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Chapter 2
Social work practice and mental health

This chapter will contribute to helping you to meet the following National Occupational Standards.

Key Role 1: Prepare for, and work with individuals, families, carers, groups, and communities to assess their needs and circumstances.
- Prepare for social work contact and involvement.
- Assess needs and options to recommend a course of action.

Key Role 2: Plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups, communities and other professionals.
- Interact with individuals, families, carers, groups and communities to achieve change and development and to improve life opportunities.

Key Role 4: Manage risk to individuals, families, carers, groups, communities, self and colleagues.

Key Role 5: Manage and be accountable, with supervision and support, for your own social work practice.
- Work within multidisciplinary and multi-organisational teams, networks and systems.

It will also introduce you to the following academic standards as set out in the social work subject benchmark statement.

Defining principles
4.3
- There are competing views in society at large on the nature of social work and on its place and purpose. Social work practice and education inevitably reflect these differing perspectives on the role of social work in relation to social justice, social care and social order.

4.7 ...Involves learning to:
- think critically about the complex social, legal, economic, political and cultural contexts in which social work practice is located.

5.1.2 The service delivery context, which includes:
- The significance of interrelationships with other social services, especially education, housing, health, income maintenance and criminal justice...

5.1.4 Social work theory, which includes:
- The relevance of sociological perspectives to understanding societal and structural influences on human behaviour at individual, group and community levels.
- The relevance of psychological, physical and physiological perspectives to understanding individual and social development and functioning.

5.1.5 The nature of social work practice, which includes:
- The factors and processes that facilitate effective inter-disciplinary, inter-professional and inter-agency collaboration and partnership.

Introduction

In this chapter, we consider social work practice in a mental health context. A social work approach to mental health need would address problems of living for individuals, families and/or communities by seeking to understand how social forces have both contributed to mental health distress as well as how mental health difficulties affect service users' social circumstances and relationships. Through seeking to shore up the capacity of individuals to cope by providing links to services to respond to gaps in care and through intervening in service users' social and care networks, social work practitioners offer help at individual and systemic levels. At a broader conceptual level, social work with its aim to foster development and well-being may question naming a situation, such as living with mental health needs, as a 'problem', preferring to question limiting and disabling terms and to introduce alternatives. To this end, we may reject the idea of problems of living and prefer 'challenges' of living as noted by a recent social work text (Hutchison, et al., 2007). A strictly mental health approach based on medical factors would not disregard social forces; however, from a health perspective, practitioners responding to mental health distress may focus on individual biomedical aspects of the problem; identifying the disorder that a person seems to be experiencing, such as major depression, and providing treatment, such as prescribing a course of counselling, group support or medication.

I pose these two responses and their related points of view – the social and the medical – in some stark separateness to emphasise the potential for dichotomy between the social approach to understanding human distress and the health or biomedical perspective's conclusions about a problem. The dilemma for us and for all professions, whether aligned more with the medical or social approach, is that we may become engaged in a split way of thinking about human problems. Split in the sense that a problem may be seen to have its roots in one cause predominantly rather than being understood as an effect of multiple influences and contributing factors. Such a dichotomy may lead to trying to understand mental health need as a debate between social forces and the medical approach when it is more likely that a multiplicity of factors, some sociocultural and some physical, will influence how we develop and respond to mental health need.

Developing and considering an integrated understanding to identifying mental health need and responding to mental health distress is essential. However, in highlighting the social and medical perspectives toward mental health distress and care in this chapter, it is less to reinforce this distinction and more to acknowledge it and engage you in thinking about how to approach mental health care with greater integration. A holistic approach to identifying, understanding and responding to mental health distress would involve a bio-psychosocial framework, one that acknowledges and considers the interconnected impact of biological, medical and genetic influences along with the psychological, emotional, social and spiritual aspects of an individual. Interventions from this perspective would both treat psychological upset and offer support to respond to practical needs and deficits. As you work through this chapter and the book, you are invited to consider this more comprehensive and holistic framework and thesis through reading and reflective exercises. This approach also serves as a prompt to consider how best to acknowledge social exclusion and to promote social inclusion of mental health service users.

Mental health and mental distress

As part of your learning and development, you will be asked to think about the very nature of concepts such as mental health and mental distress and terms like symptoms, diagnoses, and treatment interventions. Tilbury (2002), in the first extract, provides an overview and summary of elements of mental health developed over several decades. By contemplating what is meant by 'mental health', we are then able to reflect on the state outside of mental health – or what is variously described as mental disorder, mental illness or mental distress. The presence of different perspectives in defining and responding to mental health needs compels us to highlight the development and change in these perspectives over time. Prior (1993) offers a sociological perspective of mental distress in the chapter's second extract and introduces his inquiry into the changing social structures and understanding surrounding efforts to deal with mental distress. Following this, Allott (2004) discusses the impact of social and cultural forces on mental health functioning, particularly considering the influence of poverty and the meaning of mental distress in different cultures, specifically less techno-logically advanced communities. In contrast to this, the fourth extract is taken from a medical students' textbook written from what may be considered a dominant discourse – that is, the medical perspective – in the current approach to understanding mental health issues and their classification. Reflecting on the contrast between these two extracts offers an opportunity to explore how different groups in society contribute to the social construc-tion of an issue which in this case involves defining mental health need and what is classified as a mental health problem. Finally, Beresford (2005) introduces the perspective of service users as formulators of knowledge in relation to mental health both in policy considerations and in how mental health support is delivered. The voice of service user experience will help-fully offer a counterpoint to the previous extract's medical perspective and may also stimulate your thinking about the longstanding hierarchical dynamic that persists in doctor–patient interactions and relationships.

