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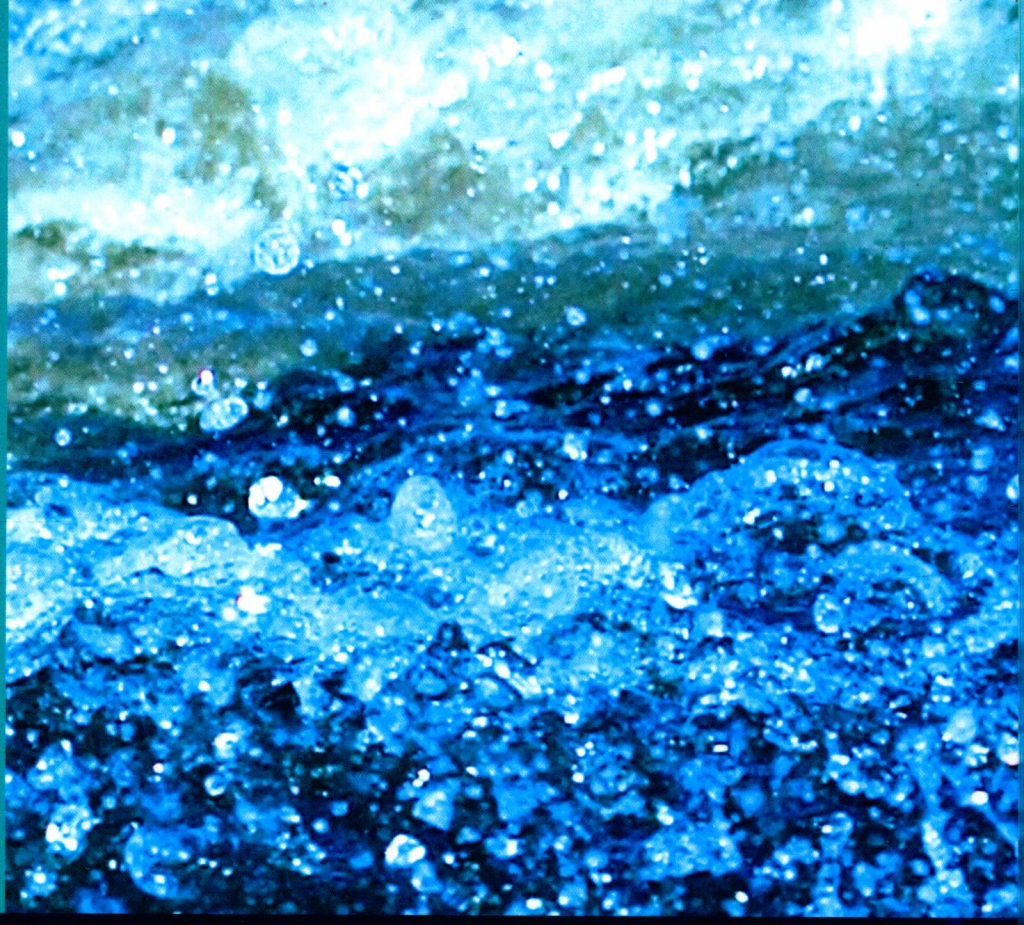

FOURTH EDITION

Key Concepts in Mental Health

DAVID PILGRIM

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Key Concepts in

Mental Health

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About the author

David Pilgrim is Honorary Professor of Health and Social Policy, University of Liverpool, and Visiting Professor of Clinical Psychology, University of Southampton. After training and working as a clinical psychologist, he completed a PhD examining psychotherapy in the organisational setting of the British NHS. He then went on to complete a Master's in sociology. He has worked at the boundary between clinical psychology and medical sociology for the past 20 years and has produced more than sixty articles based upon his research into mental health policy and practice that were published in peer-reviewed journals. His years working in the British NHS provided him with extensive everyday experience of the theoretical and policy aspects of mental health expressed in practical settings. One of his books, *A Sociology of Mental Health and Illness* (3rd edn, Open University Press, 2005), co-authored with Anne Rogers, won the British Medical Association's Medical Book of the Year Award for 2006. Currently, he is writing a book on child sexual abuse and public policy.

