changing in what is essentially a contested and dynamic arena. Finding a unifie definition of what constitutes mental 'health' and mental 'illness' can be a frustrat ing exercise and something of a holy grail. For example, mental health can b defined either negatively, as 'the absence of objectively diagnosable disease' (WHO 1946), or positively, as 'a state of well-being in which the individual realises his o her own abilities, can cope with the normal stresses of life, can work productivel and fruitfully and is able to make a contribution to his or her community' (WHO 2001a). The Mental Health Act 2007 introduced a single definition of 'mental dis order' as 'any disorder or disability of the mind'.

The confusion and controversy surrounding mental distress is also clearly reflecte in the diverse terminology used in the field – mental health; mental illness; menta disorder; mental health problem; mental distress. Although these terms are ofte used interchangeably, they actually derive from quite different philosophical, theo retical and ideological perspectives. That is, the terminology used to describe a per son's mental health status is grounded in the particular approach to understanding mental health subscribed to by the particular individual, group or organization using the term. So for example, broadly speaking, traditional mainstream psycho logical or psychiatric literature will opt for the terms mental illness and/or menta disorder in keeping with a psycho-*medical* paradigm, while critical social scientific or user-centred literature tends towards the terms mental health problem or menta distress reflecting a psycho-*social* paradigm. These contrasting models of menta health are discussed later in this chapter.

In this book we have shown a conscious preference for the term 'mental distress', as this most closely reflects both our value position in relation to people who use mental health services and our critical social scientific approach to the subject. Occasionally we use the terms mental illness and/or mental disorder where we fee it is important to remain consistent with the original context in which the term is used (for example, when discussing official definitions used in mental health law o policy), but when doing so we indicate the contested nature of that term through th use of single inverted commas – as in 'mental illness'.

EXAMINING OUR ATTITUDES TO MENTAL DISTRESS

From the outset it is important to acknowledge and reflect on our own *individua* feelings, attitudes and understanding of mental health and mental distress. Nei Thompson (2006) explains how practitioners need to be aware that they do no practise in a moral and political vacuum. His 'PCS' analysis (Figure 1.1) is a extremely useful tool in assisting practitioners to develop their understanding of th relationship between wider society, popular culture and individual attitudes.

Thompson (2006) reminds us that the way we come to understand and behav towards the world around us, and the people within it, is primarily shaped by th culture in which we live. As essentially subjective beings, health and social care pro fessionals are no less immune to the influence of prejudicial ideas, attitudes an behaviours. Acknowledging this fact is an important first step towards becoming

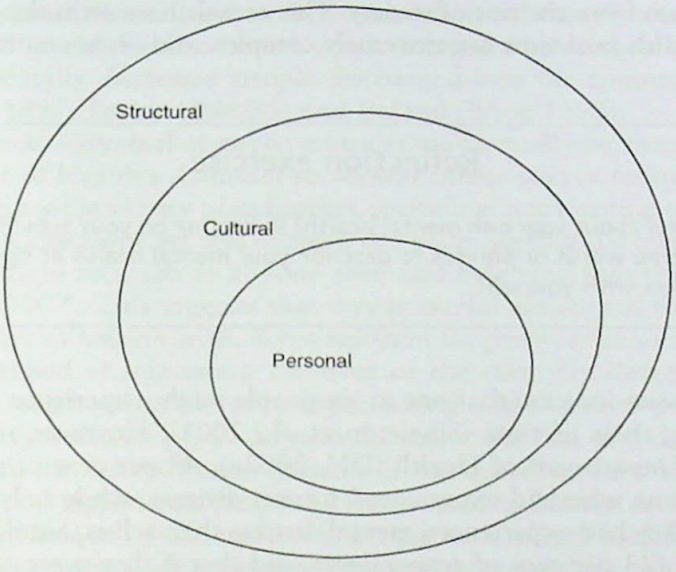

Figure 1.1 Thompson's (2006) PCS Analysis

critically self-aware practitioner, capable of identifying and then redressing any personal discriminatory beliefs and practices. We will return to Thompson's analysis and discuss its application to anti-oppressive social work practice in mental health more fully in Chapter 6.