Identifying mental health need

Service users may seek help and relief in relation to their mental health needs. This will prompt them into contact with the broad range of providers who offer mental health care. The first part of this equation involves service users' mental health needs. According to a survey of psychiatric morbidity among adults living in England, *one in six (16.5%) of the population surveyed ... exhibited symptoms in the week prior to interview sufficient to warrant a diagnosis of a common mental health problem* (London Health Observatory [n.d.]). This finding suggests that mental health need is perhaps more widely present than expected. Thinking about our family, work colleagues and social networks, it would be pos-sible – using this statistic of one in six – to imagine the prevalence of mental health need. Realising this, I wonder if you thought about yourself as these figures were introduced. If you have not personally experienced mental health need, you may be able to relate to having 'down days' or being constantly active as a means of avoiding troubling feelings. You may have friends or family members who have experienced mental health difficulties. Keeping this in mind will be helpful so that you may be supportive to clients and others in tending to their mental health needs. As part of this reading and your related training, you will develop greater understanding of the range of mental health needs and services that are available and needed so that you will be able to share your understanding. In becoming

a source of information and support, you will be able to help educate people about the importance of being open to considering or asking for help. By educating others, you will promote well-being as highlighted in the IFSW's (2002) definition of professional social work. In the following extract, Tilbury introduces ideas about mental health, mental health's parameters and thoughts about how mental distress is defined.

EXTRACT ONE

Tilbury, D (2002) Determinants of practice: Defining mental health and mental illness, Chapter 1 in Working with mental illness: A community-based approach. *2nd edition. Basingstoke: Palgrave, pp1–3 and p10.*

What constitutes mental health

What constitutes mental health is difficult to define. Most attempts at definition (Jahoda, 1958; Maslow, 1969; Vaillant, 1970; McCullogh and Prins, 1978; Hershenson and Power, 1987) appear to group around three elements:

1. The idea of the mature self – *the sort of people we are. Mentally healthy people will be satisfied with and enjoying their lives. They will have a positive self image but be realistically aware and accepting of their limitations. Their self identity will be linked to an underlying philosophy or value system which forms the basis of their integrity and their internalised standards for behaviour. They will have a capacity to learn and develop, factors worthwhile in themselves and necessary if they are to maintain their mental health as their life circumstances change.*

2. Self-management in social relations – *Some literature suggests that our most important capacity is the ability to make and sustain intimate relationships. The number and nature of such relationships may not be specified, but the inference is that close relations with one's parents, one's children and at least one friend are very significant. The epitome of a healthy capacity to relate would appear to be a successful marriage or cohabitation: an ongoing relationship with a member of the opposite sex which includes physical intimacy. Where this leaves stable homosexual relationships is not quite clear.*

   With this ability to make and sustain intimate relationships is the notion of the ability to retain one's autonomy: the 'one flesh, separate persons' concept of Skynner (1976). Despite the intimacy, the partner is not essential for survival. This idea of autonomy links to another, of being in control of oneself and one's circumstances. A mentally healthy person is not at the mercy of their inner needs, desires or feelings but can control, express and direct them in a socially constructive way. Nor are they at the mercy of other people: they can resist emotional demands, pressures and manipulations without either meekly submitting or angrily rejecting. They can tolerate frustration and postpone gratification as necessary. They can read and respond to social situations with realism and appropriateness; exercise choice and make decisions with objectivity and a greater chance of a successful outcome. Even when engaged in 'non-intimate' relations of the day-to-day kind, they will interact with interest, sensitivity and

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receptivity to others' messages, conscious of what they are communicating, aware of its effects and modifying matters where this is called for.

3. The discharge of social roles, *whether these relate to home-based life within family, kinship and neighbourhood groups, to work-related functions, or to recreation/interest activities. To discharge any social role involves a realistic understanding of what general social expectations accrue around that particular role as well as the more particularised ideas of one's immediate social groups. Effective role performance will depend on one's capacity to meet the obligations of that role, together with the ability to adjust that performance, since many roles, such as parent, are developing, not static. Other role performances may have unexpected challenges thrown up within them, from new technology at work to a friend becoming seriously ill, which demand adjustment.*

Adjustment is to be distinguished from conformity. Mentally healthy people will be able to choose whether they conform. They have the capacity to evaluate and weigh the social and personal consequences of conforming or not. Most societies and groups will tolerate, in varying degrees, some flexibility in the way roles are executed; but there can be times when individuals are faced with painful, even dangerous choices. To be mentally healthy is not always comfortable, as the records of Amnesty, to name but one organisation, demonstrate.

