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Theories of mental health

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No single discipline can lay claim to ‘owning’ the paradigm that is mental health. Attempts to do so have provoked resistance and debate for centuries. Cicero (106–43 BCE) rejected Hippocrates’s earlier theories of imbalanced bodily fluids (‘humours’) to posit that low mood was related to emotions. Later, in the Middle Ages, monks displaced these ideas in favour of humour-rebalancing bloodletting, whilst using prayer and dogma to promote well-being. In fact, the way emotional distress is understood tends to evolve in line with the cultural ideas of the day. So as science became more influential in society, then a scientific understanding of mental ill health naturally followed.

The medical model

The biological model of mental ill health is often described as the ‘medical model’ (see Chapter 6). It is a mistake to consider this a single entity as within it live many dynamic traditions. The neurologist, for example, might have one conceptualization, whilst a geneticist would have another. What they share is the underlying positivistic view that mental illness is a phenomenon (that is, it is something real that can be observed) and that the cause – and therefore cure – lies in the biology of the human body. Since the 1950s, the dominant model of mental disease in industrialized states has been related to the action of chemicals that affect the central nervous system. The dysfunction of these ‘neurotransmitter’ systems is hypothesized to lead to specific and categorizable signs and symptoms that have been clustered into diagnostic categories, codified internationally in the *International Classification of Disease* (*ICD*; World Health Organization, 1993) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 2013). These publications have become hugely influential and have had far-reaching effects.

The cutting edge of this science is now moving beyond the neurochemical theory and is exploring novel fields, such as quantum biology. Here, researchers theorize that the components of individual cell elements (such as the microtubule cytoskeleton) affect the actions of individual molecules in ways that manifest on a gross level as the specific and observable symptoms of diagnostic taxonomies (see Gardiner, 2017, for further discussion).

The diagnostic tradition that guides psychiatric medicine has, however, proved problematic. There are many criticisms that can be made here, one of which is that unlike their colleagues in physical medicine, psychiatrists take for granted the phenomena they are observing but have little objective evidence that it independently exists (Szasz, 1961). Szasz, along with other critics such as Laing (1965), challenged the orthodoxy of psychiatry in an attempt to humanize its practice but, overall, have had little impact on the profession itself. They have, however, inspired indirect developments such as user movements and given rise to the legitimacy of criticism.

Making a diagnosis requires belief in the validity of a social construct that cites distress as a sign of pathology. The labelling of various symptoms into a disease is, at face value, attractive. It reduces complex behaviour into a single explanatory framework: mental illness. Critics of this approach disagree. They would argue that diagnoses are over-reliant on subjective symptoms, with no recourse to observable signs. This leads to unreliability, bias and misinterpretation. The bias introduced by sociocultural and political norms negates, on the whole, the social and psychological impacts of inequality, oppression and exploitation and has the side effect of making the individual somehow responsible for their condition (Rogers & Pilgrim, 2010).

There are also arguments about the self-referential nature of psychiatric medicine. In the latter part of the 20th century, the diagnostic tradition in psychiatry has been seen as tautological, in that it uses symptoms typically found in a patient group to diagnose a person as being part of that group, with no independent criteria for inferring the condition in the first place (Bentall, 1990). This reification of ideas is circular, and the notion of mental illness being an objectively verifiable disease process continues to be hotly debated.

Diagnoses are also not free of social value. They are generally stigmatizing and can remove hope and construct in the minds of professionals and the public alike notions of dangerous and manipulative individuals who are both untreatable and responsible for their condition (see Chapter 26). Such conceptualizations have been unhelpful and are part of the explanation for low levels of social recovery and inclusion for those labelled in such ways (Perkins & Repper, 2013).

Challenge is however being generated internally. Authors such as Bracken and Thomas (2005) critiqued the psychiatric profession as being unable to see past its institutional origins to view a future that is free of the unhelpful elements of its historical legacy. Their 'postpsychiatry' agenda cites a profession committed to moving to contextualized, ethical and less coercive practices. This emancipatory approach continues to be globally disseminated through international organizations such as the Critical Psychiatry Network and Hearing Voices Network.

The psychological model

The dominant position of medicine in the field of psychiatric care has also been challenged by the psychological movement. Sharing some of the positivistic characteristics of medicine, psychology has long posited a range of alternative theories of mental ill health, some of which are directly opposed to the dominant model. These models place at their core the primacy of perception and the processes of thinking. Several distinct traditions, such as cognitive behavioural therapy (see Chapter 16), have evolved, many of which have become the treatment of choice for a range of mental disorders and are often used in complex casework where often the evidence base for pharmaceutical interventions is lacking (National Institute for Health and Care Excellence [NICE], 2009).

