Part 1

Fundamentals of Mental Health Nursing
Chapter 1

What is mental health?

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Learning outcomes

By the end of this chapter you will be able to:

• Understand the different ways of defining mental health.
• Recognise the implications of different theories of mental health on approaches to nursing care delivery.
• Explain how social, political, biological and psychological factors promote or compound mental well-being.

Test your knowledge

1. What does the term ‘mental health’ mean to you?
2. What factors do you think cause mental illness?
3. Can you think of any interventions which are used to treat mental illness?

Introduction

Mental health problems are one of the most significant health issues in modern society and are predicted to increase in the future (Longley et al., 2007; WHO, 2011). This has consequences for the social and economic well-being of communities alongside increasing demand on health services as a whole. As a student nurse or healthcare professional it is important to consider the implications of this on the way in which mental health services are delivered and structured. There remains debate surrounding the factors that influence mental well-being. This is due to the lack of definitive proof supporting one explanation and the difficulties with representing the complexity of mental distress.

This chapter will provide a range of definitions of mental health and consider the debates that surround understanding and explaining mental health problems. It will introduce the key theories underpinning interventions that aim to improve mental health. Activities are included to support your understanding of theories of mental health problems.
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Mental health in context
Historically, people who experience or have experienced some form of mental distress have not been served well by society at large. Early civilisations believed that mental illness was a curse from god and those people suffering ill health were considered evil, or, in particular, some women were classified as witches. The Middle Ages were not much better and people experiencing mental illness were deemed to be in possession or controlled by some form of evil demons. The early 19th century asylums, a spill-over from the workhouses where the poor and destitute were housed, had mainly a custodial function as many of the residents were incarcerated via the penal system (Nolan, 1993).

The Mental Treatment Act 1930 was supposedly a nudge towards a more enlightened period of treating patients with mental illness, where some were admitted to mental hospitals voluntarily. Goffman (1973), however, sheds light on the inhumane practices and rituals which often took place in these institutions where patients were stripped of their individuality and dignity (Morgan et al., 2013). The UK media in recent years has often reinforced stereotypical messages and images about people, including celebrities, experiencing mental health problems.

Contemporary mental health services are now mainly provided in the community, at home or in places as near to service users as possible, where care, support and treatment are focused on recovery. Despite these developments there are still fierce debates within mental health circles to what causes mental ill health, how (and why) it is classified and what treatments and interventions produce the best outcomes for people who use mental health services.

Definitions of mental health
The World Health Organisation (WHO) defined mental health as ‘a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO, 2011). This concept of mental health acknowledges that it is more than feeling healthy and well but is an experience also characterised by a social, economic and community life. Mind, an important mental health charity and campaign group, have extended this concept of mental health to suggest that mental health is when:

You care about yourself and you care for yourself. You love yourself, not hate yourself.
You look after your physical health – eat well, sleep well, exercise and enjoy yourself.
You see yourself as being a valuable person in your own right. You don’t have to earn the right to exist. You exist, so you have the right to exist. You judge yourself on reasonable standards. You don’t set yourself impossible goals, such as ‘I have to be perfect in everything I do,’ and then punish yourself when you don’t reach those goals.

(Mind, 2011)

Reflective exercise 1.1
Having read these statements defining mental health, make a list of the factors that you believe contribute to your own mental health and well-being. An example has been given but these could include anything that you feel is important

<table>
<thead>
<tr>
<th>Statement</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling good most of the time</td>
<td></td>
</tr>
<tr>
<td>Spending time with my family</td>
<td></td>
</tr>
</tbody>
</table>
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When you have made the list, rank these in order of importance. When complete you might want to reflect on:

1. Is there anything that these statements have in common?
2. What influenced your ranking of the statements?
3. What features (e.g. relationships, emotions) does your list include?