The discharge of social roles will call for qualities such as a sense of responsibility and a reasonable self-reliance, but will also require the associated technical and social skills. Modern living is making increased demands in technical terms (domestic appliances, computers, cars, form-filling and so on) and in the social sphere (negotiating with bank managers, resisting sales pressures, holidaying abroad, meeting neighbours from different ethnic backgrounds and so on). These represent routine demands: the literature goes on to suggest that the really mentally healthy will also be able to cope with emergencies. They will need problem-solving skills, the ability to handle crises and manage stress, to recognise where to find help when it is needed and a willingness to use it.

Approaches to defining mental illness

The widest stance regards as mental health problems all breakdowns in coping and the associated pain ...

Though the range is still wide, Hershenson and Power (1987), for example, limit what they consider mental ill health to four broad areas of problem: (a) social behaviour (disabilities in social skills, making relationships, handling aggression and coping with social expectations); (b) emotional behaviour (where problems give rise to depression, anxiety, phobias and so on); (c) health-related issues (a diverse group including insomnia, pain control and destructive behaviours from smoking to drug abuse); and (d) work-related issues (another extensive group ranging from boredom to burnout; from unemployment to 'workaholicism').

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Having read Tilbury's (2002) summary of attributes of mental health and the broad definitions of mental health need, what are your criticisms or comments about these ideas?

Comment

As social work students or practitioners invited to engage in critical thinking, you may have wondered about the utility of providing discrete classifications of either mental health or mental distress since they may be too limited to provide specificity and sensitivity in describing the lived experiences of most people. Tilbury (2002) also questioned these definitions by summarising a review of literature critical of these mental health definitions and highlighting that research often overlooks two significant groups: children and young people and older adults. He also challenges lists meant to define mental health, as they suggest that mental health is an absolute without taking into consideration people's changing life circumstances, their abilities to cope and their varying tolerance of change or distress.

You may have noted the difficulty in segmenting mental health and mental distress or you may have simply posited that mental health was the absence of mental distress. In some ways, it may be easier to think about the state of mental distress than to think about mental health. How do we define what many of us might take for granted, particularly if we or those close to us have not experienced intrusive emotional or psychological difficulties? Tilbury cited the work of Jahoda (1958), who offered a variety of definitions related to mental health, including:

● the absence of mental illness;

● the ability to introspect with clarity of action and reason;

● the capacity for growth, development and self-actualisation;

● integrating internal drives or achieving ego identity;

● the ability to cope with stress;

● having autonomy;

● seeing the world as it really is;

● satisfaction in love, work, leisure and interpersonal connection

(cited in Gross, 2001).

Suggesting that mental health is *not* having a mental health problem as noted above should engage your critical thinking because such a formulation highlights a point made in the first chapter in relation to power which emphasised that there are rarely two polarised concepts or binary positions. Mental health and mental distress do not need to be considered as two dichotomies. Remaining conscious of this dilemma is essential as the concepts of mental health are fluid and will inevitably be influenced by society and culture. What is considered mentally healthy in one society or culture, such as being assertive or sticking up for oneself, may be considered abnormal in another. The challenge involves offering distinctions about normality and abnormality while both respectfully striving to make sense of the struggles of persons with serious and intrusive mental health symptoms and offering treatment and intervention that prove helpful. Further challenges exist as changing ideas about these concepts and even definitions will occur over time and with societal influences.

Societal perspectives on mental health

Delineating what is mental health or what is mental distress is influenced by changing perspectives within society which encompasses the medical or professional field as well as changing views espoused by individuals – who may or may not need mental health support – and institutions, such as provider groups and government. In the following extract, Prior (1993) introduces his sociological inquiry of mental illness. His book, *The social organization of mental illness*, is a review of evaluative work he did investigating the experiences of two groups: patients within a psychiatric hospital in the late 1980s, and those who had been discharged and were living in the community. The extract makes mention of these two social experiences; he also highlights other significant variables, like work roles, types of therapy and diagnosis. As a prelude to this extract, it may be helpful to review the work of a seminal theorist, Emile Durkheim, whose writing on the changing social conditions in the early part of the twentieth century led to the birth of the field of sociology. Durkheim (1964, p7, cited in Prior, 1993) writes that *the collective aspects of the beliefs, tendencies and practices of a group ... characterise truly social phenomena.* When reading Prior's (1993) work and Allott's subsequent piece, you will want to keep in mind the Durkheimian precept about collective aspects in relation to beliefs and practices. Thinking about how the United Kingdom collectively considers mental health needs and responds to the diversity of mental health need may stimulate your thoughts.