Reflection exercise

How do *you* feel about people in mental distress? Write down as many words as you can to describe your feelings. Be honest with yourself!

It is highly likely that somewhere on your list the words 'fear' and 'sympathy' will have appeared, or at least words that convey similar meanings. These are extremely common emotional reactions that people have to those in mental distress. The diverse, complex and extraordinary ways in which mental distress is manifest in human beings can be disturbing, and at times frightening, for those experiencing it, those close to them and those working with them. The UK Department of Health has conducted regular surveys of people's attitudes to mental distress since 1993 and these two themes have featured prominently and consistently in people's responses. Moreover, although fear and sympathy might initially appear to reflect quite different value positions, people often express sympathy and concern for the mentally distressed while simultaneously expressing support for actions that effectively stigmatize

and exclude them from the rest of society. This reveals how attitudes towards people with mental health problems are extremely complex and often contradictory.

Reflection exercise

How do you feel about *your own* mental health? Reflecting on your own life experiences, write down some words or phrases to describe your mental health at significant times. Again, be honest with yourself!

Official statistics indicate that one in six people might experience a mental health problem during their lifetime (Singleton et al., 2001). However, in research conducted by the Department of Health (DH, 2003a), 49 per cent of people reported knowing someone who had experienced mental distress, while only seven per cent admitted that they had experienced mental distress themselves. Similarly, in a MORI survey in 1995, 23 per cent of respondents said that if they were receiving psychiatric treatment they would be reluctant or unwilling to admit this to their friends:

> It often seems a good idea to keep quiet about my mental distress. Yet when I am asked why I don't drink or why I took a year out from university, it would be nice to say, 'I was ill with schizophrenia' or 'I take medication for schizophrenia' without fear of a negative reaction. (Service user, cited in MIND, 2007a)

This suggests that although mental distress is statistically a common experience and part of everyday human existence, we have a tendency to want to distance ourselves from it – to see it as something far removed from us. Furthermore, this seems to confirm the existence of a deep-seated fear of, or taboo around, mental distress in our society: 'I found that people do one of two things. They look at you in one of two ways. Some look ashamed and furtive because ... I suppose everyone talks, and everyone is afraid of madness'. (Nicola Pagett, from *Diamonds Behind My Eyes*, cited in MIND, 2003a).

There is plenty of historical and cross-cultural evidence to show how the mentally distressed have been feared and excluded from mainstream society. In *Madness and Civilisation* Foucault tells us how:

> Suddenly, in a few years in the middle of the eighteenth century, a fear arose – a fear formulated in medical terms but animated, basically, by a moral myth ... the fear of madness grew at the same time as the dread of unreason: and thereby the two forms of obsession, leaning upon each other, continued to reinforce each other. (1967: 192–200)

Denise Jodelet's (1991) longitudinal research in rural France illustrates the persistence of alienating and exclusionary practices towards the mentally distressed despite their deinstitutionalization and official integration into the community. The rhetorical acceptance of these people into the community was not matched by the

reality of their status within it – their 'otherness' dictated that they only had a token place in the real world. Similar evidence has emerged from research into the social networks of mentally distressed people discharged into the community in the UK (Repper et al., 1997; Taylor 1994/95) and Ireland (Prior, 1993).

