
CHAPTER 1

An introduction to mental health and mental illness

Mental health concerns everyone. It affects our ability to cope with and manage change, life events and transitions such as bereavement or retirement. All human beings have mental health needs, no matter what the state of their psyche. Mental health needs can be met in a variety of settings including acute hospital settings, primary care settings, self-help groups, through social services and of course through counselling and psychotherapy. This book is written specifically for counsellors and psychotherapists, working from any theoretical orientation and across the public and private sector, with a view to providing guidance on working with individuals who are experiencing mental illness. The background to the current context of mental health care, treatment and management both within the United Kingdom and internationally is outlined. Ways of defining mental health are discussed as a means of drawing attention to the complex and diverse understanding of what constitutes mental illness. This chapter also provides a general overview of the book along with some broad guidelines about how to make the most of the text. Relevant local and national policies are referred to in order to bring the reader's attention to the contemporary changes in mental health care as they impact on the work of the counsellor and psychotherapist.

Defining mental health and illness

Psychological distress is to some extent necessary for people to function; without the heightened awareness and sensitivity that psychological distress brings to social situations and life experiences we may find ourselves risking our lives at one extreme and under performing at the other. However, there is a point at which psychological distress can topple over into what might be termed or diagnosed as a mental disorder. At what point health promoting and seemingly 'normal' responses can be defined and classified as mental illness is, as one might expect, debatable and highly contentious. Mental

health and mental illness can be thought of as a continuum, rather than a polarised dichotomy, with people positioned at various points depending on life events (external factors), genetic inheritance and stages of development (internal factors). There are many definitions of mental health, the majority of which are simplistic, partial and inevitably subjective. To locate and subscribe to one definition not only reinforces the belief that the concept of mental health can be pinpointed and concretised, but of course it is in itself also too simplistic and partial. Indeed those appointed to draft the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) themselves argued that the term mental disorder could not be a more unfortunate term, preserving as it does an outdated mind–body duality (Kendall, 1996). (See Chapter 2, question 2.1 for a comprehensive explanation of the DSM-IV). Tudor (2004) argues that it is more helpful to think in terms of concepts of mental health and illness. This idea was first adopted by Jahoda (1958) who identified categories within which concepts of mental health could be represented. He described these as follows:

- mental health is indicated by the attitudes of the individual towards themselves
- mental health is expressed in the individual's style and degree of growth, development or self-actualisation
- mental health is based on the individual's relation to reality in terms of autonomy, perception of reality, environmental mastery
- mental health is the ability of the individual to integrate developing and differing aspects of themselves over time.

Having ascertained that mental illness is not a neutral, value-free, scientifically precise term and as such cannot be clearly defined, we turn now to the issue of normal and abnormal, or, as most commonly referred to, the sane and the insane. It is not easy to distinguish the normal from the abnormal, indeed there is a great deal of conflicting evidence relating to the use of such terms as 'sanity, insanity, mental illness and schizophrenia' (Rosenhan, 2001). Moreover, it is open to question as to whether the diagnoses of mental illness reside in the patients themselves or in the environment. Rosenhan says: 'We might like to believe that we can tell the normal from the abnormal, but the evidence is not compelling . . . there is a great deal of conflicting data on the reliability, utility and meaning of such terms as "sanity", "insanity", "mental illness", and "schizophrenia"' (2001, p. 70). He goes on to ask: 'Do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environment and contexts in which the observers find them?' Despite these important questions, it is of course necessary to have some way of monitoring the extent to which an individual's behaviour deviates from what is viewed as 'the norm', in order to ascertain a framework for structuring treatment and care. To this end a number of indices have been developed

classifying mental health diagnoses. Two of the main classification systems are mentioned below and are referred to throughout the remaining chapters.

Classifying mental illness

Manning (2001, p. 77) argues that the process of classification is 'fundamental to any science'. The two main classification systems used within mental health care are the International Classification of Diseases (ICD-10) developed by the World Health Organization (WHO, 1992) and the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) (discussed in detail in Chapter 2). Different epochs foster distinct types of mental disorder in its members. The mental disorders that characterise individuals living in contemporary society have implications for all health practitioners including counsellors and psychotherapists. Psychiatrists have for many years distinguished between the major mental illnesses, known as the psychoses (such as schizophrenia) and the neuroses (such as anxiety disorders and phobias). Many counsellors and psychotherapists are already familiar with these terms; however, it is perhaps worth outlining the contemporary thinking around these and other diagnostic categories.