EXTRACT TWO

Prior, L (1993) Introduction: Social representations and social worlds. Chapter 1 in The social organization of mental illness. London: Sage, p3.

The lives and worlds of the patients and ex-patients ... were, of course, structured both in terms of the practical contingencies of everyday interaction, and in their terms of a system of concepts, ideas, and theoretical frameworks ... Thus, both the concept of the psychiatric hospital and the actual physical structure in which patients were treated and cared for had come into existence during the first decade of the present century (i.e. twentieth century). In addition the official diagnostic system by means of which most of the patients' disorders were recognized and described had been emerging since 1911, whilst the forms of therapy to which patients were and had been subject – occupational therapy, shock therapy, drug therapy, and in some cases, surgical intervention – had been woven into psychiatric theory and practice at quite diverse points of the twentieth century. And when one reflects on such facts it becomes evident that just as abstract theory requires reference to essential detail, so the study of personal biography and social worlds requires cognizance of larger conceptual and ideational contexts. Indeed, it is plain that such personal detail cannot be fully understood by restricting oneself to the immediate empirical context of action in which patients commonly find themselves. Thus, when a social worker talks to a 'schizophrenic patient' in a hospital ward about how that patient would consider the possibility of living in the community, we can legitimately ask a whole series of sociological questions about the entities and processes which underpin the entire conversational transaction. Why, for example,

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are the interactional roles structured in terms of social worker and patient in a hospital environment? Why is it only during the latter quarter of the twentieth century that the question of living 'in the community' adopts a new meaning and a new significance? And what in any case is a schizophrenic patient?

POINTS TO CONSIDER

- *Considering Prior's (1993) final questions, what do you think he means by the* roles *of social worker and patient?*

- *Since 1993, what changes have happened in the terminology we use to define roles in the field of mental health?*

Comment

Prior helpfully ends with a series of difficult, and unanswered, questions about the then changing nature of society's contract with its members – those with mental health difficulties and those without them – in terms of care provision. In the late 1980s when this work was being done, many countries were continuing a process of discharging persons from psychiatric hospitals where they had been living for long periods of time. Prior, further along in his book, asks what changed. Did these individuals suddenly no longer have mental health needs? Did their needs no longer require hospitalisation? Did mental health providers begin to question the ethical nature of long hospital admissions? Certainly some of these factors contributed to this change, as did several others, including advances in medical treatments and more recognition of the rights of those living with presumably mental health problems.

You were invited to reflect on the terminology of the piece and to comment on the idea of roles within the mental health context that Prior (1993) described. In your reflection, we have the benefit of living 14 years following the publication of his book and can compare our current understanding with his findings. In relation to roles, Prior is acknowledging the idea of role theory, which notes that the roles we take up in an interaction will influence how we behave and how we are perceived. At a basic level, the first question notes the difference between a social worker and a patient, which recalls some thinking from Chapter 1 in relation to power and authority. It also highlights the change in terminology as well as a shifting trend in service use to reject assigning a 'patient' role to people with mental health needs but rather to identify people as 'service users'. By changing this term, we attempt to acknowledge not only illness but health in people. This provides an example of an ongoing and still evolving social construction in relation to delivering and seeking mental health help in the contemporary UK social context. As we work further through this chapter, this discussion will re-emerge.

Mental health and social exclusion

Allott (2004), whose extract follows, considers the impact of poverty on the development of mental health problems; he also fosters a useful discussion about cultural implications in terms of how people perceive and respond to mental distress, which further emphasises the influence of society on naming and understanding phenomena.

EXTRACT THREE

Allott, P (2004) What is mental health, illness and recovery? In Ryan, T and Pritchard, J (eds) (2004) Good practice in adult mental health. London: Jessica Kingsley, pp17–19.

Mental health, poverty, culture and social justice

Prilleltensky (2001a, p. 253) defines mental health as a state of psychological well-ness characterised by the satisfactory fulfilment of basic human needs. Prilleltensky highlights that some of the basic human needs for mental health include a sense of mastery, control, and a sense of efficacy; emotional support and secure attachment; cognitive stimulation; sense of community and belonging; respect for personal identity and dignity; and others identified by the Basic Behavioural Science Task Force of the National Advisory Mental Health Council (1996a, 1996b).

Given the above it is not surprising that the experiences we identify as 'mental illness' are closely connected with poverty and social injustice and what might more accurately be referred to as 'disempowerment' or 'losing control over one or more aspects of one's life.' Prilleltensky (2001a, p. 254) highlights the importance of cultural assumptions on mental health, particularly cultural assumptions about poverty and social justice, the way this is framed and society's response to it. He summarises his view that:

> Cultural assumptions exert a direct influence on mental health through definition of the good life and the good society and through psychological definitions and solutions to problems. Notions of the good life derived from competition and individualism lead to social isolation and psychological stress. When these problems are defined in individualistic terms, the person is viewed as responsible for her or his suffering. But cultural assumptions also exert an indirect influence on mental health via society's definitions of social justice. The way we frame justice determines how we allocate resources, and the way we allocate resources has a direct impact on the mental health of the poor and the vulnerable.