Looking towards the future of psychology, the publication of *The Power Threat Meaning Framework* (Johnstone et al., 2018) has been set out as a viable alternative to psychiatric diagnosis. It is intended to address many of the single-paradigm issues addressed above. It is theorized within the model that this approach will bring together the social, biological and psychological elements of experience that together produce the phenomena of distress. One way in which it diverges from a medical approach is that it views biology as a mediating rather than causal factor.

Psychological approaches are, however, open to criticism. There are again tautological concerns that psychological explanations are often self-referential. Critics also believe psychological approaches define how people should present through their concordance with established models, which problematizes diversity (Grant, 2011). Some authors have also noted that these approaches do not contextualize the person into their ecosystem, and therefore, their symptoms have no context. This leads to what Smail (2004) calls 'interiorization'. This occurs when the effects of real-world problems, such as abuse or poverty, are turned into problems of internal perception or process. This form of neo-Cartesian thinking, where the mind is independent from the world it inhabits, leads to responsibilizing the individual for their distress. This raises issues for practitioners following the anti-oppressive base of social work.

Recovery in psychology is often measured by changes in scores on validated rating scales. This is problematic in that it is an arbitrary set of values that decides if someone has recovered or not and ignores the subjective experience. 'Recovery' and 'distress' are professionally defined and quantified. Rather than reflect the subjective reality of emotional distress, approaches using such methods construct distress and recovery in ways that become scientifically plausible and dominant. But, as Grant (2011, p. 38) reminds us: 'The textual portrayal of human suffering is never neutral, in that the politics of representation inform the struggle over the definition and experience of selfhood'. The power of psychiatric and psychological labels are both far-reaching and potentially harmful (see Goffman, 1963), especially when used in a reductionist manner to redefine well-being in terms of rating scale scores.

Social factors

Neither the psychological nor the medical approaches truly manage to incorporate the real worlds that people live in. Industrialized countries have struggled to value and provide appropriate care for those considered mentally ill. Within the field of physical health, there is a well-recorded phenomenon that people who experience mental health problems have worse outcomes in terms of physical health. Once help is sought, they also receive sub-standard levels of care for a range of common but serious medical conditions (Bressington et al., 2018). Many of these conditions are easily treatable, but due to sub-optimal service, a person with schizophrenia can expect to lose 14.5 years of life when compared to a peer without the condition (Hjorthøj, Stürup, McGrath, & Nordentoft, 2017). These numbers are very significant and clearly present as a matter of social justice. Within the UK, these issues are believed to arise in part from a lack of 'parity of esteem' between physical and mental health services. Such structural and cultural inequalities are not easily addressed, and within the UK, the Health and Social Care Act 2012 is being used as a legal remedy. The fact that legal avenues are needed, however, says a great deal about the social positioning within a society of those with mental health problems.

Authors such as Marmot (2010) and Wilkinson and Pickett (2009) have also established that adverse social conditions, such as poverty and poor housing, can have a deleterious effect on physical and mental health. There are also strong links between social disadvantage and exclusion. Labonte (2004) provides a useful formulation of exclusion as the result of social processes, which differs perhaps from a currently more dominant neoliberal perspective of exclusion relating to a failure of the individual to take advantage of the opportunities afforded by a market economy. Indeed, van der Wel, Saltkjel, Chen, Dahl, and Halvorsen (2018) show that the current wave of European 'austerity' policies increases health inequalities with an association that grows over time, which further undermines the neoliberal argument of personal or moral failure.

There is a general tendency for unequal social systems to become self-perpetuating, and in socio-economic terms, these can often be characterized by racial groupings (Galabuzi & Labonte, 2002). Unequal societies tend to have higher rates of social and emotional problems than those that are more equal (Marmot & Wilkinson, 2006), and inequalities are strongly linked to poor mental health (Allen, Balfour, Bell, & Marmot, 2014). For many social workers, their daily work involves either helping to change unjust systems or helping people live with the effects of them. Part of these roles may be to facilitate the inclusion of those excluded into areas of society that are currently closed to them. Such areas may include better housing, employment and social contacts. In this sense, social work in mental health is always a political activity as social inclusion is an act of political will on behalf of the dominant groups. Of course, this approach needs to be used with care as sometimes the opening of opportunities results in little more than further exploitation of citizens if driven by market rather than humanitarian concerns.

Risk

Concepts of risk assessment and management have become integral to mental health practice. Many authors have noted how the issue of risk has become more prominent in recent years, driven by discourses around society's perception and expectations of risk. Beck (1992), most notably, described the 'risk society' which reflected this growing trend more widely. In mental health practice, Tew (2011) refers to the emergence of those with mental health problems as objects of risk despite the lack of actuarial evidence to support this. He points to the pathology of the individual as a dominant narrative, whereby dangerousness, and consequently blame, are placed within the individual service user, whilst contributing social factors are ignored. This may help explain the international phenomena whereby people with mental health problems are more likely to be victims of violence than perpetrators (Sin, Hedges, Cook, Mguni, & Comber, 2009).