Psychoses are diseases in which the individual's capacity to recognise reality and their ability to make appropriate communications and judgements are seriously impaired. They are sometimes accompanied by the presence of delusions and hallucinations (Craig, 2000). Psychoses can be further divided into functional and organic: the former are associated with a primary disturbance of mood, normally accompanied with some psychotic symptoms (for example schizophrenia); the latter refers to brain pathology that results in psychotic symptoms (as in dementia).

Many psychological theorists have written on the subject of neuroses: Freud (1914) originally wrote of neuroses as repressed conflicts between ego instincts and sexual libido, whereas Jung saw neuroses as being closely related to the individuation process. Jacoby (1990, p. 97) states that 'They often have an ultimate prospective purpose, since their function is to coerce the individual into a new attitude that will further the maturation of his personality'. Whereas Horney (1991) defines neurosis as a disturbance in one's relation to self and to others, neurotics can really only be differentiated from the general population by the degree to which they experience disabling symptoms. Thus, it could be said that where the psychotic person has an uncertain grasp on reality, the neurotic experiences a heightened and debilitating level of stress resulting in such disorders as, for example, obsessive compulsive disorder (OCD) and phobias.

In the recent past one specific psychiatric diagnosis, that of personality disorder, has received a great deal of professional and media attention. One

of the most contentious diagnoses, personality disorder is generally defined as consisting of deeply ingrained, enduring behaviours leading the person to behave in socially unacceptable ways. Manning (2001, p. 76) contests that 'personality disorder is the site of considerable psychiatric controversy', stating that it has been 'separated in British legislation from the two conventional conditions of mental illness and mental disability, as a third type of mental disorder – psychopathy'. Sometimes referred to as moral insanity (and occasionally interpreted as borderline), it is the behaviour of such individuals that separates them from the more easily identifiable disturbed mental processes and obvious organic malfunctioning diagnosed in the mentally ill or mentally disabled. In psychoanalytic terms individuals with a personality disorder experience an instability of identity leading to a mixture of alienation from others, feelings of grandiosity, dependency and disdain. There is a tendency to polarise people and project out primitive emotions of rage and shame. Personality disorders can be further classified into sub-groups, three of the most common being anti-social personality disorder (ASPD), paranoid personality disorder (PPD) and emotionally unstable personality disorder (most often associated with 'borderline personality'). There are few treatments that are known to be successful in the management of personality disorders. Where treatment is successful it is heavily reliant on the individual's willingness to accept responsibility for their actions, which in turn requires a degree of introspection and honesty.

It is worth mentioning that classifications of mental disorder also draw distinctions between common mental health problems and serious mental illness (SMI). Unfortunately, attempts to distinguish common mental health problems from serious mental illness have relied heavily on such markers as the presence of a psychotic diagnosis, which as Ryrie and Norman (2004, p. 22) point out, means that 'SMI is synonymous with "psychoses" and common mental health problems with "neuroses"'.

There is a further mode of understanding and organising mental illness, one that is very familiar to most counsellors and psychotherapists, and is linked to psychological schools of thinking such as psychoanalytic and humanistic theories. Psychological frameworks have proved useful in helping to determine treatment plans, and also enable the therapist and client to create a shared understanding of how the client's life processes are unfolding.

Frameworks for understanding mental illness

A number of psychological frameworks have been influential in informing the theory and practice of mental health, and whilst they propose distinct explanations for the aetiology of mental illness and in turn imply different treatment modalities, they also overlap. Those most often referred to are the

psychodynamic, behavioural, biological and medical, humanistic and systemic (Dallos, 1996). As previously noted, counsellors and psychotherapists are already well acquainted with these psychological frameworks, and have often been trained as practitioners in at least one of the above modalities. Nevertheless, for the purpose of this book, it might be helpful to revisit each theoretical orientation and outline the way in which mental illness is understood in each.