Definitions of mental health can be helpful for us to start to understand what the absence of health means and when this may lead to people needing the support of mental health services. Examining notions of mental health is important to recognise that mental health is an experience that concerns us all, enabling consideration of how this mental health can be promoted across communities. Yet there are many ways of conceptualising mental health and some have criticised the usefulness of definitions. MacDonald (2006) highlights that they can mean that we see mental health as a state which is fixed; it is either something you have or something that you do not. This can overlook the fluid nature of well-being. The definitions also often exclude the possibility of experiencing a range of human experiences such as sadness as well as happiness, which it can be argued is an important and potentially enriching part of human life. Definitions of mental health and well-being are problematic as they often reduce conceptualisations of health to a very individual level and ignore those social factors such as poverty that may influence health (McDonald, 2006). This can be seen to a degree in the WHO definition – if you cannot work does this automatically mean you are unhealthy?

Capturing notions of mental health can be difficult, with a diverse range of views on what it is and how it should be defined. This issue is translated into understanding mental health problems too, as a wide variety of explanations has been offered as to what causes and how best to treat emotional distress. The following sections in this chapter briefly outline a series of models that seek to explain the experience of mental health problems.

Theories of mental health: biological theory and interventions

Brain structure

The brain is a complex grouping of nerve cells and other structures involved in thinking, reaction to surroundings and forming decisions and plans. Parts of the brain with the nervous system regulate our vital bodily functions, for example breathing and heart beat. Different areas of the brain are linked to learning, memory and emotions, alongside the five senses (sight, smell, hearing, taste and touch) (Blows, 2010).

For the mind and body to function, billions of nerve cells (neurons) must communicate with each other to be effective. Neurotransmitters (brain chemicals) communicate by electrical signals or messages from a sending to receiving neuron. These communicate with different parts of the physique. The individual then responds in the form of behaviours, some consciously where we can assert control and some which are more automatic (Blows, 2010).

Research in recent years has shown that the brain plays a major role in mental health conditions. Mental illness impacts negatively, altering the individual’s thoughts, emotions and behaviors, affecting the ability to relate to others and ability to self-care (McCandless-Sugg, 2013). There is also evidence that the different brain regions interact to produce and regulate emotions. This has important implications for the emotional intelligence of people
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Pre-synapse (Neurotransmitter is released)  

Post-synapse (Binding takes place)  

Synapse

Figure 1.1  Neurotransmitters

about their understanding of taking positive control of their emotions (Davidson & Begley, 2012).

Neurochemistry

Researchers studying the role of the brain in these illnesses have found strong evidence that excess or deficits in certain types of neurotransmitters can cause abnormalities in communication among neurons (McCandless-Sugg, 2013). Communication between the brain and the body is compromised, resulting in symptoms of mental illness (Blows, 2010).

In addition to imbalances in brain chemicals, changes in the size and shape of actual structures in the brain can also contribute to certain mental illnesses. Dementia is a clear example of the link between brain abnormalities and psychiatric symptoms. As an illness with both neurological and psychological symptoms, dementia affects thoughts, personality, feelings and behaviour. The causes of dementia, although not fully understood, have been in large part traced to structural and chemical deterioration in the brain (Blows, 2010).

During neurotransmission, the chemical neurotransmitter is released from a storage vesicle in the pre-synaptic cell, crosses the synapse and is recognised by the receptor on the post-synaptic cell membrane (this recognition is called binding) (Fig. 1.1).

The following are common neurotransmitters associated with mental health conditions:

- Acetylcholine (associated with dementia).
- Dopamine (associated with psychoses and schizophrenia).
- Noradrenaline (associated with mania and depression).
- Serotonin (associated with depression).
- Gamma aminobutyric acid (GABA) (associated with anxiety).

Genetics

Genetics are thought to account for 40% of a person’s susceptibility to mental disorders, while psychological and environmental factors account for the other 60%. It appears that conditions occur because of multiple changes in genes rather than just one. Even if a person inherits these abnormal genes it does not mean they will develop mental illness (McCandless-Sugg, 2013). This is where the environmental and psychological factors are strong indicators. Schizophrenia, bipolar disorder and Alzheimer’s disease are examples where hereditary factors are strong (Gejman et al., 2011). Family linkage and twin studies have indicated that genetic factors often play an important role in the development of mental disorders, although these are not conclusive, again showing ‘nurture’ determinants to be a key factor (Blows, 2010). In addition, some associated mental health conditions, for example severe depression, bipolar disorder, attention deficit hyperactivity disorder (ADHD), schizophrenia and autism, have been traced to the same inherited genetic
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### Table 1.1 How psychopharmacological treatments act on the neurotransmitters

