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# Caring for Adults with Mental Health Problems

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*Edited by*

**I. PEATE**

*University of Hertfordshire*

**S. CHELVANAYAGAM**

*University of Hertfordshire*



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# 1 Introduction

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I. PEATE AND S. CHELVANAYAGAM

*Caring for Adults with Mental Health Problems* aims to offer a foundation for those who provide, or wish to provide, health care and support for people with mental health problems. Those who have contributed to the book come from various backgrounds – both practice and academia. The authors are committed to creating and sustaining a positive mental health environment for all; they believe that each person is a unique being with individual needs and aspirations – each chapter of this book reflects these values, attitudes and hopes.

Caring for those who have mental health problems can be complex and rewarding; making a difference really does mean that. It is estimated that at least as many as one in six adults experiences mental ill health at some time in their life; furthermore, the World Health Organization predict that by 2020 depression will be the leading cause of disability (Collishaw *et al.* 2004). Those who have mental health problems can face discrimination and prejudice in society, for example they may have difficulty in accessing education and other statutory services as a result of their illness. There are some members of our society who are excluded from accessing services because of mental health legislation; Lee in her chapter concerning legal matters (Chapter Six) considers those individuals.

We wholeheartedly believe that people with mental health problems deserve the best possible care and support; in order to offer this, mental health professionals must have an understanding of the context of the individual service user's life, both in the community and also within the various healthcare settings. Those who are supported effectively in the community can remain well. This text is designed to encourage the reader to push forward the possibilities associated with mental health care, providing innovative and contemporary approaches to care and support. The notion of partnership is central to effective client-centred care. It is vital that care and support are to be delivered in the most appropriate manner, and this text encourages the reader to apply this approach to care delivery in any situation in which they may be working. In Illingworth's chapter (Chapter Four), the importance of partnership working and the benefits that this may bring the patient are emphasised, looking beyond a disease-orientated approach to one where the patient is central. Such an approach is in tandem with the current Government's

desire to provide a health service that is designed around the patient, as opposed to the needs of the patient being forced to fit around the service already provided (Department of Health 2006).

The primary audience for this text are nursing students, those who are undertaking NVQ/SNVQ, Access to Nursing, Cadet nursing programmes of study and those returning to practice, but not exclusively those cited. The text may feel as comfortable on the shelves of a book case at home as in an academic library. However, the text should not be seen as a comprehensive book discussing all the needs of the person with a mental health problem – that would be an impossibility – rather the reader is encouraged to identify further topics of importance that have not been considered here and to delve deeper. The terms and the philosophies applied to this book can be adapted to suit a number of health care workers at various levels and in a range of settings in order to develop individual health care workers' caring, informed skills.

The book uses up-to-date information that the reader will require in order to begin to understand how to help, support and care for those with mental health problems both in the institutional setting (e.g. the hospital) and in the community (e.g. the home setting). The material is organised in such a way that it reflects contemporary practice in a user-friendly manner; in addition, information is related to clinical practice issues that may be experienced when working with people with mental health problems, their families and friends. It is not envisaged that the text be read from cover to cover in one sitting; it has been designed to be used as a reference book (a resource, a reader) either in the clinical setting, classroom or at home.

The text should be seen as a handbook or a manual that has a sound evidence base, and one that will challenge and encourage the reader to develop a questioning approach to care provision. It emphasises the integration of theory and practice. If you are currently studying, in order to get the most out of this book you are strongly encouraged to attend all of your classes associated with your current programme of study, using this text to supplement and support your theoretical and clinical learning. Much of the discussion is placed against the backdrop of the Mental Health Act 1983 and *A National Service Framework for Mental Health* (Department of Health 1999). Other key documents, publications and statutes are also used to inform debate.

The overarching aims are to help the reader to understand the fundamental aspects of care in order to facilitate safe and effective practice; to stimulate thought and to generate discussion – this will encourage the development of effective caring skills underpinned by a sound knowledge base. This is a foundation text that will enable personal growth in relation to mental health care.

## CHANGES IN SOCIETY

It is important to set the scene, putting into context the extent to which society lives and changes in an attempt to understand the needs of those who you may need to



provide care and support for. The proportion of those who live alone is expected to increase over the next 20 years. This is due to several factors, for example an increased longevity, as well as changes in familial structures. Contemporary society is much more geographically mobile than it was 20 years ago. Twenty-one per cent of those aged 65 years or over see their family or friends less than once a week or not at all (Office of National Statistics 2001). The consequences of these changes can result in profound mental health problems and challenges, and will have an impact on the individual, their friends, carers and service providers.