Psychiatry is part of the Western medical science and as such has developed within the context of Western cultures. When one considers, in addition to the cultural assumptions identified above, the cultural differences between nations including differences of ethnicity and race and the way these issues are dealt with in a multicultural society, concepts of mental illness become very much more complex. Until relatively recently the significance and importance of differences in cultural meanings of mental health have gone unrecognised, or been ignored, and this has led to considerable social injustice; in particular the fact that many more people

from African Caribbean backgrounds in the UK experience considerably greater levels of coercion both on entry to and within the mental health system.

The importance of culture has been recognised since the beginnings of psychiatric classification (Kraepelin, 1904), but the Western societies in which we now live and our ability to travel and communicate around the world easily have created a very different context to that experienced by Kraepelin. Culture within these societies has become very much more complex. Marsella and Yamada define culture as:

> Shared learned meanings and behaviours that are transmitted from within a social activity context for purposes of promoting individual/societal adjustment, growth, and development. Culture has both *external* (i.e., artifacts, roles, activity contexts, institutions) and *internal* (i.e., values, beliefs, attitudes, activity contexts, patterns of consciousness, personality styles, epistemology) representations. The shared meanings and behaviours are subject to continuous change and modification in response to changing internal and external circumstances. (Marsella and Yamada, 2000, p12)

They highlight the work of Murdock (1980), an American anthropologist, who separated Western views from non-Western views of disease causality. He reported that Western models were based on naturalistic views of disease causation, including infection, stress, organic deterioration, accidents and acts of overt human aggression. In contrast, among many non-Western societies, disease models were based on supernatural views (i.e. any disease which accounts for impairment of health as being a consequence of some intangible force) including:

1. theories of mystical causation because of impersonal forces such as fate, ominous sensations, contagion, mystical retribution.

2. theories of animistic causation because of personalised forces such as soul loss and spirit aggression.

3. theories of magical causation or actions of evil forces including sorcery and witchcraft.

It is considered significant that many people in the United Kingdom who are 'experts by experience' (people who experience mental illness/distress, their families and friends) and have been diagnosed as 'mentally ill' have adopted a mixture of Western naturalist models of disease – including stress, accidents and acts of human aggression, including abuse – and non-Western models that are more supernaturally or spiritually based, while rejecting naturalist biological concepts of infection and organic deterioration.

Comment

Allott's (2004) extract cited Prilleltensky's (2001a) straightforward definition of mental health and relates this to a series of descriptors of mental health, similar to those previously listed. He positions mental health within a context in which 'basic human needs' are met. Allott (2004)

argues that poverty and social deprivation undermine the capacity to possess mental health, which challenges us to think as practitioners and social work students how we work to support people's basic needs as an impetus to improving mental health.

Connected to this is his contention that Western society tends to view the individual who suffers from mental health distress as someone responsible for his or her suffering; whereas a similar but non-Western culture may implicate a wider set of factors. He also introduces cultural concepts about causes of mental distress which from an anthropological viewpoint have been divided along Western and non-Western lines. Similar cultural distinctions are echoed by Fernando (1995), who discusses psychiatry's development in the Western world from a philosophical foundation of a mind and body duality based on the ideas of the French philosopher, Descartes. The culture of psychiatry Fernando (1995, p13) describes includes a *mind-body dichotomy ... a segmental approach to the individual* and stipulates that illness requires biomedical change. Through this approach mental distress is primarily understood as an illness model.

Yet, significant to this excerpt are the differing perceptions about the causes of mental distress based on culture of origin which might either conclude that causes stem from natural or supernatural forces. Illness, linked to more natural constructs, seems to represent a more Western approach to understanding mental distress. The effect of spiritual forces may relate more closely to a supernatural understanding about mental distress. As noted in Allott's (2004) excerpt, understanding persons' perceptions of the cultural and societal influences on themselves and others in relation to their mental health or distress will define mental health. This is pertinent to responding to mental distress in the UK as the cultural context increasingly reflects diverse multi-ethnic and multicultural communities.

Also significant in this piece is Allott's (2004) introduction of the moniker, *expert by experience*, which highlights the recognition by traditional mental health providers of the importance of consulting with those who use services to enhance the field's knowledge base. This term, 'expert by experience', stands in stark contrast to the earlier term of 'patient' and highlights the magnitude of this change.