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic drug</td>
<td>Block dopamine from the receptor site</td>
</tr>
<tr>
<td>Tricyclic antidepressants SSRI</td>
<td>Block the re-uptake of noradrenaline/serotonin</td>
</tr>
<tr>
<td>Acetyl cholinesterase inhibitors</td>
<td>Block the breakdown of acetylcholine</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Potentiate the function of GABA</td>
</tr>
</tbody>
</table>

GABA, γ-aminobutyric acid; SSRI, selective serotonin reuptake inhibitor.

variations according to a multisite genome-wide study (Gejman et al., 2011). These variations are a significant predictor of mental illness risk. Thus there is a high genetic input in schizophrenia and bipolar disorder; a moderate one for bipolar and depression, and for ADHD and depression; and a low one for schizophrenia and depression (Gejman et al., 2011).

### Medication

Examples of actions of psychopharmacological treatments are available for psychosis and schizophrenia, bipolar disorder, affective disorder, depression, anxiety and, more recently, Alzheimer’s and other dementia conditions (Table 1.1).

Psychopharmacological treatments can play a major part in helping the service user recover from a mental illness episode (Mutstata, 2011). However, they have significant side effects, which if not detected and managed can be as distressing as the mental health symptoms. Non-adherence to psychopharmacological drugs is significantly high (Healy, 2008) but is no different to people not taking physical health drugs (NICE, 2009).

### Electroconvulsive therapy

Introduced by Bernini in the 1930s, electroconvulsive therapy (ECT) was controversial as it involved electrocuting people into an epileptic fit without anesthesia (Gass, 2008). However, it can be a very effective therapy for people suffering with disabling mental health conditions such as severe depression where psychologically (cognitive and emotional) and physically (not eating, loss of weight, no energy) the service user functioning is of great concern (NICE, 2010).

### Vignette 1.1

Lesley is a 50-year-old woman who is being treated for depression with antidepressant medication. However, her mood has not improved, she has lost weight, is not sleeping well and is having lots of suicidal thoughts. She has approached her ‘named nurse’ for some advice as her psychiatrist has advised her she needs ECT. She is worried about the treatment and says it sounds frightening.

### Questions

1. What would you advise Lesley to do?
2. Do you think ECT is a treatment that should be used?
Theories of mental health: social theory and interventions

Social theory

It is often said ‘No man [or women] is an island’. As individuals we inhabit a social space in which we interact with a variety of people, places, organisations and institutions on a daily basis and this is generally true throughout the lifespan. Of course we all experience solitary moments and often individual strength of character enables people to flourish under some of the most extreme circumstances. A social theory of mental health, however, means we need to consider not only the individual, but the many other environmental factors that may impact on a person’s well-being. As you can see from Fig. 1.2, poor mental health can be determined by many factors including financial resources, the state of someone’s physical health and even the nature of discrimination and prejudice some people experience (Myers et al., 2005).

Economic inequalities

Not everyone experiencing a mental health problem will be economically disadvantaged or live in a deprived housing area. However, according to Rogers and Pilgrim ‘basically the poorer a person is the more likely they are to have a mental health problem’ (2011, p. 51).

A report by the Poverty and Social Exclusion (PSE) group on living standards in the UK for 2013 outlines the scale of the problem:

- Over 30 million people (almost half the population) are suffering to some degree from financial insecurity.
- Almost 18 million in the UK today cannot afford adequate housing conditions
- Roughly 14 million cannot afford one or more essential household goods

![Figure 1.2 Cycles of injustice. Source: Myers et al. (2005)](image-url)
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- Almost 12 million people are too poor to engage in common social activities considered necessary by the majority of the population
- About 5.5 million adults go without essential clothing
- Around 4 million children and adults are not properly fed by today’s standards
- Almost 4 million children go without at least two of the things they need
- Around 2.5 million children live in homes that are damp
- Around 1.5 million children live in households that cannot afford to heat their home (PSE, 2013)

As you can see the extent of financial insecurity and poverty in the UK is quite staggering. Moreover, there is a double edge to this sword for people with low disposable incomes with poverty both causing and contributing to poor mental health. As can be seen in Fig. 1.3, adults in the poorest income range are much more likely to be at risk of developing mental illness than those on average or high incomes.