Preface to the fourth edition

I am grateful for the opportunity to update this book. The feedback from colleagues at Sage about the strengths and weaknesses of the previous edition has been very helpful. New entries have been added in light of that feedback and adjustments have been made to some others in light of recent changes relevant to the subject outlined.

I want to repeat acknowledgments from earlier editions. I am particularly grateful to Anne Rogers for working with me since 1993 on editions of *A Sociology of Mental Health and Illness*, which has informed many entries here. I have also been helped in my editing task by conversations in recent years with Richard Bentall, Roy Bhaskar, Mary Boyle, Pat Bracken, Tim Carey, Jacqui Dillon, Chris Dowrick, Bill Fulford, John Hall, Dave Harper, Lucy Johnstone, Peter Kinderman, Eleanor Longden, Ann McCranie, Nick Manning, Joanna Moncrieff, Nimisha Patel, John Read, Helen Spandler, Nigel Thomas, Phil Thomas, Floris Tomasini and Ivo Vassilev. In the preface to the first edition of this book, I acknowledged an even longer list of helpers, who remain important here. As with the previous editions, any errors of omission or commission, which might be spotted in the coming pages by the reader, are my responsibility alone.

David Pilgrim

Contents

Part 1
Mental Health

Mental Health

DEFINITION

Mental health is used positively to indicate a state of psychological wellbeing, negatively to indicate its opposite (as in 'mental health problems') or euphemistically to indicate facilities used by, or imposed upon, people with mental health problems (as in 'mental health services').

KEY POINTS

- Three different uses of the phrase 'mental health' are examined.
- Reasons for the use of 'mental health' in preference to other terms, such as 'mental illness', are discussed.

Alternative connotations of the term 'mental health' indicated in the above opening definition will be discussed below, in relation to positive mental health, mental health services and mental health problems.

- *'Mental health' as a positive state of psychological wellbeing* A sense of wellbeing is considered to be part of health according to the World Health Organization (WHO), which in 1951 described it as: 'the capacity of the individual to form harmonious relations with others and to participate in, or contribute constructively to, changes in his social or physical environment' (WHO, 1951: 4). This has been built on over time (see entry on Mental Health Promotion). Various attempts have been made to describe mental health positively by psychoanalysts (Kubie, 1954) and social psychologists (Jahoda, 1958). The latter reviewer described the term 'mental health' as being 'vague, elusive and ambiguous'. The range of definitions offered can be challenged on a number of grounds, related to their compatibility with one another and their internal consistency (Rogers and Pilgrim, 2014). Existential psychologists such as Maslow (1968) developed the idea of 'self-actualisation', which refers to each person fulfilling their human potential. But what if a person self-actualises at the expense of the wellbeing of others? Similarly, a statistical norm can be used to define mental health, but what of a society which contains unjust and destructive norms? One recurrent difficulty with defining positive mental health is the same one that dogs the definition of mental illness or mental disorder: it is not easy to draw a clear line between normal and abnormal mental states. Differences in norms over time and place are the main undermining factors in such attempts. What is normal in one society may not be so in another. Similarly, definitions of psychological normality and abnormality can vary over time in the same society. Is homosexuality a mental abnormality? Are hallucinations indicative of a

spiritual gift or a mental illness? Posing these sorts of questions highlights the impermanent dividing line between mental health and mental abnormality.