Psychiatry and classification

Another strand that is relevant to the discussion of mental health relates to how and if mental health distress is labelled or categorised. Prior (1993, p3) wrote about an *official diagnostic system ... [that had] been emerging since 1911*. Classification systems have been developed by the medical profession, usually by physicians, psychiatrists and, in some cases, nurses, to provide a label for behaviour, symptoms and client functioning; this label is considered a formal diagnosis (see Chapter 5 for related discussion). Classifying mental disorders or illness dates back to the early 1900s when Kraepelin (1904), as cited in Prior (1993), proposed terms to describe mental distress. This approach to naming mental distress has been refined over a century. The point at which mental distress becomes categorised as a diagnosis depends on multiple factors such as severity of symptoms, duration of distress and types of symptoms being described by the person seeking or in need of help. Developing a system of classification has been proposed to facilitate communication between providers and to make judgements on treatment. As you will see in the following

extract, there are two classification systems attempting to classify and distinguish psychiatric diagnoses.

The use of such classification systems has not been without difficulty, prejudice and oppression. As Tilbury (2002) noted in his inquiry into mental health, previous thinking in psychiatry would have labelled homosexuality or affectional relationships between members of the same sex as a pathology needing hospitalisation or treatment. Such beliefs within the medical and mental health system were officially in place as recently as three decades ago. Golightley (2008), Allott (2004) and Fernando (1995) among many others have highlighted the ongoing inequity in treatment of African-Caribbean and black persons within the mental health and forensic systems in relation to diagnosis, treatment and restraint. This reality emphasises that a classification system, which may be useful, is still not objective; its application is influenced by the thoughts and feelings of the person who by nature of role and training has the authority to make the diagnosis as well as by the prejudices and biases that may be dominant in society at any given time. Please keep this in mind as we consider psychiatric classification.

The following extract includes sections about psychiatry and classification from a textbook, *Clinical medicine*, used by medical students. Through this, you have a brief entrée into the learning of another profession as it introduces a specific type of psychiatry working with people with physical health problems.

EXTRACT FOUR

White, P and Clare, A (2002) *Psychological medicine*. In Kumar, P and Clark, M (eds) (2002) Clinical medicine. 5th edition. Edinburgh: W.B. Saunders, p1225 and p1231.

Introduction

Psychiatry is the branch of medicine that is concerned with the study and treatment of disorders of mental function. Psychological medicine, or liaison psychiatry, is the discipline within psychiatry that is concerned with psychiatric and psychological disorders in patients who have physical complaints or conditions. This chapter will primarily concern itself with this particular branch of psychiatry.

Many doctors believe that psychiatric disorders imply that the cause or even the disorder itself is psychological. All your tests are negative so it must be 'all in your mind'. But absence of evidence is not the same as evidence of absence. The last 10 years has seen an explosion of research which has consistently shown that the brain is functionally or anatomically abnormal in most if not all psychiatric disorders. This evidence is breaking down long-held beliefs that diseases are either physical or psychological. We now know that doctors must consider both physical and psychological factors, and their interaction, in order to understand and thus help their patients. This philosophical change of approach rejects the Cartesian dualistic approach of the mind/body medical model and replaces it with the more holistic biopsychosocial model …

Classification of psychiatric disorders

The classification of psychiatric disorders into categories is mainly based on symptoms, since there are currently few diagnostic tests for psychiatric disorders. The

fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association *(DSM-IV) provides descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat people with various mental disorders. This scheme has five axes:*

I   Psychiatric disorders.

II   Personality disorders, learning difficulty.

III   General medical conditions.

IV Psychosocial and environmental problems.

V   Overall level of functioning.

Another classification system – the International Classification of Mental and Behavioural Disorders *(ICD-10) has been published by the World Health Organization.*

Comment

Reflecting on the ideas present in Allott's (2005) writing about causes of mental health symptoms and responses to address them is usefully juxtaposed with the overview of the psychiatric perspective introduced by White and Clare (2002). The latter is heavily couched – as one would suppose – in medical terminology in relation to symptoms and diagnoses and also introduces the growing evidence that solidifies the link between brain chemistry and mental health symptoms. This emphasis on medical causes and physiology is somewhat tempered by advocating a bio-psychosocial approach. Allott's perspective, in the previous extract, offers an argument that social deprivation and poverty need to be recognised more clearly as a potential cause of mental distress in contrast to purely physiological and organic causes, and needs to be addressed more successfully in prophylactic strategies to reduce deprivation and poverty thereby reducing damaging or limiting psychological or mental health difficulties. The ideas from both of these extracts need to be considered critically; physiological causes of mental distress, psychiatric labelling and the very issue of diagnosis would be usefully scrutinised.

The table presented as Figure 2.1 offers a more detailed list of mental disorders with main terms and key symptoms. The ICD-10, which was developed across several continents at the behest of the World Health Organisation (WHO), is most commonly used in the United Kingdom.

Service user perspectives

Beresford (2005) writes eloquently about the growing foundation of service user involvement in the development of knowledge in relation to mental health. This would stand in contrast to the areas of policy, research, and practice being dominated and influenced by professional and academic bodies that may not incorporate service user perspectives. The following extract is a chapter drawn from a text that seeks to promote and develop social perspectives in responding to mental distress. Beresford (2005) highlights some of the

contradictions in governmental policy on mental health between its embrace of service users as socially inclusive and its seemingly contradictory stance of increasing the powers of compulsory mental health treatment. In the latter part of the extract, Beresford (2005) relates service users' contributions to this developing discourse.