![Figure 1.3](image.png)

**Figure 1.3** Income levels and risk of developing a mental illness. Adults in the poorest fifth are much more likely to be at risk of developing a mental illness than those on average or high incomes. Data are the averages for 2008 and 2009, with those for England updated in March 2011. Source: Health Survey of England

**Social and cultural inequalities**

Income inequality is just one factor contributing to poor mental health; many people are further marginalised from mainstream society, including access to mental health services, often as a result of their sexuality/sexual belief, marital status, their gender/sex, their spirituality, their race/ethnicity, their age or for even from being pregnant. For example, the Mental Health Foundation (2013) states, in general, people from black and minority ethnic groups living in the UK are:

- More likely to be diagnosed with mental health problems.
- More likely to be diagnosed and admitted to hospital.
More likely to experience a poor outcome from treatment.
More likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

Therefore, as mental health nurses, it is important when we are planning care and supporting recovery with people experiencing mental health problems that we look beyond the formal diagnosis and take into account the social, cultural and economic factors which can impact on an individual’s well-being. For example, culture refers to a group’s shared set of beliefs, norms and values and can account for variations in how people communicate their experiences along with which ones they report as distressing. Culture influences whether people even seek help in the first place, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental health problems. Culture also influences the meanings that people impart to their experiences.

Consumers of mental health services, whose cultures vary both between and within groups, naturally carry this diversity directly to the service setting. What follows are numerous examples of the ways in which culture influences mental health and mental health services. For further detailed exploration of how these variations impact the nature of mental distress and the care received please take some time to explore publications within the *International Journal of Culture and Mental Health*.

It is our role as nurses to advocate on behalf of service users to try and break down the barriers that lead to health inequalities and social exclusion. Of course it is not always easy for nurses, or service users for that matter, to confront these societal and environmental problems.

**Structure/agency**

Often it is governments and powerful organisations that determine the policies which impact on employment rates, minimum wage requirements or the type and amount of welfare benefits an individual will receive. Clifton *et al.* (2013) call this the structure/agency conundrum. That is, what is the extent to which mental health nurses can enable social inclusion and reduce inequalities? Consider social housing, as we saw, over 18 million people in the UK cannot afford adequate housing conditions. Is it the responsibility of government to supply adequate housing, or should individuals strive to work harder so they can afford better housing? What if they cannot find a job, or if the job they are currently employed in only offers the minimum wage or worse still a ‘zero hour’ contract where you do not know how much you will earn from one week to the next?

These are big questions and are not always easy to answer, but as you can see from this brief introduction to a social theory of mental health, there are many environmental factors that can and do impact on people experiencing mental health problems. Indeed many of these factors such as poverty, unemployment, malnutrition and poor housing both cause and contribute to poor mental health. It is not that governments cannot do anything about health inequalities. Figure 1.4 highlights that health and social problems are worse in countries which are more unequal. As you can see, the UK (alongside Portugal and the USA) has a very high distribution of income inequality – hence it has much worse health and social problems compared with more equal countries such as Sweden and Norway (Wilkinson & Picket, 2009).
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Figure 1.4  Income inequality. Health and social problems are worse in more unequal countries

Vignette 1.2

I moved to the UK from Africa in the summer. Dad was looking for work and mum stayed at home to take care of me and my brothers. I go to school but the other kids say they can’t understand what I’m saying. I miss my friends from back home. I feel different to people here, I look different, sound different. I’m lonely.

Questions

1. Thinking about what you have read about social theories of mental health, what factors do you think could influence this person’s mental well-being?
2. How do you think gender might influence this person’s reaction to this situation?

