Social perspectives on severe mental distress

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Social perspectives on severe mental distress

- Ways of understanding mental distress
- Contributory factors and build-up: models and research
- Social responses to mental distress
- Recovery and what may enable this
- Positioning of social work

Questions and discussion

How do we understand mental distress?

One account became dominant in the late 20th Century

- historically and culturally specific
- mental distress to be seen as a 'technical' issue that should be resolved by the application of science
THE BIOPSYCHOSOCIAL MODEL

'Bio

Psycho

Social

'A bolt out of the blue'

A person is hit by a biochemical brain event that impacts on how they think, feel and behave and has implications for their family life, employment, friends...
‘A bolt out of the blue’ cont.

So, if we treat the illness, the rest will sort itself out (with some help and support)

Or, they have a chronic illness and will require ongoing treatment, care and surveillance

Some implications of ‘A bolt out of the blue’

- Experiences of mental distress have no meaning or connection with social experience
  - just symptoms of an illness

- People are powerless to do much about mental distress – except for accepting medical treatments

Culture of compliance
Emerging critiques (and alliances): critical psychiatry

- “For 150 years, psychiatry has fanned the flames of public hope and expectation, holding out promises of ‘cure’ and treatment for an ever-wider range of complex human and social problems. But these promises have failed to materialise... We believe that psychiatry should start a ‘decolonisation’, a phased withdrawal from the domains that it has laid claim to, including psychosis, depression and PTSD, by admitting the limited nature of its knowledge” (Bracken and Thomas, 2001)

Emerging critiques (and alliances): clinical psychology

- For “psychiatric diagnoses such as schizophrenia ... there is substantial evidence for psychosocial factors in aetiology, and very limited support for a disease model”

Emerging critiques: research findings and personal experience

- Model does not work very well in practice – Western recovery rates much lower than in some other societies – e.g. Kerala (Warner, 2004)
- Service users have not been convinced that their experience is meaningless – e.g. Hearing Voices Network
- Positive life changes (e.g. getting back into mainstream employment) can lead to reduction in level of ‘symptoms’ (Burns et al, 2009)

So how about the ‘lived experience + socio-psycho-bio’ model?
Towards a new story

What role do social factors play in serious mental distress?

What tips us over the edge?

A different starting point

Mental distress is a potentially meaningful response to challenging social and personal circumstances
The *biological* and the *social* connect
– but we may need to conceptualise this in a different way *(Tew, 2011)*

Evidence from brain scanning shows that

- Early childhood experiences of trauma or deprivation can become reflected in the ‘hard wiring’ of neural pathways in the brain
- Brains remain ‘plastic’ and positive life (and therapeutic) experiences may lead to positive ‘re-wiring’ in later life

Reconceptualising the relationship between social experience and biology

- Our genetic make-up *and* our social experience may lead us to respond to situations in particular ways
  - and these response patterns result in vulnerability *and* resilience
- These response patterns (e.g. learning to trust; hearing voices) can be reflected in the hard-wiring and biochemistry of our brains
  - and exposure to positive social experiences may enable the brain to re-align neural pathways
- Medication *can* work for *some* people as a way of managing certain aspects of their distress at particular times
  - but may also get in the way of recognising and resolving underlying issues.
Mental distress may be understood as (Tew, 2011):

1. An expression of an unresolved ‘problem of living’.
   - Social defeat / trauma / powerlessness (Brown et al, 1995; Read et al, 2004)
   - Not being able to deal with unease
   - Indirect signal that all is not well / ‘intermediary language’ (LeFevre, 1996)

2. A coping or survival strategy
   - The best available way of coping in the face of otherwise ‘unliveable’ painful or stressful experiences (Dillon, 2010).

The build-up:
Stress / vulnerability model (Zubin and Spring)
But actually it is a bit more complicated….

We also have positive experiences

And can develop resilience out of negative experiences

The build-up

Vulnerability ↔ Resilience

Stress and powerlessness ↔ Social capital

Social support ↔ Likelihood of mental distress
And actually it can get really complicated….

We have all sorts of experiences and reactions

SOCIAL / TRAUMA MODEL
(based on Plumb, 2005)

ABUSE

GUILT/ShAME

SELF-HATE

ANGER

LOW SELF ESTEEM

DEPRESSION

NEED TO CONTROL

ANOREXIA

SELF HARM

OCt

SOCIAL ISOLATION

DEPENDENCY

ABUSIVE RELATIONSHIPS

DISSOCIATION AND PTSD
Research evidence: some of the social factors that contribute to vulnerability

- Poor educational attainment; unemployment (Fryer, 1995)
- Being brought up in a poor and socially disorganised neighbourhood (Harrison et al, 2001)
- Maternal loss in childhood; looking after >three children under the age of 14; unemployment (Brown and Harris, 1978)
- Relative inequality and deprivation (Dohrenwend, 2000; Wilkinson and Pickett, 2009)
- Trauma (Read et al, 2005; Larkin and Morrison, 2006)

Power and identity issues contributing to vulnerability and stress

Discrimination and oppression:
- Race
  - higher incidence of ‘schizophrenia’ among African-Caribbean people in UK (but not in Jamaica) (Fearon et al, 2006)

- Gender / sexuality
  - over-conformity to or rebellion against gender stereotypes (Read, 2004)
  - Heterosexism and homophobia (Jorm et al, 2002)

Sexual and physical abuse (inc bullying) (Read et al 2005; Sourander et al, 2007)
Impact of family life on mental health: ‘Expressed emotion’

- Exposure to particular patterns and emotional dynamics may influence the likelihood of relapse (Kuipers et al, 2006)
  - Can relate to level of stress experienced by family members
  - Termed high ‘Expressed Emotion’

- Actually what can be most detrimental tends to be:
  - intrusiveness and over-involvement
  - hostility – including simmering or covert hostility (i.e. high unexpressed emotion).