Psychiatric diagnoses and conditions	Key symptoms[1]
Mood (affective) disorders	
● Depression	Pervasive sadness, apathy, fatigue, suicidal ideation, hopelessness as well as appetite and sleep disturbances
● Mania/Bipolar disorder	Elevated or irritable mood, mood lability, excessive energy, decreased need for sleep, racing thoughts, grandiosity
Schizophrenia, schizotypal and delusional disorders	
● Schizophrenia of various types, delusional disorders and substance-induced psychotic disorders	Sensory hallucinations, delusions, thought disorders and loose associations as well as flattened or grossly inappropriate affect. Negative symptoms including social withdrawal and lack of motivation
Neurotic, stress-related and somatoform disorders	Emotional distress, nervousness and apprehension, heightened arousal, intrusive anxiety-provoking thoughts, sleep disturbance, breathing difficulties, and palpitations
Adjustment disorders	Depression and/or anxiety of less severity which is directly related to an identifiable stressor in the recent past
Disorders of adult personality and behaviour	Persistent, maladaptive life behaviours that interfere with interpersonal relationships and interactions
Mental and behavioural disorders due to psychoactive substance use	Excessive misuse of alcohol, narcotics, stimulants, cannabis or other illicit or prescription drugs leading to physiological and psychological dependence
Disorders of childhood including intellectual development, psychological development and behavioural or other emotional disorders	
● Learning or intellectual disability and developmental disorders	Delay in emotional, social or intellectual functioning based on generally prescribed developmental milestones
● Conduct or behaviour disorders	Pervasive and intrusive problems related to lying, stealing, and verbal and/or physical aggression
● Attachment disorders	Excessive anxiety and fearfulness that precludes social development
● Disorders of attention and hyperkinetic behaviour	Extreme and persistent restlessness, sustained and prolonged movement and activity and difficulty maintaining attention
Organic disorders	Dementia involving severe problems of memory loss and impaired problem-solving and planning as well as brain trauma, delirium and other problems of thinking with adult onset.

[1] This is not an exhaustive list of mental health or behavioural diagnoses. Symptoms and order of table have been adapted from McDaniel, S (1999) incorporating terms used in the DSM-IV-TR (APA, 2000) and the ICD-10 (WHO, 1992).

Figure 2.1 *Key symptoms of selected mental health diagnoses*

Beresford, P (2005) Social approaches to madness and distress: User perspectives and user knowledges. In Tew, J (ed.) Social perspectives in mental health: Developing social models to understand and work with mental distress. London: Jessica Kingsley, p37 and pp43–4.

User involvement became one of the guiding formal principles of mental health policy. Requirements for it have been built into mental health guidance and processes. It is meant to operate at individual and collective levels. Provisions for user involvement have been at the heart of assessment procedures established with community care 'care management' and the 'care programme approach'. State interest in user involvement led to a massive expansion in market research and consultation initiatives in mental health as in other areas of health and social care (Beresford and Croft, 1993). The consumerist commitment of former Conservative administrations to user involvement became embedded in New Labour managerialist/consumerist 'third way' variants which have followed (Beresford, 2002; Giddens, 1998).

Thus the emphasis on user involvement in mental health policy and practice means that we should be hearing from other voices and accessing different viewpoints and understandings. To some extent this has happened. But mostly people as mental health service users have internalised the dominant mental illness/health model of understandings. They are often under enormous personal pressure to do so. It offers some kind of explanation which, at times of great individual difficulty and pain, may seem helpful. It is likely to be the only framework for understanding that many people are offered or can access. Service users also express concerns that much user involvement has only been able to operate within existing frameworks of policy, analysis, organisations, 'treatment' and so on, thus restricting the opportunities service users have had to generate their own ideas on equal terms …

New survivor-led understandings of madness and distress

While mental health service users/survivors may not have developed an agreed and discrete theory or philosophy so far, there is no doubt that they and their organisations have developed different ways of understanding their experience, feelings and perceptions and, as a result, different approaches to and understandings for support and services. There can be little question that these are based on a thought-through ideology, albeit one that is frequently not articulated in any depth. This ideology follows from their own experiential knowledge and is strongly suggestive of an implicitly social approach.

For example, as long ago as 1987, Survivors Speak Out, the pioneering organisation of psychiatric system survivors, at its founding conference in Edale, produced a 'Charter of Needs and Demands' which were agreed unanimously. These demands prioritised the provision of non-medicalised services and support, the value of people's first-hand experience, the rights of service users and the ending of discrimination against people with experience of using mental health services (Survivors Speak Out, 1987).

Significantly, the understandings that mental health service users/survivors have developed about their 'illnesses' have generally followed less from knowledge production through research, than from knowledge production through collective action and reflection.