Biological and medical frameworks (sometimes referred to as the disease model) view psychological problems as resulting, in the main, from physical causes such as brain defects, hereditary factors or as the results of accidents or injury. Recent developments in this area suggest that disorders such as schizophrenia are linked to deficits in neurotransmitters located in the brain and can be inherited through genetic make-up. Further, diseases such as depression are attributed to changes in serotonin levels in the brain or a similar chemical imbalance. The biological model draws on traditional medicine and attempts to identify the presence of a 'stable' phenomenon called mental illness through scientific objectivity. One of the consequences of viewing mental illness in this manner is the belief that such illnesses can be identified and classified (as in the *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association, 1994) and the *International Classification of Disease* (World Health Organization, 1992)) (see Question 2.1). Additionally, where a physical or biological cause is identified as the basis of a mental disorder, treatments are in the main determined by a person's biology, leading to the administration of psychotropic drugs, alongside psycho-education and electroconvulsive therapy (Dallos, 1996). There is little doubt that a complex and dynamic interplay exists between the psychological and physical dimensions of the self, and it is well known that many physical diseases can cause or precipitate mental illness, and vice versa (Martin, 1997). In the words of Frances, First and Widiger (1991) 'There is much that is physical in the so-called mental disorders and much mental in the so-called physical disorders. Moreover, writers such as Kendell (1996) point out that: 'The distinction between neurological disorders of the brain like Parkinson's disease and psychiatric disorders like schizophrenia is particularly artificial and can only be understood in the light of the different historical origins of psychiatry and neurology and the unfortunate nineteenth century dichotomy between the mind and brain' (p. 23). This is the focus of the questions in Chapter 3, which clearly defines the relationship between the mind and the body, articulating what effect the physical systems can have on the mind and vice versa. The psyche-soma connection has been long debated and continues to be developed and examined. However, biological frameworks have a tendency to apply and are criticised for applying knowledge in an authoritative way that encourages recipients of treatment to remain passive and submissive. Other frameworks lean towards enabling the individual to learn for and about themselves, although some are more rigid than others.

Behavioural frameworks are closely aligned to learning theories and have long been associated with early exponents of conditioning theories. Symptoms of mental distress, considered to be learned habits, arise from the interaction between external stressors and the individual's personality. Thus, in behavioural models, the symptoms and their associated behaviours are the result of maladaptive responses and as such *are* the mental illness. A diversity of techniques have been developed using behavioural principles including behaviour modification, systematic desensitisation and more latterly cognitive-behavioural (CBT) approaches. Interestingly, although CBT is the youngest psychological model of the ones outlined here, it has become extremely popular since the mid-1990s, and is the preferred choice of counselling intervention in many primary health care settings. Much comparative research has been conducted in the efficacy of this and other psychological treatments, some of which is reviewed in questions in Chapters 6 and 7.

The psychodynamic framework argues that mental health problems are determined by the history of the individual's prior emotional experiences, which unconsciously serve to disrupt the normal path of development through psychosexual or psychosocial stages. Psychodynamic theories can also be seen to draw on a broad range of foundations, including biological and evolutionary theory, religion and the arts and as such 'psychiatric disorders are not viewed as illnesses with disease based causality but as conflicts between different levels of mental functioning' (Ryrie & Norman, 2004, p. 6). Psychodynamic approaches generally view mental health problems as rooted in negative childhood experiences, with treatment emphasising the therapeutic alliance and the effects of early attachments on current relationships.

Whilst humanistic frameworks do not deny the existence of the unconscious, they tend to view the individual as motivated by the need to grow and develop and as potentially creative. Using a holistic approach, humanistic theories are concerned with the integration of all aspects of the person, including dreams, sensations, emotions, cognitions and behaviour.

Systemic frameworks do not locate problems that are residing simply within the individual, but are concerned with the way in which the wider network of relationships influences the patterns and actions of the person. This type of framework is closely related to the social model, in that family beliefs are understood to be related to wider sociological context including shared values and norms. Questions in Chapter 5, with its focus on spiritual aspects of mental illness, highlight some of the ways in which both the social model and systemic models can enhance, delay or prevent treatment. Indeed, Chapter 5 might seem a rather surprising inclusion in this volume, but spiritual beliefs are an important part of many people's lives. Interestingly, many patients with mental health problems have experienced rejection from their place of spiritual worship

at the time when they have most needed to feel the unconditional love and kinship of their spiritual community.