- *'Mental health' as a prefix to describe one part of health services* Since the Second World War, the term 'mental health services' has now replaced that of 'psychiatric services' (although the latter is still sometimes used). Prior to the Second World War, there were hospitals, clinics and asylums. These were either under parochial control, with a 'voluntary' or charitable history, or they served a specialist regional or national function. At that time, though, they were not called 'services'. As Webster (1988) notes, prior to the NHS in Britain, there was an admixture of charitable hospitals and medical relief offered to those in the workhouse system. This is why many of the older general hospitals were adapted poorhouse buildings. However, a major exception to this mixed picture was the network of dedicated mental illness and mental handicap hospitals which, since the Victorian period, had been funded and run by the state (Scull, 1979). The notion of a 'health service', post-1948, when the NHS was founded, reflects a shift towards a coherent system of organisation and a notion of a publicly available resource (at the 'service' of the general population). Currently in Britain, most specialist mental health services are within the NHS. In addition, there are privately run mental health facilities. These vary from small nursing homes to large hospitals which receive NHS patients who cannot be accommodated by local NHS mental health services. With devolution in the UK, specific policies about mental health service organisation now vary from one country to another (Department of Health, 1998, 1999; Scottish Office, 1997; Welsh Assembly Government, 2002).
- *'Mental health' as a prefix to 'problems'* Just as the term 'mental health services' has probably carried a euphemistic value for those responsible for them (managers and politicians), the same is true of the term 'mental health problems'. By adding 'problems', to invert a notion of 'mental health', a less damning and stigmatising state can be connoted. The professional discourse of diagnosis ('schizophrenia', 'bipolar disorder' and so on) is stigmatising. Indeed, sometimes psychiatrists simply do not communicate diagnoses such as these to their patients because of their negative connotations. In this context, the term 'mental health problems' may be less offensive to many parties. However, this might simply be a diversionary euphemism and perhaps not persuasive as a tactic to avoid stigma for those with the label.

The terms 'mental health services' and 'mental health problems' may have been encouraged for additional reasons to those noted above. During the 19th century in Britain, all patients were certified under lunacy laws. That is, the state only made provisions for the control of madness. The fledgling profession of psychiatry (this term was first used in Britain in 1858) was singularly preoccupied with segregating and managing lunatics (Scull, 1979). With the onset of the First World War in 1914, soldiers began to break down with 'shell shock' (now called 'post-traumatic stress disorder') (Stone, 1985). From this point on, psychiatry extended its jurisdiction from madness to versions of nervousness provoked by stress or trauma. Later, in the 20th century, more abnormal mental

states came within its jurisdiction, such as those due to alcohol and drug abuse and personality problems.

Today, 'mental health services' may be offered to, or imposed upon, people with this wide range of problems, although madness or 'severe mental illness' still captures most of the attention of professionals. In this context, 'mental illness service' would be too narrow a description of the range of patients under psychiatric jurisdiction. The more accurate description, of 'mental disorder services', would be more inclusive. However, this term has not emerged in the English-speaking world. Also, the term 'psychiatric service' does not accurately reflect the multidisciplinary nature of contemporary mental health work. So, for now, the term 'mental health service' serves as a compromise description. It avoids some inaccuracies but in some respects it is also mystifying.

Another aspect of the term 'mental health problems' is that some people, critical of psychiatric terminology, would object on scientific or logical grounds to notions like 'mental illness' or 'mental disorder'. An acceptable alternative for these critics is 'mental health problems', although another currently favoured alternative is 'mental distress'. Thus, use of the term 'mental health problems', and the even more vague 'mental health issues', sidesteps the potential offence created by psychiatric diagnoses, given that the latter do not have scientific or personal legitimacy for everyone.

See also: ICD; *mental health promotion; wellbeing.*

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Wellbeing

DEFINITION

Wellbeing (or well-being) is now a common term and yet it defies a simple definition. It can be conflated with contentment, the common good, quality of life, mental health or even health as a whole. Various permutations of cognitive elements (especially about meaning) and affective elements (especially about happiness) are connoted when the word is used.

KEY POINTS

- Wellbeing can be defined in a range of ways.
- It has become an important priority for politicians in the developed world as an alternative or additional goal to economic prosperity.
- It is now an opportunity for the political advancement of the mental health professions.
- The derivation and nature of wellbeing are discussed in a variety of ways by religious and secular disciplines.

