabs, etc.

The patient will reproduce the figure of a human being on the chosen support in a scale and position determined by said support and the participant’s will. The human outline is the simplest to represent, and the participant’s silhouette is the easiest to execute. This will facilitate the identification of the person and their iconographic representation.



However, the most important thing is creative freedom, leaving each participant free to choose the technique of representation and the dimensions and arrangement of the figure; the participant should also be able to depict the anatomical proportions he or she wishes to, without prejudice of any kind (tall, short, thick, thin) or with “particular elements” such as large hands or heads. The important thing is that the person feels identified with the figure depicted, that it forms the frame of the composition and that this space becomes his or her “symbolic space” to depict his or her bodily autobiography.

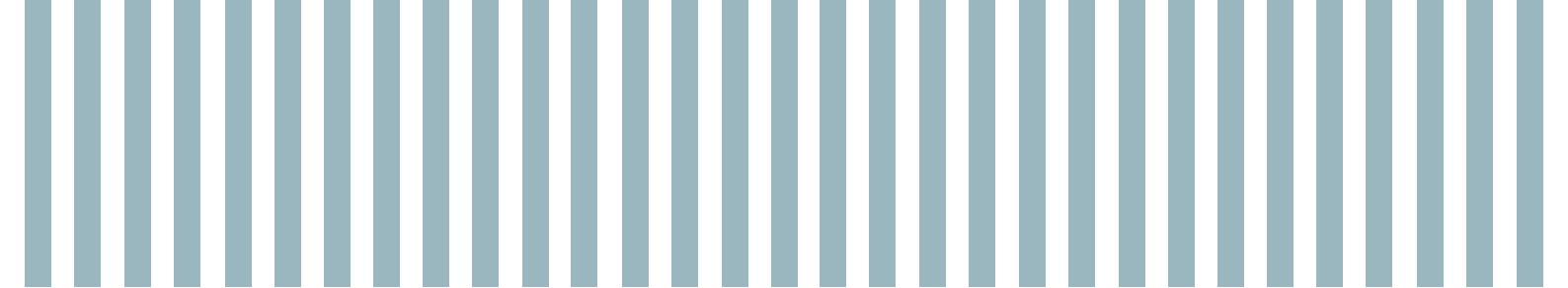
Subsequently, the person will be able to use all kinds of materials: coloured pencils, graffiti, paints of all colours, fabrics, coloured wool, different types of paper, cotton wool and anything

else that might be available.

The idea is to provide symbolic elements representing their experience. By superimposing these elements, the figure will be transformed to represent the body and the experiences that the person decides to work on.

This would be the first representational level reflecting the most personal, the intrinsic, such as the characteristics of the symbolic self-image.

Finally, elements coming from outside, such as the discourses elaborated by the culture and social beliefs in which each participant has lived, would be represented with images, words, and messages also of a symbolic nature, but differentiating these extrinsic elements formally through a specific colour or ma-



terial or framed in a poster so that they can be differentiated.

The two distinctive levels are the intimate and the social.

In this second part, we should already have the plastic representation: a human body representing the person and the physiological elements we want to depict symbolically. For example, eyes, nose, mouth, hair, heart, lungs, genitals, etc., And depicted in different ways: eyes open, closed, in the form of windows in the eye area, a mouth open, closed, expressing a smile, a heart with a door and a lock on it, different colours, scales, etc.

In this same space, above the figure representing each participant, we will include icons showing the sociocultural impact, such as phrases repeated to them by their teachers or en-

gravings, signs, objects, etc., representing things which impacted the patient.

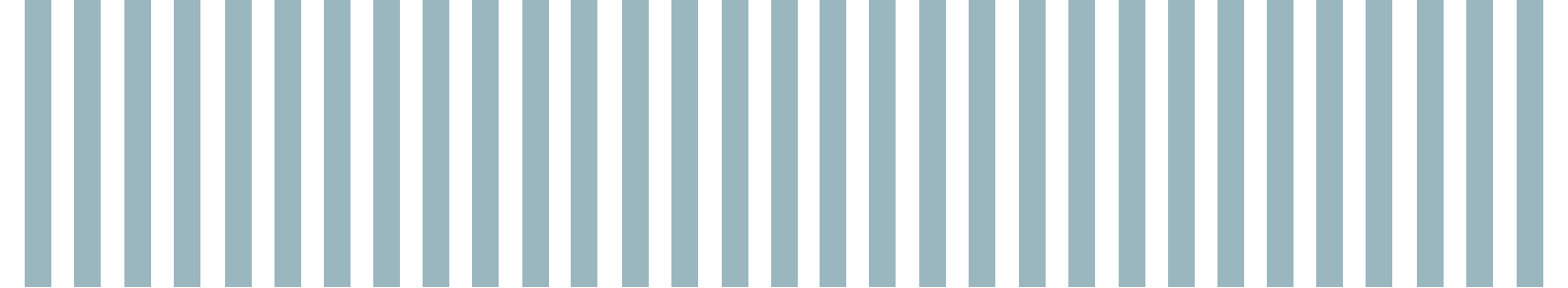
PART THREE:

E. Closing of the activity

In the detailed work on the body map, each constituent element's decision is a personal and intimate decision of each participant: it must result from inner dialogue and a reflection of their self-interpretations.

Therefore, in the third phase, a space must be provided where each group member voluntarily shares their experience respectfully and without interruptions or non-consensual interpretations by third parties.

Each participant will decide whether to share their "Body Map".



The individual decides whether they accept sharing their plastic representation with the group and whether they want to share what they experienced during the creative process. It is also up to them to decide whether they want to talk about it with the rest of the group, whether they want to listen to third-party interpretations, and whether to accept questions in this respect.

In the first part, we work with the narrative dimension that helps us recover fragments of our memory and their interpretations; in the second part, these are projected onto the material support, constructing a body map that shows all these fragments of memory embodied in each person. Thus, in the third part, participants can see themselves represented and visualise an inner image expressed through shapes, colours, textures, words, etc., which they have chosen to represent a part of themselves.

This is the time to interpret and understand oneself, to dialogue, if you like, with one's companions, and to become aware of oneself as a human being incarnated in one's physical body.

Materials

- Paper and pens.
- Recorder.
- Fabrics.
- Other substrates: cardboard, boards, cork sheets, expanded polystyrene, foam board, fine stone slabs, slate slabs, etc.
- Brushes.
- Coloured pencils, graffiti, paints of all kinds.
- Fabrics, coloured wool, cotton.

GUÍA RÁPIDA DE APLICACIÓN

HERRAMIENTA DE LOS
MAPAS CORPORALES



¿Qué debemos saber sobre los Mapas Corporales?

- Herramienta de aplicación individual y/o grupal para facilitar una expresión corporal de aquellos contenidos, recuerdos y eventos psíquicos y cognitivos
- Mediante el cuerpo y lo físico se trata de facilitar que aquellas memorias y vivencias de mayor complejidad tengan una vía alternativa de procesamiento y expresión.
- La experiencia de la persona que participe debe contar con el apoyo sensibilizado de un/a profesional que facilite y proteja la participación y contenidos compartidos.

El grupo y el espacio

- La participación debe ser voluntaria y se tratará de aportar información y comentar los riesgos antes de realizar la actividad, buscando un compromiso y colaboración del grupo.
- La/el profesional que acompañe debe prevenir en la medida de lo posible que se respete a todas las personas participantes.
- Se ha de ser ético/a y prudente a la hora de dirigir la actividad, respetando la intimidad y la diversidad de experiencias y expresiones y evitando utilizar o analizar la información más allá del ejercicio.

Desarrollo de la actividad

- a) **Línea de vida:** representación gráfica en la que se ordenarán cronológicamente distintos eventos y experiencias significativas de la persona.



b) **Escritura autobiográfica:**

Sobre los contenidos de la línea de vida se plantearán (individual o grupalmente) distintas preguntas para sumar a las experiencias detalles relacionados con el contexto, las relaciones y momento personal en el que sucedió cada evento.

c) **Relatar lo escrito**

Con los contenidos más detallados y elaborados, se procederá a realizar una lectura –si se desea, en grupo– de los hechos, profundizando cuanto y como se quiera sobre cada hecho.

e) **Cierre de la actividad**

Tras haber realizado el mapa corporal –ya sea, de manera individual o grupal–, se genera un espacio donde quien desee, de manera voluntaria podrá compartir con el grupo su trabajo y experiencia.

Deberemos facilitar que la persona pueda realizar una exposición libre y autónoma sin interrupciones –no consentidas– y sin interpretaciones o participaciones de terceras personas.

d) **Mapas corporales**

Con toda la información procedemos a la parte creativa del ejercicio. Proporcionaremos distintos materiales y papelería para el ejercicio. La consigna propuesta sería: "dibujaremos símbolos, palabras o mensajes que representen tu cuerpo y las experiencias que tú decidas trabajar" (*leer el documento ampliado)



Futuro & Co.

Innovación
y comunidad
para la autonomía
de jóvenes
sin hogar

