The Helping Profession: Is It Really Helpful?

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The role of medical and psychiatric social work in dealing with the mentally ill has been considerably enhanced due to the community mental health movement. What is the role of the social worker? How adequately are they trained for handling their task? In this article the author, herself a trained social worker, addresses these questions and presents a critique of psychiatric social work programmes as they exist today in the context of the Indian situation.

IT is generally accepted today that the causative factors for mental ill health are multifarious and interlinked and so their handling on many fronts—curative, preventive and promotive—is done by a multidisciplinary team. Traditionally, and till today, mental ill health has been seen as an illness in a clinical sense, and so the doctor is the person with whom the mentally ill person comes in contact for treatment. But increasingly, and cardinally, through the influence of developments in this field in the west, other professions have been roped into the field of mental health. Psychiatric social work is one such profession.

Who is helped through the intervention of social work, the "helping" profession, in the field of mental health? What were the roles assigned to it historically, and how have they changed to fit the mental health situation in India today?

Evolution and Contributions of Psychiatric Social Work

The concept of what constitutes mental health and ill health has always varied, and with it has changed the role of the social worker. The western practice upto late 19th century was to segregate the mentally ill persons in asylums, away from the mainstream of society. Since such persons were considered incurable, no psychiatric attention was given to them; social work intervention was also non-existent. By the end of the 19th century the understanding of mental illness in western society had changed considerably: mentally ill persons were now considered "sick" and various physical and psychological therapies were tried on them. The underlying assumption of such an approach was that people became mentally ill because of their inability to adjust to the pace and demand of urban industrialised life. Various theories citing psychological factors intrinsic in the "sick" individuals were put forward as the cause of their maladjustment; but whatever the understanding and the line of treatment, the end goal of the process was definite—the mentally ill person had to be treated such that he/she would be able to adjust back to society.

In the practical application of this conceptual framework there was tremendous scope for social work. Medical and psychiatric social work emerged in the USA and Great Britain in late 19th century because doctors there felt the need for a person who would supplement the service of medical care provided through hospitals. Social workers were used by them to get a more complete picture of the patient's background by providing psycho-social data about the patient. In India psychiatric social work started because Indian doctors had gone abroad and had seen psychiatric social workers and wanted them to act as "acolyte" to the high priest, the doctor. (Marulasiddaiah and Sharriff, 1981).

Right through the sixties, in the west, the treatment of the mentally ill was predominantly individualistic, institution-based and curative; this is the approach which is prevalent in India today. The role of the social worker was to understand the behaviour of people when they are (mentally) ill, the potentialities within individuals and their families, the resources in the community, the environmental effects associated with the disease, creation of insight into their problems, to bring out a social diagnosis and to suggest means of treatment together with physical and other psychological methods which would help them *revive their strengths and become active citizens* (emphasis mine) (Marulasiddaiah and Sharriff, 1981). In other words the social worker used all possible means and resources to help the person adjust to the very conditions which caused the problem. Through experience, social workers realised that other social groups to which the mentally ill person belonged, like the family and the work group, could also be used in the process of getting the person readjusted. Thus emerged treatment methods like family centered therapy and milieu therapy.

By the seventies there was a growing disillusionment with the person-centered, curative approach. Individual care in helping the mentally ill person to adjust was time consuming, expensive, and its results were seen only after a long period of intervention. Community based mental health services were seen as an alternative. In this approach like the earlier individual-centered one, the basic understanding of mental health had not changed; the contributions of social conditions—growing alienation, pressures of urban competitive life, erosion of traditional community support systems—to mental ill health were not acknowledged. Mentally ill persons, those who deviated from the norms determined by society, still had to be adjusted to fit into that society. The difference was that the adjustment would start with the community, would focus on preventive measures and would reach out to more people by training people from the community as frontline mental health workers. For the social worker the essential difference was that instead of treating the individual as an unit of work, the community became the work unit. Her major role would now be to provide psycho-social data about the community, and to plan programmes to prevent mental illness, programmes which includes recreation facilities for adolescents, family life education, and so on. Since the community health movement has not gained much ground in India, there are not many community based mental health programmes. Activities like organised recreation activities for children, fun fairs and sports days which are organised by social work agencies for disadvantaged groups usually go under the garb of community mental health programmes. These programmes may temporarily divert the attention of the people from their problems of daily living but they do nothing to alleviate them.