Recent evidence suggests that public attitudes may actually be worsening. In 2007, the Department of Health's *Attitudes to Mental Illness* survey found an increase in prejudice across a wide variety of indicators, including: not wanting to live next door to someone diagnosed with mental distress; not believing that the mentally distressed have the same right to a job as anyone else; and believing that they are prone to violence (TNS, 2007). This suggests that very powerful ideological forces are present and that these are in tension with, if not resistant to, progressive social and political developments aimed at improving the lives of the mentally distressed in society. Therefore, our reluctance to admit to experiencing mental health problems in contemporary society is not simply to do with the existential fear of 'otherness' – it is as much to do with the *material* consequences of 'exposure' in the form of inequality, discrimination and oppression (Mental Health Media, 2008). As Sayce observes, 'increasing social inequality ... impacts on people with mental health problems both because social exclusion itself creates distress and because those who are disadvantaged by the social status of the 'mental patient' become caught up in punitive, excluding policies and public moods' (2000: 41). We discuss the relationship between mental distress, inequality, discrimination and oppression more fully in Chapter 6.

IMAGES AND REPRESENTATIONS OF MENTAL DISTRESS

Research has pointed to the important role played by the news and entertainment media in constructing negative attitudes towards people in mental distress (Clarke, 2004; CSIP/Shift, 2006; Philo, 1996).

Group reflection exercise

Spend a week analysing the content of newspapers, magazines, radio, television and film, collecting examples of the use of imagery and language relating to mental health/mental distress. Share your findings with a small group of fellow students and discuss the following questions:

How do you think such images/language affect people in mental distress? How can mental health practitioners contribute to promoting a positive image of users of mental health services?

It is highly likely that your examples will include stereotypical images of the mentally distressed as violent, unpredictable and dangerous. Research demonstrates that these

are particularly dominant themes, often wildly exaggerated (Clarke, 2004; CSIP Shift, 2006; Laurence, 2003; Philo, 1996). Such representations are in stark contras to the research evidence that demonstrates how people with mental health problem are more likely to be victims than perpetrators of violence (Monahan, 1992; Taylo and Gunn, 1999). People in mental distress are three times more likely to experienc harassment (ranging from verbal abuse to violent attacks) in their local communit than the general population (Berzins et al., 2003; National Schizophrenia Fellowshi Scotland, 2001). A participant in the MIND survey *Creating Accepting Communitie* (Dunn, 1999) reported that he had been abused in the street; his house broken int twelve times and a knife put through the door. He wryly observed how, according t the media, he is supposed to be the one who is nasty and violent.

Philo (1996) explains that media representations are a very powerful influence or beliefs about the nature of mental distress and this often overrides people's persona experience – something which is very unusual in media research: 'A friend of many years, responding to media reports of killings by ex-psychiatric patients, said that psychiatric patients should all be locked up' (service user, cited in MIND, 2003a).

The examples you have noted are also likely to include the use of pejorative termi-nology associated with mental health such as 'psycho', 'schizo', 'loony' and 'nutter'. These terms are often used in conversations not directly relating to a person or per-sons with mental health problems – perhaps being used as a form of interpersonal abuse, insult or joke. This indicates how such pejorative terminology is deeply embedded in our vocabularies and how negative images of people in mental distress are partly constructed through the ordinary everyday language we use to talk about mental health. Some argue that there is no harm in such language and that to make a fuss about it is simply political correctness. However, many researchers, mental health professionals, service users and carers have written about the power of language in stigmatizing mental health patients (see for example Read and Baker 1996). Pejorative language is oppressive because it dehumanizes the person: 'Mentioning the name of my illness makes people feel as though you're Norman Bates' (service user, cited in MIND, 2003a).

The MIND survey *Counting the Cost* (Baker and MacPherson, 2000) analysed the effects of media portrayals on the lives of people with mental distress. Half of those who took part in the survey said that media coverage had a negative effect on their mental health:

- 34 per cent reported feeling more anxious or depressed
- 24 per cent had experienced hostility from their neighbours as a result of media reports
- 33 per cent felt reluctant to apply for jobs or to volunteer
- 37 per cent said their families or friends reacted differently to them because of recent media coverage.