Theories of mental health: psychological theory and interventions

Psychological theories provide important frameworks for understanding mental health problems. Many psychological models have been influential in developing the theory and practice of mental health nursing. Psychological theories provide explanations of the potential causes of mental distress and through this can guide the type of treatment and support a person might need. However, there are many different psychological models, which represent diverse philosophical positions. This section provides an overview of four key approaches, briefly examining their application to nursing and supporting people with mental health problems.
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Humanistic approach

Humanistic perspectives advocate that all humans have the capacity to grow and develop given the right conditions. We are driven by this journey to fulfil our full potential. This process is described by two important humanistic theorists, Carl Rogers and Abraham Maslow as self-actualisation. Positive forces of a sense of love and belonging are what provide motivation (Rolfe, 1992).

Key principles

- People are perceived as unique and possessed of the capabilities to heal themselves. This position focuses on the expertise that a person brings to the helping relationship, rather than seeing the therapist or healthcare professional as ‘all knowing’.
- When people are denied the right conditions and lack acceptance, problems can develop so the drive and journey to self-actualisation is interrupted. This can be influenced by early experiences, alongside interactions with others.
- Providing the right conditions to enable people to grow provides the basis of the person-centred therapy developed by Rogers (1951). Here the core conditions demonstrated by the helper of unconditional acceptance, empathy and genuineness provide the circumstances for change.

The humanistic approach is inherent within the development of therapeutic relationships, which remains at the heart of mental health nursing (Hurley et al., 2006). Interpersonal skills that communicate a person is valued and a nurse holds hope that their lives can change are highlighted as most important by service users (Adam et al., 2003).

Psychodynamic approach

Sigmund Freud was at the forefront of developing psychodynamic approaches, although many have gone on to adapt the principles on which his ideas were based. The psychodynamic perspective focuses on the role that experiences in childhood have on psychological problems and ultimately see these as the core cause.

Key principles

- Psychological distress is described as an expression of internal conflicts that are created by these early experiences.
- A person is not consciously aware of these conflicts.
- Through therapy and the relationship with a therapist these conflicts are brought into conscious awareness, therefore enabling their management.

Psychodynamic approaches provide an important means of understanding the role of early life in relation to psychological distress. Its main application as a therapeutic approach is through specialist training. However, there are some key principles of a psychodynamic framework that can help mental health nurses explore emotional and interpersonal components of their work. For example, the notion of transference arises from a psychodynamic perspective and explains the process whereby emotions that have been experienced by a person towards another in their early life are brought out and may be felt towards the nurse. Countertransference refers to the professionals responses to this (Hughes & Kerr, 2000).
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Cognitive behavioural approach

The cognitive behavioural approach is a combination of two significant psychological models. The behavioural model focuses on the 'here and now', defining people's behaviour as that which has been learnt. This learning takes place through reinforcement and conditioning. As behaviour is something that has been learnt, this model advocates that it can therefore be modified through certain processes. The cognitive model grew out of dissatisfaction with the behavioural theory as it was perceived to ignore the internal influences on our behaviour. The cognitive approach advocates that it is our way of thinking that controls our behaviour.

Key principles

- The cognitive behavioural model therefore examines the links between our thoughts, feelings and behaviour (Fig. 1.5).
- Problems are created through distorted thinking and the reinforcement of problem behaviours, for example avoidance.
- Enabling people to deal with their problems is achieved through changing the way people think about an event or experience alongside helping them change behaviours and potentially deal with the emotional experiences associated with this.

Cognitive behavioural models are influential within contemporary mental health practice. Mental health professionals have been able to access training initiatives to enhance their psychological interventions skills, many of which have been based on cognitive behavioural therapy.

![Figure 1.5 Cognitive behavioural model](image)

The trauma model

The trauma model emphasises the importance of traumatic experiences, particularly in early life, on the development of mental health problems.
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Key principles

- Trauma can occur when a person experiences an ‘uncontrollable event which is perceived to threaten a person’s sense of integrity or survival’ (Mueser et al., 2002, p. 123). This encompasses any situation that may incur psychological trauma but commonly this involves experiencing physical or sexual violence.

- Evidence suggests that people with serious mental health problems are more likely to experience childhood abuse, with some studies quoting up to 53% (Mueser et al., 2002). Romme and Escher’s (1989) seminal work on voice hearing found that in 70% of people in their study who heard voices these were triggered by traumatic events.