Though the role of the psychiatric social worker has changed through various approaches to the treatment of mental ill health, her contribution to society has remained the same: to identify mentally ill persons, to treat them in a congenial manner through social work techniques, to resocialise the person to the requirements of society, and if such resocialisation is not possible, to segregate the person from society so that other normal people are not disturbed in their daily functioning. In fact, the social control aspects of the job generally remain in the background, and what emerges for the mentally ill person and the public at large to behold is a gentle, caring woman (psychiatric social worker) whose entire function is to be at their service and to look after their problems. Most medical and psychiatric social workers are women; other specialisations of social work like community development or criminology are considered the male domain. Medical and psychiatric social work

is probably seen by most people as an extension of the traditional role assigned to women as the caretakers of the sick and helpless members of the family. Moreover, traditionally, the woman bears the responsibility of socialising the child and psychiatric social workers, as an extension of this traditional role, resocialise the mentally ill person who has lost the social skills which are necessary to survive in an industrial, competitive world. Thus through their legitimately assigned task of labelling (diagnosis), treating and/or confining persons with deviant behaviour, the psychiatric social workers perform a subtle and sophisticated form of social control. Her efforts to identify and change the stress inducing elements inherent in the way society has been organised are negligible. The present day social work education programmes are partly responsible for this state of affairs.

Psychiatric Social Work Training Programmes

Entrants to the field of psychiatric social work are trained for the profession through a two year course, generally conducted at the post-graduate level. Some schools of social work in India offer specialised training in medical/psychiatric social work. At such schools, in the first year students are taught basic courses in the methods of social work, human behaviour, man and society, and some electives. It is in the second year generally that courses related to the specialisation are taught. These usually include courses on psychiatric information for social workers, courses on methods of social work used by psychiatric social workers—mainly casework, or working with an individual and his family—and concepts from different schools of thought, like Freud, Rank and Parsons which have practical use in casework. Much of the theoretical base and action of medical and psychiatric social work is derived from Talcott Parsons' model of the sick role, in which, sociologically, illness was seen as a form of social deviance where an individual adopts a specific role. The sick role was characterised by the patient's temporary exemption from social responsibilities, and freedom from blame for being sick. However, since the role was considered undesirable and socially not approved, the sick person was expected to seek professional help to get well, and to comply with the treatment prescribed by the medical personnel. Though Parsons' model of the sick role provides the basis of work for the psychiatric social worker, in terms of treating mentally ill persons and getting them back to perform their socially defined roles, it also is a legitimisation of the power of mental health personnel over mentally ill persons who have to comply with the treatment of the professionals in order to have the label of social deviant removed. In the theoretical part of the training most emphasis is given to casework than on any other method of social work. In casework the focus of content is on various theories which explain human behaviour and which therefore help the psychiatric social worker understand, arrive at a social diagnosis and plan out the treatment of mentally ill clients. Thus these courses tend to stress psychiatric analysis of individual problems rather than skills in dealing with the core of the problem situation itself. They are also institution centres and stress the remedial aspects in mental health (Miranda, 1985). At the level of theoretical training mental health is not seen in its wider sense with contributions from other courses on social work methods. Specialisation courses are so compartmentalised that students of psychiatric social work generally cannot take courses offered by other specialisations like community development or family welfare, even though the information content of these courses may be very relevant for the psychiatric social work student to develop a holistic understanding of her field of training.

Field work is the practical component in the training to become a psychiatric social worker. Field work experience, in which the student is attached to various social work agencies for two or three days per week for the entire period of the training, is largely limited to institutional urban settings like child guidance clinics, mental health day care centres, and psychiatric departments in wards of urban hospitals. Here the student gains maximum experience in casework or in working with individuals who are diagnosed as mentally sick. Any experience in community mental health is usually unplanned and incidental. It is expected that when students become practitioners they will be able to transfer their skills to other settings. This never really happens. In field work students spend more time learning about the "what" and the "how" in field work tasks than in engaging in the "why" or analytical and conceptual learning (Miranda, 1985). Hence, students are more bothered about what are the symptoms and how to counsel a mentally ill person than in understanding why he has been labelled as sick, and what were the forces in his immediate and extended environment which caused him to behave in a different way than is normally expected.

Field work is critical learning experience for the social work student because this is the period when her concepts about the practice of the profession are being formed, based on her practical experiences; she is also trying to work out her professional role as a social worker. Relating theory to practice becomes the major learning activity in field work. When theory and practice focus exclusively on the mentally-ill person and on his treatment so as to get him resocialised and readjusted to the demands of society, it is inevitable that by the end of the training period the student social worker has equated working on treatment and rehabilitation of mentally ill persons as the main role assigned to her. She in turn becomes a practitioner and carries on this tradition.