The ambiguities noted in the definition above are unpacked below in summary. When we look at the psychological literature on wellbeing, we find a range of authorities with overlapping concerns about how humans can live their lives to the full (Ryff and Singer, 1998). For example, we find preferred terms such as 'self-actualisation' (Maslow, 1968); 'individuation' (Jung, 1933); 'the will to meaning' (Frankl, 1958); 'personal development' (Erikson, 1950); 'basic life tendencies' (Buhler, 1972); 'the fully functioning person' (Rogers, 1962); and 'maturity' (Allport, 1961).

HEDONIC AND EUDEMONIC ASPECTS OF WELLBEING

Since antiquity, the concerns of the above writers have broadly focused on positive mood (being happy in a predominant or sustained way in life) or on positive meaning and fulfilment. The former are 'hedonic' and the latter 'eudemonic' aspects of wellbeing. Hedonism was a philosophy that emphasised the pursuit of pleasure, whereas eudemonia (or 'eudaimonia') from Aristotle emphasised the pursuit of a meaningful life (Ackrill, 2006). The two can go together in our experience but not always. For example, we might find meaning in suffering in various forms, such as being depressed (Andrews and Thomson, 2009).

Our chances of subjective wellbeing are at their best if we live peaceably with a network of good friends and have enough money to avoid poverty. People with a faith also tend to fare better (Myers, 2000). Faith provides us with both social capital and

'existential ordering' in our lives. Thus, for those without faith (for example, atheists and humanists), these matters of social capital and existential ordering remain particularly important to reflect on as they have to be reinvented contingently in human life.

Some psychologists emphasise the objective aspects of the good life, for example Skinner's utopian vision of *Walden Two* in which our world contains predominantly positive reinforcement to ensure peaceful harmony in society (Skinner, 1948). Others (most of the authors noted above) tend to use more subjectivist or experiential criteria. Within American humanistic psychology, we find a convergence about the pursuit of positive wellbeing within the 'human growth movement'. In the American tradition of individualism, we find Carl Rogers echoing Aristotle's emphasis on eudemonia:

> for me, adjectives such as happy, contented, blissful, enjoyable, do not seem quite appropriate to any general description of this process I have called the good life, even though the person in this process would experience each one of these at the appropriate times. But adjectives which seem more generally fitting are adjectives such as enriching, exciting, rewarding, challenging, meaningful. ... It means launching oneself fully into the stream of life ... (Rogers, 1962: 5)

Whereas Rogers focuses on the inner life of individuals and Skinner on the outer world of positive contingencies, both convey important aspects of our current public policy agenda about wellbeing.

POLITICAL INTEREST IN WELLBEING

The current interest of politicians in wellbeing suggests that the leaders of developed societies are exploring a measure of progress beyond the economic. There is little point in people being richer if they are no happier and even the latter term begs a question about its relationship with values and meanings (Layard, 2005). Happiness is an emotional state, which is transitory and can even be artificially induced (by drugs and other forms of consumption). It may or may not be linked in the lives of people with a long-term sense of fulfilment, inner peace and contentment or with giving and receiving support and affection.

But outside of this recent political interest in the topic, the disciplinary perspective of those studying it frames its nature. For example, through the lens of comparative religion, we can explore what the great faiths have said about wellbeing. This is relevant today because of the world distribution of faith groups that encourage particular ways of thinking about wellbeing. Deistic religions emphasise fulfilment in life though serving God and so eschew homocentric definitions of the good life. However, the latter is often defined by striving for peace, love and understanding in our dealings with others. Non-deistic traditions like Buddhism emphasise compassion, authenticity, the transitory nature of life, the acceptance of suffering and the futility of the individual ego grasping for either possessions or permanence.

More secular approaches to the topic in human science are divided between those that privilege social relationships and those that privilege the individual mind.