The social model, which is referred to in depth in Chapter 4, is predominantly concerned with the way in which people react to unexpected and unpleasant life events. Proponents of the social model are particularly vociferous when it comes to the relationship between the different experiences of some ethnic groups in mental health services, particularly those of the African-Caribbean community. As is pointed out in questions in Chapter 4, persons of African-Caribbean race are more likely to be detained under the mental health act and to be labelled as schizophrenic (Goater, King & Cole 1999). The social model does not have a fixed idea of what constitutes a mental illness; rather psychiatric illness is understood from within the individual's context and cultural society. Sponsors of the social model focus on enabling people to take up an acceptable role in society rather than emphasising corrective behavioural and medical treatments.

Managing mental illness

At least one in four people are affected by a mental health problem at some point in their lives, many of them (about 20 per cent) presenting in primary care settings (Singleton et al., 2001). The *National Service Framework for Mental Health* (Department of Health, 1999a) reports that the incidence of mental illness rises in certain contexts. Influencing factors were mentioned at the beginning of this chapter and include stress, drug and alcohol abuse, social exclusion, traumatic early life experiences and unemployment. (Here incidence is referring to the number of new cases of a disorder that arises within a population, within a given time period, whilst prevalence refers to the number of people with a specific disorder within a given population.) Whilst neurotic problems are the most common form of mental illness (1 in 6), serious mental illness affects approximately 1–2 people in every 100.

The problem of how to manage the mental health of the population is a very real one. By 2020 the World Health Organization (WHO) warns that death from mental health disorders will be the second most common cause of mortality. Reasons for the increase in mental illness abound but remain speculative. Some conclusions about the nature of contemporary mental illness have been made (Freshwater, 2003). Tod Sloan (1996) determines that contentedness seems to be scarce, arguing along with Mirowsky (1989) that this is a price we pay for the lifestyle we call modern. Most people experience some degree of emotional dissonance, ranging from vague anxiety, inability to concentrate, manic work habits, the desire to drug oneself, alienation, estrangement and fantasies of a radical change of lifestyle.

Policy and research developments

As a result of fairly radical and heavily contested changes in mental health policy many people with a severe and/or chronic mental health disorder now live and are cared for in the community. This is usually associated with financial hardship, poor social relationships, lack of employment and a lower than average standard of living. As a result of the recent modernisation agenda, complex mental health services are now delivered by multiple agencies across a varied terrain of disciplines. In 1992 the British Government published its vision for the future and its legislation in the policy document *The Health of the Nation* (Department of Health, 1992). This was followed, and to a certain extent backed up by the subsequent policy document *Our Healthier Nation* (Department of Health, 1999b). Both documents cast cursory glances at the problem of mental illness, which alongside coronary heart disease, cancer and strokes became national targets for health improvement. Since then further focused policy has been developed, most notably the *National Service Framework for Mental Health* (Department of Health, 1999a) and *Making it Happen* (Department of Health, 2001). The *National Service Framework* sets out the agenda for improving mental health services through constituting national standards and increasing investment in mental health services. Such roles as the graduate mental health worker and the gateway worker, early intervention and crisis resolution teams are part of that investment and are the topic of several questions throughout the book.

The new Mental Health Bill (a reform of the 1983 Mental Health Act) is a further development of the overall modernisation of mental health care. Whilst the majority of individuals with mental health problems are not treated under the Mental Health Act, compulsory detention is sometimes necessary. Mental health legislation through the Mental Health Act provides appropriately qualified individuals with the legal authority to treat people without consent for their own and the general public's protection (this is discussed at length in Chapter 7).

One aspect of the *National Service Framework* (Department of Health, 1999a) relates to the importance of collaborative working. Community Mental Health Teams (CMHTs) were commissioned in the 1980s. It is fair to say that mental illness places demands on services that cannot be met by one agency or discipline alone. *The Capable Practitioner* framework (Sainsbury Centre for Mental Health, 2001a) notes that the process of delivering mental health care requires working across a range of services in order to draw on the diversity of expertise and resources available. These include the legal system, social systems and political (policy) systems as well as the wider health and social services. Developing partnerships between health professionals, clients and carers is believed to be an important step forward in promoting effective working alliances in all the health services. Whilst many practitioners see the

need for collaboration across services, it is not always easy. Despite numerous attempts at improving and coordinating services, through joint planning, restructuring, production of guidelines and refinement of procedures, there are countless examples of failure in collaboration, some of which attract media publicity. Hornby and Atkins (2000) argue that in addition to a structural approach to collaboration, a relational approach is also needed, one which is concerned with the human element of working together. One might argue that this is the bread and butter of a therapist's daily work, that is, the development of a collaborative alliance through a relational approach. But one could also question whether counselling and psychotherapy services are working in an integrative and seamless partnership with those that provide services to the mentally ill.