## **MENTAL HEALTH ISSUES AND THE OLDER POPULATION**

The number of those aged 65 years and over with mental health problems is growing. Those aged 65 years and over with mental health problems will rise in the next ten years by 10%, with the greatest burden being on those who are aged over 80 years. Depression and dementia are common problems that will increase in the elderly population (Department of Health 2005). Hahn in her chapter regarding the dementias (Chapter Thirteen) discusses these issues further.

## **A WORD ABOUT TERMINOLOGY**

Often a difficult task when writing a textbook is the choice of the terms to be used. It is important to define terms from the outset as different terms can mean different things to different people. There are a diversity of terms that can be used to describe people with mental health problems. Using any term can lead to labelling; Brownbill in his chapter considers the implications associated with using labels in his discussion on contemporary views associated with mental health and mental illness (Chapter Three).

A common expression that is often used within the NHS is ‘patient’, and on a few occasions this has been used in this text. It is acknowledged that not everyone supports the use of the passive concept associated with this term; it can emphasise the medical focus of the relationship between the person and the service.

The use of ‘client’ can have the potential to emphasise the professional nature of the relationship. Client and consumer have their roots in health care provision during the 1980s and 1990s, when market forces and consumerism were to the fore.

More recently, the term ‘expert’ has been used, the emphasis being placed on a participative approach, which acknowledges a person’s capacity to work towards their own rehabilitation. Experts are seen to be on a par with the experts who provide care, for example a nurse or doctor. This term values the views and experiences of the expert: the service user.

Not all people like the terms ‘service user’ or ‘user’; such terminology could lead to the grouping together of an otherwise diverse community of individuals with very individual needs. The term ‘user’ may also have some negative connotations

associated with it. It could be used to identify those who are involved in the use of illicit substances.

‘People with mental health problems’ is a term that has already been used in this introductory section. This is a broad definition that is often used by various agencies. In this context, it has the potential to acknowledge that many people can experience mental health problems and that those problems cannot necessarily be understood in terms of being an illness or a disease.

‘Survivor’ is a term that is relatively new and can be used to describe people who have experienced life events such as sexual abuse, torture, racism or sexual oppression. When used appropriately, it can empower the person. Often the term is used by self-help groups and other voluntary organisations.

This text uses various terms and aims to promote the care and support of those with mental health difficulties and mental health distress. The terms used here cover a wide range of experiences that may affect anyone at any time. There are many terms, which should be avoided, that will only result in stigma and prejudice, causal words such as ‘mad’ or ‘crazy’ must be avoided at all times. Try to listen to and respect the terminology that is being used by those who are experiencing mental health difficulties themselves.

The phrase ‘carer’ has been used on many occasions in this book. This term is used to describe those who look after others, whether they be ill, healthy or have a disability. ‘Carer’ has many interpretations and may refer to a professional health care worker or to an unpaid relative, friend or volunteer providing care. It has been estimated that there are approximately six million unpaid carers in the UK (Carers UK 2005); this figure includes parents, grandparents and siblings who are looking after sick children.

## THE CHAPTERS

It has already been stated that this text does not attempt to address every aspect of mental health care. The chapters have been arranged in order to provide insight into the complexities of providing care to those who may have a mental health problem. This book endeavours to provide the reader with a straightforward understanding of some of the issues that may impinge on an individual’s well-being.

Chapter Two sets the scene and places mental health care in an historical context. The history of mental health care is brought up to date with a discussion of contemporary philosophies and ways of understanding the complex phenomena associated with mental health and mental health illness. Chapter Three considers the various perspectives regarding mental illness. The chapter includes a discussion of the models of mental health care that can be used and also the effects these may have on an individual’s well-being.

Chapter Four considers the importance of partnership working within mental health care. The health care worker never operates in isolation, he or she is a part of a multidisciplinary team, and effective communication within this team

is vital if the best quality care is to be provided. Caring for the person with mental health problems can sometimes be challenging, and those working in the mental health arena must liaise with a range of health and social care professionals from various statutory, independent and voluntary agencies. Those health and social care professionals and their roles are described.

Mental health promotion is primarily concerned with how individuals and communities can enhance and influence the mental health of the nation. Chapter Five identifies how emotional resilience can be enhanced to enable an individual's positive sense of well-being, promoting dignity and worth. Mental health promotion takes place in various settings, and the application of mental health promotion in some of these settings is discussed. Fulfilling an individual's health potential is central to care, and this chapter discusses various health-promotion strategies.

In Chapter Six, issues concerning the law, ethics and morals are discussed. Insight into some of the key statutory legislation that governs mental health care is provided. In addition, the chapter is designed to enhance the reader's understanding and knowledge of the legal ramifications of working with people with mental health problems in order that they may be able to confidently approach this work.

Chapters Seven to Thirteen provide the reader with insight and understanding associated with a number of common presenting mental health problems. These chapters also outline the potential interventions required. Generally, the aetiology, prevalence (if appropriate), presenting features, care and management of various mental health problems are outlined. Consideration has been taken to steer away from labelling as well as using a medical model approach. A holistic, individualised approach is advocated by the authors of these chapters.