People with mental health problems have become particularly vulnerable to pejorative media representations, with disproportionate media coverage. The resultant focus on the risk of violence by those with mental health problems is a key theme underpinning the discrimination they face (Sayce, 2016). This in turn has influenced the practice discourse of professionals involved in mental health care, with growing emphasis on safeguarding and risk management rather than need (Kemshall, 2014).

The difficulty of risk prediction is widely recognized, particularly for the high profile, though statistically rare, incidents of homicide (Szmukler, Daw, & Dawson, 2010) and also for the more frequent incidents of suicide (Heller, 2017). The concepts of false positives and negatives (see Szmukler et al., 2010) provide a useful theoretical model for conceptualizing the arena of decision-making by mental health professionals, including the significant ethical implications inherent within this. Crawford (2000, p. 152) provides an example here, citing that to prevent a single homicide by someone diagnosed with schizophrenia would require the detention of approximately 5,000 similarly diagnosed individuals who would not have committed this crime.

Social work practitioners face the challenge of working within agency guidelines which no doubt have risk prevention and management at the forefront, whilst striving to challenge any unnecessary or discriminatory emphasis on risk. This is often done within a legal framework.

Legislation

A key feature, therefore, of mental health practice is the role legislation plays in shaping services and intervention. Mental health is differentiated from general medicine through its use of treatment enforced via legislation, a course of action used by the majority of developed countries, though their methods of implementation differ (Tew, 2011). It is instructive to examine the theoretical drivers which underpin such intervention, particularly for social workers where, as Johns points out, 'the very idea of coercion in social care seems contradictory, and, to many, even abhorrent' (Johns, in Boylan & Brammer, 2017, p. 59)

Authors such as Bean (1986) and Rogers and Pilgrim (2010) have pointed to the use of mental health law as a method of social control with roots in capitalism's desire to maintain stability and economic development. A libertarian model (Sayce, 2016) argues that the legal distinction between physical and mental health is unethical, illogical and driven largely by discriminatory and stigmatizing perspectives of the mentally unwell, as well as consequently perpetuating such perspectives. A model proposed by Szmukler (2010) is for the removal of separate mental health legislation, replacing it with a single statute based solely on capacity rather than diagnosis or notions of risk. This would apply to everyone, not just those with a diagnosed mental disorder or impairment.

In the UK, for example, the introduction of the Mental Capacity Act 2005 saw a strengthening of the trend toward rights-based legislation. It defines how capacity is assessed and aims to protect those people who lack capacity to make decisions for themselves. Whilst strengthening the right of a capacitous person to refuse treatment for physical health problems, treatment for mental disorders can still be imposed via the Mental Health Act, even where a person has the capacity to object.

Social workers increasingly find their work shaped by statutory roles in adults practice (Lilo & Vose, 2016). Within the Mental Health Act, approved mental health professionals, a role still predominantly undertaken by social workers in the UK, act as an important counterweight to the medical perspective at the point of assessment, with a duty to promote a social perspective and service user rights. The act is founded on a medical framework of mental disorder and treatment which has remained essentially unchanged for several decades. By its very nature, then, this is a challenging and potentially ethically compromising role (Kinney, 2009). Pilgrim (in Matthews, O'Hare, & Hemmington, 2014) draws on concepts from Bourdieu to offer practitioners a practice model through which to explore how they carry out such statutory roles, in particular questioning the accepted assumptions that operate throughout mental health provision (see also Chapters 5 and 12). Assumptions, or 'doxa', such as 'people with mental health problems need help' and that the provision of such help is in their 'interests' are, as noted earlier, open to theoretical challenge but remain embedded as accepted and integral elements of British mental health policy and legislation. Furthermore, social workers are influenced by a process of 'secondary socialization': for example, through their training, which frames their disposition more broadly and shapes what they perceive as 'good' practice. Social workers may be vulnerable to becoming assimilated into medical discourses as a result of their organizational arrangements (Nathan & Webber, 2010). The challenge for the mental health social worker is to maintain an independent, socially orientated perspective whilst working effectively alongside their medical colleagues.

A recent area of development has been how theories underpinning mental health legislation have been exported to the community setting through the introduction of involuntary treatment in the community, known as community treatment orders in the UK. Those in support of this development point to the high number of 'revolving door patients' who could be spared repeated compulsory detention through enforcing their treatment in the community. Enforced treatment at home is less draconian than that taking place in hospital and thus promoted the 'least restrictive' principle of the MHA. Subsequent studies in the UK and other countries have called into question the efficacy of these measures. Two issues emerge: community treatment orders have not reduced hospital admissions as anticipated (Burns et al., 2013; Maughan et al., 2014; Rugkasa, 2016), and certain groups are disproportionately represented, the most clear example being 'Black or Black British' people who were almost nine times more likely to being made subject to them (NHS Digital, 2017).