Such survivor understandings have developed from people trying to make sense of their own experience by sharing, collecting and analysing it. This has been reflected in discussions of their individual experience, their history and their 'treatment' (Campbell, 1996; Chamberlin, 1988; Craine, 1998; Mental Health Media, 2000; Read and Reynolds, 1996). Most important, perhaps, it has also emerged from efforts to reinterpret and make better sense of their experience than they feel that the psychiatric system and the predominant medical model have done. This is a common theme, in all the key areas where mental health service users/survivors have renewed thinking about the psychiatric categories into which they have been placed. They have challenged (and rejected) medicalised understandings of the experience as pathological and only negative. They have implicitly challenged the 'illness' model.

Instead they have placed an emphasis on people's first-hand understandings of themselves and their situation. This is exemplified by the development of the international hearing voices movement and in the UK of the Hearing Voices Network. Instead of accepting the diagnostic category 'schizophrenia' and victim status as a sufferer, the emphasis has been on trying to make sense of hearing voices both at a personal and at a societal level. There is no denial of the phenomenon or attempt to minimise the difficulties it may cause individually or socially. Instead the accent is on acknowledging and exploring the experience, recognising its power relations and learning to comprehend and deal with it better (Coleman, 1999; Coleman and Smith, 1997; Romme and Escher, 1993).

POINTS TO CONSIDER

Turning back to the beginning of this chapter, re-read the Key Roles and responsibilities that are listed there or look at the full list of the NOS. Reflect on the roles and responsibilities of social workers while taking into account Beresford's thoughts about contradictory aspects of government policy in relation to mental health.

- *How would you work to ensure that you follow social work tasks as framed by the Key Roles while incorporating service user perspectives?*

- *Would you notice any contradictions in this work – perhaps in relation to managing risk, for example, or other contexts?*

Comment

Clearly evident in the benchmark statement was a reference to *competing views in society ... on the nature of social work and ... differing perspectives on the role of social work in relation to social justice, social care and social order* (QAA, 2008, p6) These competing views seem evident in Beresford's (2005) writing. As social workers, we are often working within statutory parameters and compelled by legislation to take actions that may include acts of social control; in mental health this particularly involves social workers who work as Approved Social Workers (ASWs) and must make decisions about compulsory hospitalisation. (The term Approved Social Worker and the role will change with the implementation of the amended Mental Heath Act 2007. The role will include additional mental health providers from the fields of nursing, occupational therapy and psychology, so the term will change to Approved Mental Health Professional. See Chapter 3 for further information.) A task like this, linked more to Key Role 4, may seem to sit uneasily next to a facilitative and collaborative social work approach that actively includes service users in identifying goals and fosters person-centred goal planning. Perhaps you also wondered about how as a social worker you may advocate for responses to mental health distress that do not necessarily incorporate medical interventions solely, such as medication, but identify and work towards improving a service user's social experience and thereby their mental well-being. Tasks like this, more aligned with Key Roles 1 and 3, might include the use by a service user of direct payments to engage in a weekly art therapy group or to attend an evening class in photography. Incorporating these ideas and interventions when aligned with a service user's own goals contributes to working within a bio-psychosocial framework in your social work practice.

C H A P T E R   S U M M A R Y

Mental health distress may prove a very troubling and intrusive experience for people living with such distress and for those surrounding them as friends, family and partners. Such distress may also be felt by providers who work in this field, though it may be assumed that they are removed from it. With statistics showing that one in six persons reports experiences that could be classed as a definable mental health problem, it appears that a sizeable percentage of us either have an experience of mental distress or are close to someone who may. The concepts of mental health and mental distress brought us to a variety of definitions of these two states and conflicting viewpoints; usefully, it prompted reflection about the very nature of mental health. The impact and influence of society featured in two extracts as we considered the changing perspectives of mental distress and the impact of culture. One cultural impact is the role of psychiatry in responding to mental health needs and, as noted by Beresford (2005, p36), the dominant trend *to interpret ... madness and distress in predominantly medicalised individual terms,* both of which influence understanding and treating mental health difficulties. However, the psychiatry perspective clearly addressed its sense of a change in philosophy from a mind–body dichotomy represented in earlier Cartesian thinking to a more holistic bio-psychosocial approach. Finally, the tension between a facilitative social work practice and a practice that is legitimated by social policy and legislation was noted. As we embark in the next chapter on considering the policy and legal aspects of mental health, it is helpful to keep this in mind. Having read several differing and, at times, contentious perspectives on the matter of mental health, you will have a broad overview to consider the diversity of your social work role in a mental health context, striving to maintain an integrated and bio-psychosocial understanding of a person's experience.

FURTHER READING

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Pritchard explores the philosophical and historical foundation of these concepts in Chapter 2.
Subsequent chapters describe categories of psychiatric disorder.

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SCIE has a focus on disseminating good practice in the field of social care. This recent research document succinctly captures the relevance for social work to be a part of a socially inclusive and holistic approach to mental healthcare.

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