- Within trauma models there are varied explanations as to how experiencing trauma may result in mental health problems. One explanation offered in relation to the experience of psychosis suggests that people may dissociate from their situation, which results in them being vulnerable to getting lost in their inner world and losing connections with the environment and external reality (Morrison et al., 2003).

Recognising the role of trauma in the development and/or maintenance of mental health problems is important for mental health nursing. Providing the conditions where people can be open about their experiences can be significant. Morrsion et al. (2003) also highlight how mental health service design and organisation could be amended to take account of trauma.

An overview of four psychological models has been provided to promote an insight into the significant role that psychological approaches occupy in mental health practice.

Vignette 1.3

Sam experiences panic attacks when he is in crowded places. He finds it difficult to leave the house and avoids doing his shopping in the supermarket, preferring instead to use internet shopping. Last time he visited his local shops he found it difficult to breath and had to run out of the shop. Sam fears that the shop manager thinks he was shoplifting. When he was a child he became separated from his mum in the supermarket and was lost for an hour. His parents were going through a divorce at this time.

**Question**

1. Using what you have read about the psychological theories, what factors do you think may influence Sam’s mental well-being?

Theories of mental health: anti-psychiatry

The term anti-psychiatry describes the criticism of the basis of psychiatry which grew in during the 1960s and 1970s. The key players within this critical social movement in Britain were David Cooper, Aaron Esterson, Leon Redler, Morton Scatzman, Joseph Berke and, arguably the most influential, R. D. Laing. In America Thomas Szasz was equally influential through the publication of controversial views that challenged the classification of mental distress as an illness (Dammann, 1997). These figures were questioning of the distinction between madness and sanity, along with the socially controlling function of psychiatric treatments such as medication and psychoanalysis. This was based on the premise that
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society is oppressive and requires the repression of human potential for its effective functioning (Crossley, 1998).

What is notable about the anti-psychiatry movement is that the most vocal campaigners were psychiatrists themselves and formed a network with each other to attempt to initiate radical change to the way people labelled mad were regarded and treated by society. These key figures attracted a wider network of supporters who joined them to establish research associations, campaigning networks and therapeutic communities. Laing et al. also found support amongst psychiatric patients. This was viewed as a significant issue by established psychiatrists due to the questions it raised regarding their power and authority (Sedgwick, 1982). This popularity was reflected in the media as a range of plays, films and books based upon Laing’s arguments, which were extremely well received within the arts and educational fields. This climate surrounding anti-psychiatry created space where new ideas and identities could be generated, contested and transformed. Anti-psychiatry is therefore regarded as a social movement (Eyerman & Jamison, 1991).

The most significant arguments arising from Laing’s publications centred on the idea that schizophrenia is a socially constructed label and that the peculiar behaviour it refers to should be attributed to a family rather than an individual. According to Laing, this label imposed definitions on the person and gave permission for confinement within institutional settings which invalided their worth in society. He was critical of the accepted genetic explanations adopted to justify psychiatry and the subsequent control and power this offered over another. This is illustrated by this extract taken from the preface of the 2nd edition of his renowned book *The Divided Self* (Laing, 1965):

"psychiatry can so easily be a technique of brainwashing, of inducing behaviour that is adjusted, by (preferably) non-injurious torture. In the best places, where straightjackets are abolished, doors are unlocked, leucotomies largely forgone, these can be replaced by more subtle lobotomies and tranquilisers that place the bars of Bedlam and the locked doors inside the patient. Thus I would wish to emphasise that our ‘normal’ ‘adjusted’ state is too often the abdication of ecstasy, the betrayal of our true potentialities, that many of us are only too successful in acquiring a false self to adapt to false realities."

Szasz also discussed the social construct of mental illness and gave the example of how a person experiencing hallucinations in some cultures would be regarded as spiritual and therefore afforded high ranks within society. However, in most western cultures they would be considered mentally ill, treated with medication and in some cases confined within an institution. Certain behaviour associated with the illness would be viewed in western culture as disruptive and therefore labelled and condemned (Dammann, 1997).