Recovery

Although it can be argued that several traditions lay claim to the exclusive right to define and portray distress and recovery in their own terms, approaches based on more value-based methods attempt to avoid such difficulties.

Approaches using what are known as 'recovery values' are gaining increasing traction. Such approaches aim to deliver the lifestyle that is defined by the service user, not the service providers, and one that is not judged by compliance and rating scales. Models using recovery values have been postulated (e.g. Spaniol, Wewiorski, Gagne, & Anthony, 2002; Andresen, Oades, & Caputi, 2003), although it is stressed that every individual's journey will be unique to them. Such approaches share much in common with the social model of disability (Oliver, 1996; see Chapter 38), in that the societal response to symptoms can be more limiting than the symptoms themselves, so care is taken to challenge discrimination and provide education where needed.

The aim of the recovery values approach is to deliver a life that is self-defined, hopeful and meaningful. This approach also facilitates spiritual understandings of experience, which other models do not. The notion of 'cure' is somewhat a side issue as the focus is on developing a personally significant life rather than symptom reduction (Byrne, Schoeppe, & Bradshaw, 2018). The two are, of course, not mutually exclusive. Despite its popularity, there remains inconsistency in the use of the term 'recovery', and its definition has changed over time (Ellison, Belanger, Niles, Evans, & Bauer, 2018). Studies have looked to identify core elements (e.g. Slade et al., 2017; Ellison et al., 2018). Whilst it is recognized that there is considerable heterogeneity across these studies, themes of hope, identity, opportunity and empowerment frequently appear. The issue of risk appears with regularity, with the recovery model inherently linked to a more therapeutic approach to working with perceived risk, encouraging individuals to take a greater stake in the risks they are exposed to and developing capabilities to manage them rather than being protected from them (Morgan, Felton, Fulford, Kalathil, & Stacey, 2016).

A critique of the recovery model has, perhaps naturally, emerged as it has become more embedded in government policies. Approaches using recovery values have seemed to falter when encountering highly organized health and social care providers, where the dominance of the medical model, coupled with organizational responsibilities in terms of financial and legal constraints, appear to hamper the effective adoption (Miller, Stanhope, Restrepo-Toro, & Tondora, 2017). As noted above, lack of clarity over the underlying definition and philosophy of recovery mean it has risked becoming a 'catch-all' term, meaning different things to different people. It has come under criticism for its primarily individualistic focus, whereby the service user is expected to develop a new way of being to manage their condition. This reflects current neoliberal discourse, whereby the state passes responsibility for well-being and regulation of behaviour on to the individual (Morgan et al., 2016). This, of course, jars somewhat when 'risk' becomes pre-eminent, and the neoliberal model melts into a paternalistic model of practice, where statutory tools (such as involuntary detention) are often applied. Indeed, it would appear that reconciling risk management with recovery-based approaches is challenging, although authors such as Felton and Stickley (2018) believe that it can be done through narrative approaches. These provide a context in which risk can be understood and how individual strengths, control and collaboration can be used to mitigate harm.

Structural factors which may have contributed to the development of an individual's mental distress, or indeed may serve to aid their recovery from it, are thus relegated, and the link between mental distress and social injustice is lost (Harper & Speed, 2012). There are further challenges with low levels of staff and user knowledge regarding implementing the phases or stages of recovery and the difficulties in designing valid measurement tools to assess its effectiveness (Slade et al., 2017).

Conclusion: bringing it all together

For the practising social worker, the field of mental health is contested and complex, with many areas of intersectionality. Whilst the authors are not inherently opposed to psychiatric or psychological approaches to mental health, we would assert that the predominance of these two models in particular limits the opportunities for social approaches to be used in routine practice. This is further compounded by the emphasis on risk and risk management, which is codified in many legislative frameworks. This also reflects a wider societal preoccupation with the perceived threat posed by mental health service users and the need for agencies to demonstrate their accountability and effectiveness in addressing these concerns.

Interventions based on recovery values have established themselves as a credible and viable addition to the field of mental health. In this sense, recovery requires statutory agencies to personalize and democratize the therapeutic process. It also requires cultural as well as technical shifts in work patterns that challenge structural and power-related barriers. The reality of practice requires workers to be able to successfully navigate complex social, political and cultural – currents that are frequently antithetical to each other – a role well suited to social workers due to the breadth and depth of their professional knowledge.

Practitioners familiar with personalization and critical practice may find themselves drawn to recovery-based approaches, although they may also find them practically challenging to implement. That said, social workers remain the professional group most likely to embrace recovery-orientated practice with fidelity and have an opportunity to reshape the international landscape of mental healthcare to better reflect the needs of those experiencing distress.

Further reading

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