Approaches associated with mental health care are described in Chapter Fourteen in an attempt to explain how carers can help the individual, a therapeutic/helping approach is advocated. The care planning process is outlined; effective communication and interpersonal skills are central to practice. The chapter explores various types of intervention – from medical interventions to psychotherapeutic ones and art therapies, such as dramatherapy and art therapy – as well as discussing the role of the service user's family.

We have endeavoured to provide you with an interesting, informative and up-to-date snapshot of mental health care. We have enjoyed this challenge and hope that you find the chapters interesting and thought-provoking, and, most importantly, we anticipate that the care and support you provide will be enhanced as a result of your learning.

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## 2 History of Mental Health Care

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S. CLOUDSDALE

### INTRODUCTION

This chapter aims to examine the history of approaches and change in attitudes towards those living with mental illness. It will examine the treatment based upon these approaches and will consider provision of care within societies over time. An historical account related to the elements of mental health care provision is also included.

The question that must be addressed is: 'Have attitudes to those living with a mental illness changed over time and has the treatment (from the general public as well as health care professionals) changed accordingly?' The change in attitude, from a harsh to a more accepting view of the plight of the mentally ill, dictated how those with mental illness were viewed and how they were treated. This is linked to what people regarded as being abnormal or mad in a given culture or at a given time. Attitudes change and values change with them; not many in Western society will care very much if people go about almost nude on the summer beaches; however, attitudes even 50 years ago would have been very different and most people would have been outraged with present-day behaviour. The important thing here is that society's views as to what is acceptable in relation to dress have changed and attitudes to what constitutes appropriateness of controlling dress codes will have changed also, and so it is with attitudes towards those living with mental health problems.

Society's attitudes towards those living with mental health problems are guided by the prevailing and accepted explanation for causes of such behaviour.

### ANIMISM AND RELIGIOUS EXPLANATIONS

In primitive or pre-modern societies, the belief that everything has a 'soul' or 'spirit', even inanimate objects, is called 'animism'. Primitive people would have tried to explain the natural phenomena around them in terms of spirits acting upon the person and causing the events they were trying to explain. This explanation held for mental illness, or 'madness'. The explanation was that some form of spirit had taken possession of the afflicted person and was causing them to display the bizarre behaviour that was being witnessed (Rosenhan & Seligman 1995). The invading

spirit was viewed as being parasitic and was to be removed as any other parasite. Some of the physical interventions included the use of 'trephines', where holes were made in the skulls of affected people to enable the 'spirits' to leave the body of the person.

The belief was that people could be possessed by all manner of spirits: those of ancestors, animals, gods or those that the person had wronged. The view was that the person may or may not be to blame for the position they were in; and the services of helpers such as shamans or witch doctors were necessary to alleviate the symptoms of the demonic possession and ultimately to expel the unwelcome spirit (Douglas 1970). It is important to note that the bizarre behaviour sometimes demonstrated was tolerated within limits. A reason for this may be that madness was an example of what the gods could do to you and so the common view was 'who are we to punish you further?' It was also the case that many people resorted to sorcerers and witches to procure potions and spells. The classical world institutionalised sooth-saying and oracles in the form of temple religion with a pantheon of gods. The intervention of these gods was seen as the main explanation for the symptoms of madness; moreover, these symptoms, such as hearing voices, were seen as evidence of divine favour in some societies, and the affected person would have found a role that was valued by that society.

With the advent of Christianity, the position of the mad within society deteriorated. The Church would allow no avenue into the supernatural world other than by its own strictly controlled rites, and any person who seemed to possess an illegitimate and special insight into the beyond (some mentally ill people seemed to be in this category) was to be condemned as being influenced by demonic forces (Ellenberger 1970).

The rise in the view that the mentally ill were demonically controlled coincided with terrible upheavals within the Church in the sixteenth century. The Protestant reformation was a disruption that smashed the social equilibrium that had prevailed for centuries (Trevor-Roper 1970). It was within this disrupted context that the belief in the malign influence of witches flourished. The Church had considered witchcraft to be an 'illusion' at one time, but now it was viewed as a heresy and punishable by death. There were handbooks to help the religious authorities find these witches; the most famous is *Malleus Maleficarum*, which means 'hammer of the witches', which was published in the late fifteenth century by two Dominican monks, Sprenger and Kramer (Summers 1971). This document helped the religious authorities persecute thousands of people, mostly women, who did not fit into the changing structures of European society.

The mentally ill were especially vulnerable, largely because their experiences were in some cases quite bizarre and unintelligible to those investigating them. If asked if they thought they were hearing voices from another world, the person would probably answer 'yes' and thus condemn themselves.