Relevance of Training

Observing the practice of psychiatric social work today, it would appear that the effectiveness of the training is limited to the time tested casework method. However, as Desai (1981) says, the effectiveness of a profession depends on the quality of preparation of the practitioners. The objectives of the curriculum in social work training are to prepare the type and quality of manpower capable of performing tasks and functions which ultimately achieve the goal the profession has set for itself in the context of the society in which it seeks to serve. Desai analyses and lists the social realities of India as poverty, population and its interface with problems of housing, water supply, sanitation, accessibility to services; unemployment, disability resulting from social and economic inequity, and the exploitation of the vulnerable and weaker sections of society. Constant coping with these problems could lead to a breakdown in an individual's mental health functioning. Therefore the tasks of the (psychiatric) social worker would be to identify policies and socio-economic structures which are exploitative of the majority and which are not designed to achieve social goals for all. A second major role would be to develop and/or modify services and/or institutional structures for educating people to recognise their inherent capacity for action. By and large psychiatric social workers do not perform these roles because neither at the training level nor at the practice level has it been consciously realised and acknowledged that it is these societal problems of daily living which are contributing to the mental ill health situation in India.

The present day training programmes do not address these tasks. The training curricula are basically borrowed from the west, mainly the USA. They aim at helping people adjust to an urban, industrial and metropolis dominated social milieu—because Indian social scientists accept the western model of

development for the elimination of poverty. Social work was established to help the deviants of the system to adjust to it and to provide remedial services to those who are victims of new social systems (Desai, 1981).

The training and practical efforts of psychiatric social work is relevant; to whom it is so is the question. If serving the needs of the majority of the population in order to bring them into the mainstream of development is the goal of social work, then the training for psychiatric social work, particularly the knowledge about what constitutes mental health and mental ill health, the skills in treating mentally ill persons based on the understanding of what constitutes mental health, and the values embedded in such an interpretation are not relevant to the majority of the people, not even particularly to the mentally ill. Social workers have not been able, in any significant way, to work out strategies to deal with the daily problems of living of the majority—problems which take their toll in terms of familial tensions, and mental ill health. What the professions involved in mental health have successfully done is to medicalise social problems, to make it appear that problems stemming from social causes are actually due to individual deviance, solvable or at least controllable by the individual's doctor (and others involved in the therapeutic process) (Ehreinreich, 1978). Psychiatric social work, in this sense, is very relevant to the powers that be; through the semblance of a profession based on scientific knowledge, which helps deviant people adjust, it ensures that the way society is presently organised is maintained.

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UN List of Banned Products

LAST June, the UN decided to delete all trade information from future editions of the "UN Consolidated List of Banned and Severely Restricted Products", an international directory of trade and regulatory data on over 500 products contributed by 60 countries. Just this week, the UN announced its intention to reverse that decision. The reversal came after months of lengthy debates on the issue within the UN in a highly politicised atmosphere. Ultimately, reason pre-vailed over pure politics and the public interest perspective—including trade data—emerged as the only rational solution to the debate. The 1986 edition will include trade data and the unique trade name index for pesticide and pharmaceutical products.

Hundreds of very thoughtful letters from the NGO community were in a large part responsible for allowing the debate to occur at all and for eventually helping to turn the decision in the direction of including trade data. While opposition to the mere existence of the 'List' has clearly diminished over the past several years, it has not disappeared. At the present, claims are being made that the 'List' is not really useful to governments, but is only a duplication of other efforts at information sharing laready in place in other UN agencies.

The United Nations is currently preparing its report on the Consolidated List Project for the Economic and Social Council (ECOSOC) meetings to be held in July. The office preparing the report would like to include examples of instances where the List has been useful to governments. The UN has recently written letters to countries in order to collect that information from them.

NGOs could be helpful in supporting the UN effort to collect data on the List's usefulness in a number of ways:

1 Encourage your government to reply to the UN's request for information. The UN has sent requests for information on the 'Lists' usefulness to World Health Organisation correspondents, United Nations Environment Programme correspondents, and the United Nations Development Programme's Resident Representative in all countries, and have asked those Reps to contact government officials for that type of informaton.

2 Contribute your own examples of how your organisation has used the List to bring about positive changes in laws or practices in your country. Brazilian groups, for instance, have used the UN Consolidated List in their efforts to persuade their government to severely restrict certain very dangerous pesticide products. A British organisation has reported that it has found the List very useful in its work with the United Kingdom's Food and Environmental Protection bill.

If you do send data on positive contributions of the 'List', please try to make your descriptions as specific and as well documented as possible. For example, it would be helpful to include the date of any legal or administrative action taken and a copy of the actual taxt of the law with your description of the action. If it is impossible for you to collect background documents, but you know of an action that has been taken as a result of the UN 'List', please report it anyway. Background can be collected later, if needed. All information must be received by May 15, 1986, it is to be included in the UN's format report for the Economic and Social Council. The UN address is: Assistant Secretary General, United Nations, DIESA-PPCO, 18th floor, New York, New York 10017; USA. Also, please send a copy of all correspondence to us for our information.

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