One of the obvious consequences of negative stereotyping is that people avoid seeking help for their mental distress for fear of the stigma that follows (Read and Baker, 1996). Negative images and stereotypes are so pervasive and damaging that national and international campaigns and programmes have been developed to

reduce the stigma associated with mental distress. Some of these include the Care Services Improvement Partnership (CSIP) five-year initiative, *Shift* (2004–09) (www.shift.org.uk); the Mental Health Media, MIND, Rethink and Institute of Psychiatry campaign, *Time to Change* (previously *Moving People*) (2007–12) www.time-to-change.org.uk); the campaign by an alliance of five Scottish mental health organizations, *See Me* (2002–ongoing) (www.seemescotland.org.uk); the World Psychiatric Association campaign, *Open the Doors* (1996–ongoing) (www.wpanet.org/programs/opendoors-schizo.shtml); the Department of Health campaign, *Mind Out for Mental Health* (2001–04); the Royal College of Psychiatrists campaign, *Changing Minds* (1998–2003); and the MIND campaign, *Creating Accepting Communities* (1998–99). In the Moving People (2008) survey, *Stigma Shout*, 87 per cent of service users reported actual or anticipated stigma and/or discrimination.

Sartorious informs us that 'the stigma attached to mental illness, and to the people who have it, is a major obstacle to better care and to the improvement of the quality of their lives' (2002: 1470). Therefore it is essential that mental health practitioners and policy-makers challenge negative, damaging language, representations and attitudes in order to develop non-stigmatizing, accessible mental health care. Ironically, however, there is evidence to suggest that mental health professionals and mental health services may actually contribute to the stigmatization of people in mental distress – both through the diagnostic labelling process and in the way that treatments and services have traditionally been provided (Angermeyer and Matschinger, 2003; Sartorious, 2002). Sartorious (2002) illustrates how diagnostic labels can be an obvious source of stigmatization. While they might be useful in general medicine as a means of shorthand communication about a person's physical condition, their relevance and/or appropriateness in the mental health field has been questioned. Moreover, mistakes in psychiatric diagnosis can have devastating consequences – for example, the case of Kay Sheldon (cited in Double, 2001) who was forced to make a claim for medical negligence against her Health Authority after being misdiagnosed and treated for schizophrenia. The critical psychiatrist Pat Bracken highlights another downside to diagnosis and the medical framing of distress:

> It can cover up as well as illuminate the reasons for our pain and suffering. It is often presented to patients as 'the truth' of their condition and serves to silence other possibilities. Psychiatric diagnosis is often little more than a simplification of a complex reality and by formulating an individual's experiences in terms of pathology it can be profoundly disempowering and stigmatising. (2002: 27)

It seems astonishing that in the round table discussions on mental health during the 54th World Health Assembly it had to be conceded that 'most importantly, stigmatization, by all health professionals including mental health workers needed to be overcome' (WHO, 2001b). In the UK context, a Mental Health Foundation survey (2000) found that 44 per cent of respondents had experienced discrimination from their GPs, while 32 per cent had experienced discrimination from health care professionals other than GPs. Prominent among them were:

- nurses and other hospital staff on both general and psychiatric wards
- psychiatrists and consultants
- emergency staff, particularly in A&E departments in response to self-harm
- community and social services, such as CPNs and social workers.

Similarly, in research by Thornicroft (2006) two-thirds of service users identified th attitudes and behaviours of GPs and other health professionals as stigmatizing Incidents reported included being deliberately punished by staff or treated with lack of respect. Other first-hand accounts of people who use mental health service reveal a disturbing picture of stigmatizing and oppressive treatment as illustrated i the following quotations:

> Many mental health staff seem to embody the same stigma and discrimination that we might meet anywhere in society. Some staff treat us as if we are bad rather than mad, or talk to us as if we are naughty children.
>
> I have observed or experienced so many occasions where staff are clearly making a situation worse by shouting at people, or threatening people … it only leads to further humiliation and shame for us. How hard is it to maintain any kind of self-esteem in the face of this?
>
> For over 12 years I have been a service user and have encountered an enormous amount of prejudice and total disregard for my feelings and intellect by the medical profession. I am a real life person with thoughts and feelings.
>
> What most frustrates me is being treated like a dangerous animal … . The only violence in my 14 years of contact has been perpetrated by staff on me: once as I came down a flight of stairs I was jumped, my arms pinned behind my back, and my head and chest over the banister and then being 'restrained', prone on the floor with four nurses pinning me down and two deliberately inflicting pain because I dared to want to sit in the garden.
> (Selection of service user accounts, cited in The *Guardian*, 18 October 2006)

Chaplin (2000) draws attention to other aspects of psychiatric practice that maintai the stigma of mental distress – for example, the highly visible presence of medical, socia work and police services in compulsory Mental Health Act assessments, and th overt physical side-effects of medications prescribed by psychiatrists (such as droolin and involuntary movements) that can make individuals appear socially undesirable Similarly, McKay notes the stigmatizing effects of advertisements for psychiatri drugs that appear in medical journals:

> How can we expect the general public to have a rational and informed approach to people with schizophrenia when learned journals accept advertisements that promote a product through negative stereotyping? Perhaps our willingness to allow this to happen is in accord with work in the field, which suggests that health professionals may have even more negative attitudes to mental disorder than the general public. (2000: 467)

THEORIZING MENTAL HEALTH – MEDICAL AND SOCIAL MODELS

In Western societies mental distress is almost universally understood as a belief that there is a disturbance in one or more areas of human functioning – thoughts, feelings and behaviours. Nevertheless, explanations for mental distress are a fiercely contested and debated area. Theories about the causes of mental distress vary between, and to some extent within, the various disciplines concerned with the field of mental health, though most conform to what is termed the medical or disease model. The medical model emerged from the mid-nineteenth century onwards, shifting earlier moral or religious frameworks of explanation for mental distress towards an illness framework. Psychiatry consolidated itself in the twentieth century through its assimilation with medicine, and the concept of 'mental illness' evolved as a generic term embracing a diversity of behaviours and phenomena. The modern day language and practice of mental health mimics that of the medical sciences in so far as it involves: the *observation* of human emotions and behaviour; the *identification* of pathological 'symptoms'; the *diagnosis* of 'disorders' or 'illnesses' and the prescription of appropriate *treatment* for these.

The medical model approach is underpinned by the belief that mental health diagnosis simply involves the accurate naming of an objective disease process (Bracken and Thomas, 2000). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (2000), is the system used most often by psychiatrists in diagnosing mental disorders. The *International Statistical Classification of Diseases and Related Problems* (ICD) is a less widely used system published by the World Health Organization (1992). Both systems assume medical concepts and terminology and outline categorical disorders that can be diagnosed by set lists of criteria. The DSM has been revised five times since its inception in 1952. It was initially developed to create a standardized taxonomy that would enhance effective communication between psychiatrists to facilitate mental health research, diagnosis and treatment. The most recent version of the DSM is the DSM-IV-TR published in 2000.

Ostensibly, through the development of these formal diagnostic and classification systems, the medical model appears to provide practitioners with answers and certainties, but this can be a misleading assumption. Although they are modelled on the scientific paradigm, research has demonstrated that classification and diagnostic systems in the mental health field do not necessarily produce objective professional judgements. The process relies heavily on the interpretation of human emotions and behaviour, with diagnosis clearly capable of being influenced by subjective attitudes and beliefs (Double, 2002; Kirk and Kutchins, 1999). Double reminds us that 'psychiatrists do not want to admit the uncertainty that there is around diagnosis. One only needs to attend a psychiatric case conference to realise that diagnosis is not an exact science. Many different opinions will be expressed' (2001: 42).

The experience of learning to diagnose 'mental illness' is also influenced by the social, cultural and political contexts in which psychiatric training takes place, with a distinctly patriarchal, Western world-view dominating contemporary theory and practice