A conservative estimate is that from the fifteenth to the seventeenth centuries about 100,000 people, mostly women, in Europe and in the American colonies were put to death as a result of this persecution (Deutsch 1949). How many of these people were mentally ill, it is impossible to know with any accuracy; however, it

must be remembered that it was not normal behaviour that brought these people to the attention of the authorities.

As was stated at the beginning of this chapter, the treatment that the mentally ill received was dependent on the prevailing view regarding its causation. Those who were thought to be possessed by demons underwent various forms of exorcism, where these spirits were supposed to be driven from the body of the victim. If this was unsuccessful, casting the person out of society or ostracism was the next step. However, once the affected person was in this position they were vulnerable to the full terrors of the Church.

## PHYSICAL EXPLANATIONS

Alongside the supernatural explanation for abnormal behaviour, there has been a long history concerning the physical causation of mental illness. The evidence concerning trephining in ancient Egypt is an example of how a physical intervention could help to alleviate mental distress, albeit from a supernatural cause. The most notable example of a physical cause being ascribed to a mental illness is contained in the explanation of hysteria. Early Greek physicians took the view that the epileptic-type seizures and complaints of anxiety, dizziness, paralysis, depression, blindness and physical disability were caused, in women, by a wandering uterus.

These physicians believed that the uterus could become detached from its usual place and move about all over the body. The uterus was thought to attach itself to places and organs in the body and thus affect the body's ability to function effectively. If the uterus were to attach itself to the liver, the woman would lose her voice; if it moved to the chest, it would cause convulsions and epilepsy (Rosenhan & Seligman 1995). This view held for many centuries; however, the Roman physician Galen (second century CE) alleged that the uterus was not an organ that wandered about the body like a separate animal but rather that it was a stationary sex organ that became inflamed, and that this was the cause of the symptoms of hysteria. Galen suggested that mental distress had a sexual origin in both women and men. He came to this conclusion after observing that both men and women suffered similar symptoms after sexual abstinence; the view that some mental distress has a sexual origin is one that has survived to this day (Veith 1965).

For the most part, physical explanations settled on an 'animalist' point of view. This maintained that because animals and some mad people were not in control of themselves there were similarities between them, and the most obvious similarity was that both lacked the power of 'reason'. This view allowed people to treat the mentally ill in much the same way as they treat animals, i.e. without restraint and cruelty. The mentally ill person could be kept in strict and miserable conditions:

The ease with which certain of the insane of both sexes bear the most rigorous and prolonged cold... On certain days when the thermometer indicated... as many as 16 degrees below freezing a madman could not endure his wool blanket, and remained

sitting on the icy floor of his cell. In the morning, one no sooner opened his door than he ran in his shirt into the inner court, taking ice and snow by the fistful, applying it to his breast and letting it melt with a sort of delectation. (Foucault 1965)

The development of more modern medical approaches pointed to a more enlightened view of mental illness. The view developed, in the nineteenth century, that mental illness was a disease of the body and, therefore, could be treated as any other physical disease. Present-day pharmacology echoes this transition towards a more humane and medical model of treatment.

Most treatments for mental distress before the late eighteenth century, from a physical perspective, were based on the concept of the four humours:

- blood
- black bile
- phlegm
- yellow bile.

It was thought that these four fluids had to be in equilibrium to preserve a person's health, both physical and mental. If any one of these fluids predominated, the person would fall ill. The physician would seek to bring the person back into equilibrium by relieving the body of the excess fluid. This mostly involved bleeding the person by opening a vein or purging the person by administering either an emetic to make them vomit or an aperient (enema) to purge their body of impurities. The mentally ill were subjected to this form of treatment and it was found that those who were excitable or raging could be made calm by copious bleeding (Rosenhan & Seligman 1995). However, those who could not afford such physical treatment, the majority, were cared for by their families as best they could.

## PSYCHOLOGICAL EXPLANATIONS

The ancient world had views on the psychological nature of the origin of some mental illnesses. Through observation, Galen found that thoughts alone could have an effect upon the body; for example he found that the pulse rate could be affected by thinking about emotionally charged situations – such as being in battle or thinking of one's lover. However, this approach was forgotten for centuries until it revived in the middle of the eighteenth century. One of the first to put forward a purely psychological interpretation of mental illness was Franz Anton Mesmer (1734–1815). Mesmer put forward the notion that many instances of mental distress could be explained by reference to 'universal magnetic fluid'. This 'fluid', which was invisible and impalpable, flowed through the human body. Its obstruction was the cause of the symptoms of hysteria, depression, anxiety and loss of reason. The universal magnetic fluid was later called 'animal magnetism'. Mesmer worked in Paris in the 1770s where he provided 'clinics'; at these clinics, people gathered around