How important are social factors?

When all other factors are taken into account, incidence of psychosis can be:
  - 9x higher for people of African Caribbean descent living in England (Fearon et al, 2006)
  - 7x higher for people brought up in deprived economic backgrounds as children (Harrison et al, 2001)

Information about frequent bullying and victimization at school age identified 28% of those with a psychiatric disorder 10 to 15 years later (Sourander et al, 2007).
Impact of genetic and social factors on adoptees (Tienari et al, 2004)

<table>
<thead>
<tr>
<th>Genetic risk</th>
<th>Family dynamics</th>
<th>Diagnosed with schizophrenia in later life (%)</th>
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<tr>
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<td>‘Healthy’</td>
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<td>Low</td>
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<td>5</td>
</tr>
<tr>
<td>High</td>
<td>‘Dysfunctional’</td>
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Social factors – what can happen after you become mentally distressed?

**Social model of disability:**
- What may be experienced as most disabling is not people’s impairment, but societal responses to it.

**Stigmatisation:**
- Demonisation of mentally distressed as “a menace to the proper workings of an orderly, efficient, progressive, rational society” – Roy Porter
The ‘triple whammy’ *(Tew, 2011)*

1. Distressing mental experiences (which may connect with prior adverse social circumstances)
2. Stigmatising or distancing responses from friends, family, professionals and society at large
3. Others’ responses can make social circumstances even worse and this can impact on severity of mental distress

The recovery movement

*Recovery involves resolving personal and social issues and ‘getting a life’ rather than just ‘taking the pills’*

- Connecting with others
- Hope for the future
- Finding positive personal and social Identities
- Meaning and purpose
- Empowerment *(Leamy et al, 2011)*
Social experience and recovery – what do we know?

Key processes in recovery include (Tew et al, 2012):

- Empowerment and being able to take more control over one’s life
- Supportiveness and mutuality in personal relationships (Topor et al, 2006; Schon et al, 2009)
- Social inclusion / participation
- Reclaiming positive personal and social identities

What seems to matter most is having a ‘place in the world’ to recover into (Bradshaw et al, 2007)

How important are social factors in longer term recovery? Population level evidence:

In West during 20th century:
- no correlation between recovery rates (social and clinical) and the introduction of new forms of treatment
- strong correlation with economic cycles.

Recovery rates can be 2x higher in low and middle-income countries where there are limited mental health services and (perhaps) people may be quickly re-inserted within family and community life – and expected to make a contribution (Warner, 2004)
A conceptual model for recovery and social inclusion

Mental distress
Anguish, disconnection and powerlessness

Social engagement

Personal journey

Finding a place in the world
• Positive self identity
• Connectedness

What makes recovery possible: underpinning resources (capitals)

- **Personal capital**
  - Education, dispositions, coping strategies

- **Relationship capital**
  - Mutuality, trust, acceptance

- **Identity capital**
  - Positive and coherent sense of self; valued social identities

- **Social capital**
  - Supportive network of ‘useful people to know’

- **Economic capital**
  - Income and ability to earn; purchasing power

Tew (2013) Recovery capital: what enables a sustainable recovery from mental health difficulties?
Some research evidence

- Size of social network and respondents’ subjective rating of its supportiveness are predictors of recovery outcomes (Mattson et al, 2008; Hendryx et al, 2009)

- Getting back into mainstream employment (with support) can lead to improvements in wider social functioning and reduction in level of ‘symptoms’ (Burns et al, 2009)

- Being able to choose one’s options in terms of social participation makes an important difference (Mezzina et al, 2006)

What happens when you have socially inclusive mental health services?

Long term evaluation of Open Dialogue in Finland (Seikkula et al, 2011):

- 81% of patients did not have any residual psychotic symptoms
- 84% had returned to full time employment or studies.
- Only 33% had used neuroleptic medication

Even better than Kerala!
PRACTICE: WHERE SOCIAL WORK SHOULD BE AT THE HEART OF CHANGE

Inclusive ways of working
- Whole family approaches
  - E.g. Open Dialogue, Family Group Conferencing
- Whole systems approaches to recovery
  - Community action / community development
  - Social engagement, education, employment

PRACTICE: CHANGING THE POWER RELATIONS

Co-productive and asset/strengths–based ways of working
- Working with people to (re)build the forms of capital that may be necessary to underpin recovery:
  - Personal, Relationship, Identity, Social and Economic
- Intentional Peer Support, Recovery Colleges
- Personal budgets (Tew et al, 2015)
So could this model be the future for mental health services?

LIVED EXPERIENCE

SOCIAL  PSYCHO  BIO

Your comments and questions
References


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