In terms of the lasting effects of the ideas associated with anti-psychiatry, there is limited evidence to indicate any substantial influence. Laing is often regarded as mad himself and was struck off the medical register due to drunkenness and bad behaviour. His name is also inaccurately associated with the closure of mental institutions, which many view as an inhumane solution to treatment of the seriously mentally ill (Tantam, 1991). Similarly, the problematic nature of conceptualising mental distress as an illness, discussed by Szasz, has also had limited impact and the disease model remains the most dominant influence on approaches to treatment. However, the values-driven nature of this position has been more widely debated and the acknowledgement of how values guide our work within mental healthcare is more openly accepted. Furthermore, within the user movement, Laing et al. are regarded as providing an argument that conceptualised their identities in a more positive way and cleared a space for their voice to be heard (Crossley, 1998).
Critical psychiatry

It is the voice of service user organisations which has now given strength to critical psychiatry. This current social movement is based upon the criticism that although the location of mental healthcare has moved from institutions to the community, the fundamental problems of psychiatry remain. Thomas and Bracken (2004) summarise how critical psychiatry identifies with the following themes:

- Psychiatry is based on a set of assumptions about the nature of mind, meaning and knowledge and the relationships between psychology and sociocultural realities. These assumptions can be questioned. They do not represent a universal truth.
- Service users and governments are asking psychiatry to move beyond the narrow and sometimes simplistic frameworks that guided the discipline in the 20th century. This should not be construed as a threat but rather as an opportunity to reconfigure the relationship between medicine and those who suffer.
- There is a need for psychiatrists to develop more flexible ways of engaging with states of madness and distress. This means paying more attention to the different ways in which service users understand their experiences.
- Critical psychiatry is involved in campaigns to limit the control of psychiatry by corporations, most notably those of the pharmaceutical industry. It is also involved in campaigns to reduce the coercive side of psychiatric practice.

These themes demonstrate the influence of anti-psychiatry but have moved on from arguments that focus on the existence or not of mental illness itself. The attention is drawn to the power present within the psychiatric discipline and how this can be used effectively to promote, as opposed to compound, recovery.

Summary

- As mental health nursing students it is important we can recognise and understand the notion of mental well-being; this allows us to plan and facilitate recovery for people using mental health services.
- There is no single factor that explains why some people are susceptible to mental health problems; it is important we are aware of the biological, psychological and social factors that impact on an individual’s mental health.
- The basis of contemporary mental health nursing work is within the therapeutic relationship that we develop with service users in order to establish a relationship where people can be open and feel safe enough to share their thoughts and feelings.
- As we learn more about the way certain chemicals react in the brain and we develop more sophisticated drugs that target particular neurotransmitters, it is impossible to ignore biological approaches when considering mental health.
- Medication can only provide part of the solution to these problems and it is vitally important that mental health nurses consider the social factors which can both cause and compound mental distress.
- Poverty, inequality and poor housing are social factors which can and do impact on an individual’s well-being and recovery.
- Service users are now at the forefront of the critical psychiatry movement, campaigning and demonstrating against those mental health services which, often, on the face of it appear as coercive as the asylums and institutions of the past.
- Many mental health service users feel disempowered within a system that focuses on biological approaches at the expense of the psychological and social factors which are so paramount to understanding mental health.
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Test your understanding
1. Name three neurotransmitters associated with common mental health problems.
2. What does the term structure/agency mean to you?
3. Is schizophrenia an appropriate term to label mental health service users?

Word search
Find the words listed in the following grid.

Anti-psychiatry, Dementia, Humanistic, Neurotransmitters, Recovery, Serotonin, Service user, Social inclusion, Trauma

Suggestions for further reading

Some websites to visit
Centre for Mental Health: http://www.centreformentalhealth.org.uk
Department of Health, UK: www.dh.gov.uk
Mind: http://www.mind.org.uk
Rethink Mental Illness (previously the National Schizophrenia Fellowship): www.rethink.org
World Health Organisation (WHO): http://www.who.int/topics/mental_health/en
(All websites last accessed March 2017.)
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