In the United Kingdom the government acknowledges in its 'Mental Health Policy Implementation Guide' (Department of Health, 2001) that few Primary Care Trusts provide the full range of mental health services. Typically, more specialised services are provided by Mental Health Trusts, and a variety of key services are provided by local councils as well as by the non-statutory sector and the charitable and voluntary sectors. With the number of different and differing agencies involved it is clear that the quality of collaboration between health and social care, statutory and non-statutory and voluntary services is of the utmost importance.

Currently a new integrated primary care liaison team is being piloted to replace the Community Mental Health Team. The aim is to provide services for patients with common mental health problems who require specialist interventions such as psychiatric or psychotherapeutic treatment. It is also the aim to provide support for those with more severe mental illnesses who cannot be supported in primary care alone. Whatever their title, it is envisaged that these new liaison teams, alongside primary care, will provide the key source of referrals to the newer teams.

It is recognised that in order for the new framework to operate effectively barriers between primary and secondary care and between health and social care should be tackled. To facilitate an effective partnership between health and social care, the Health Act of 1999 introduced powers enabling health authorities and local authorities to pool their budgets to commission and provide psychosocial interventions. This encouraged a multidisciplinary or interprofessional focus between for example, nurses, occupational therapists, general practitioners, social workers, health visitors, counsellors, psychologists and psychiatrists.

According to Mellor-Clarke (2000) there are now counsellors working in half of all general practices, and the government has set out clear guidelines on treatment choices including counselling and psychological therapies, although each local Primary Care Trust is developing its own protocol. It is perhaps part of the responsibility of counsellors working within or alongside

the Health Service to familiarise themselves with these recommendations and the basic framework of change, in order that they too can contribute to an improved mental health service through increased collaboration.

Although it has been acknowledged in the *National Service Framework for Mental Health* that most mental health problems are managed in primary care and that one in four consultations with GPs are with people who have mental health problems, mental health receives only 41 of a possible 550 clinical points available to GPs in the new GMS contract (four per cent of the total). This seems inappropriately low. In addition to the low scoring and therefore low revenue, the majority of points that *are* available are awarded for performing annual checks. Three of the five mental health indicators are to do with patients on lithium therapy. Of the remaining two, one is a register of people with severe long-term mental illness and the other is a review, again of patients with severe long-term mental illness, linked to physical health, medication and secondary care. As with all quality frameworks this is linked to outcomes and, with mental health issues, measurable outcomes are hard to define. The exception to this is the quantitative recording of suicide statistics, the reduction of which has become the (inappropriate) focus of the *National Service Framework for Mental Health*. The huge amount of research conducted into areas such as psychological therapy since the mid-1960s has to a large extent failed to influence the design of either services or treatments (Parry, 1996). Such issues are addressed in depth in Chapters 6 and 7.

Labelling and stigma

In spite of the increased prevalence and incidence of mental health problems, mental illness is still surrounded by fear and misunderstanding and remains even now deeply taboo. Tudor (1996) notes that the history of mental illness is one of exclusion, separation, distinction and otherness. It is well known that the stigma and discrimination that is associated with mental health issues add to this experience of isolation, exclusion and distress (Mental Health Foundation, 2000). The Department of Health (2003) publication *Attitudes to Mental Illness* observed that attitudes towards people with mental health problems are often inconsistent and contradictory. Stereotyping, that is the belief that all people in a certain group conform to an unjustifiably fixed mental picture, is widespread and often leads to prejudice expressed through intolerance and ignorance. This is compounded by media stereotypes of individuals with mental illness, who are often portrayed as violent criminals.

Psychotherapists and counsellors do much to challenge the dominant discourses around psychiatric and mental illnesses. However, they can also, unintentionally, perpetuate the negative and uninformed views that lead to labelling, stigmatisation and subsequent isolation. This can simply be through

lack of knowledge and understanding of the relationship of mental illness to their everyday clinical practice. The chapters that follow are therefore dedicated to providing a deeper appreciation of the wider influencing factors governing mental health, so that counsellors and other professionals who work in the psychological therapies can provide a more complete service to those experiencing mental distress.

