Social Work Education on Mental Health: Postmodern Discourse and the Medical Model

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This article provides a pedagogical approach to presenting alternatives along with the traditional medical model in the context of mental health treatment and service provision. Given the current influence of the medical model in community mental health, this article outlines a rationale for challenging the model and considering alternative models and/or interpretations of severely disordered behavior. The first premise of this approach, that social workers need to avoid having the deficit-based, problem-saturated, and pathologizing language of the medical (or any other) model dominate their practice, is inherent in all strengths-based approaches to practice. The second premise, that one can utilize the postmodern language of narrative therapy to constructively discuss alternative approaches, expands on previous social work contributions in this area.

KEYWORDS   narrative therapy, mental illness, psychopathology, medical model, postmodern

INTRODUCTION

According to Pardeck, Murphy, and Chung (1994), Hartman first brought the philosophy of postmodernism to social work's attention, focusing on how vocabulary used in the classroom shapes the Weltanschauung of budding practitioners. From a postmodern perspective, the meaning of words used in discourse shapes the way an individual views the world (Hartman, 1991;

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Parry & Doan, 1994). This article aims to expand previous discussions on postmodernism in social work by applying postmodernism and concepts from the postmodern school of narrative therapy to social work education on mental health.

For several decades in the U.S. and British mental health arenas, consumer activists and psychiatric survivor groups have consistently highlighted pathologizing and stigmatizing aspects of the dominant medical model, and they have emphasized a need for alternative conceptualizations and vocabulary (e.g., emotional distress rather than illness diagnosis, recovery rather than chronicity or maintenance; Chamberlin, 1990; Everett, 1994; Hellerich, 2001; Stastny & Lehmann, 2007). The meaning of words and the dominant discourse used in mental health practice settings, therefore, would seem to be critical from the consumer as well as from the postmodern perspective. Consumer feedback, always important for social work practice and practitioners, becomes even more important when it conflicts with dominant sociocultural narratives—as it does with the medical model of mental illness. Given the influence of the medical model on psychiatry today, this article first provides a rationale for challenging the vocabulary of that model in the classroom and follows this with a review of postmodernism. The traditional medical model consists of diagnosis, treatment, and cure or management of disease, and this framework is used as a basis for the discussion. The vocabulary of narrative therapy is then presented as language that can be used to consider alternative models and/or interpretations of severely disordered behavior, thereby generating alternative discourses and facilitating increased cultural sensitivity in mental health venues. This is particularly important in the United States, where social workers provide a majority of mental health–related treatment and services for individuals diagnosed with major mental disorders such as schizophrenia (Brekke & Slade, 1998).

RATIONALE

Social work education emphasizes a biopsychosocial ecological systems approach to practice that is both strengths based and client centered. Once in the field, however, social workers in U.S. mental health settings are exposed to the medical model and its primary focus on somatic treatments (e.g., neuroleptic medications, electroconvulsive therapy; Casstevens, 2007). Diagnosis, documentation, billing, and reimbursement procedures reinforce this model's deficit-based conceptualization of illness/disorder and treatment. The State of California represents a developing exception to this otherwise prevalent model in community mental health: Subsequent to the recent passage of Proposition 63, social work training in mental health in California has shifted to focus on the new peer-recovery model endorsed by consumers.

Service provision reimbursement whether by Medicaid, Medicare, or private medical insurance provider generally requires a formal psychiatric diagnosis, and education for graduate-level social work students reflects this: Master of Social Work curricula include material on the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 2000) diagnostic categories. In addition, students are taught how to use *DSM* diagnostic categories in clinical diagnosis, despite disagreement on the role of the *DSM* in the classroom (Kutchins & Kirk, 1995; Williams & Spitzer, 1995). This is the case despite ongoing professional concern about the validity, reliability, and usefulness of many *DSM* diagnostic categories (Boyle, 2002, 2006; Kutchins & Kirk, 1997; Stoll et al., 1993; Tomm, 1990), concerns often highlighted in Master of Social Work classrooms.

The medical model operationalized in the *DSM* fourth edition text revision (American Psychiatric Association, 2000) minimizes cultural and person-in-environment components of severe mental disorders, as did the earlier *DSM-IV* (American Psychiatric Association, 1994; Kutchins & Kirk, 1995). The recent shift in psychiatry toward a recovery paradigm for mental disorders (e.g., Andresen, Oades, & Caputi, 2003; Jenkins & Carpenter-Song, 2005; Padgett, 2006/2007) even among medical model adherents (e.g., Noordsy et al., 2002) highlights the *DSM*'s lack of emphasis on the nonbiological factors associated with mental "illness." Despite paradigmatic shifts embodied in the aforementioned Proposition 63 in California, and in currently funded National Institutes of Health mental health–related research, it remains to be seen whether the recovery paradigm will be absorbed into a medical model framework (as has happened with some cognitive behavioral therapy of psychosis literature; e.g., Nelson, 1997). If this does not occur, the recovery paradigm's focus on hope, taking responsibility and control, and rebuilding or "getting on with" life, as key components of an ongoing process of recovery, will continue to contrast with the traditional medical model's emphasis on symptom management.

Exploration of treatment alternatives is all the more important given recent research on neuroleptic medication (specifically, antipsychotics) that highlights the neurological effect of long-term medication use (Lieberman et al., 2005). In addition, prescription drug cocktails (i.e., polypharmacy) are now the norm, yet they remain essentially unstudied (Lehman, Carpenter, Goldman, & Steinwachs, 1995; McCue, Waheed, & Urcuyo, 2003). Potential drug interactions are not necessarily known or understood, the possibility of increased neurological damage (e.g., tardive dyskinesia) from cumulative dosages of multiple drugs is seldom considered, and residual long-term physiological responses to drug cessation (i.e., withdrawal that may include tardive psychosis) confound assessment of responses to additional medication(s) prescribed (Cohen, 2002). Failure to explore alternative approaches to treatment is no longer an option for ethical professionals in mental health–related disciplines (Cohen, 2002; Jacobs, 1995). With the medical model

emphasis on somatic treatments (e.g., neuroleptic medication) in Western psychiatry, it is perhaps unsurprising that developed countries report some of the poorest long-term outcome data for major mental disorders (Hopper, Harrison, Janca, & Sartorius, 2007). It is critical that social work educators provide a basis from which budding social work professionals can assess and examine mental health–related input they receive in the classroom and in the workplace. Postmodern discourse and the language of narrative therapy can provide such a basis and are subsequently presented in this context.

POSTMODERNISM

Postmodern thinking developed in the mid-20th century as a reaction to modernism, which in turn was a product of the late 1800s. If modernism seeks to identify observable, replicable phenomena as really real and truly true, postmodernism declines to acknowledge any one true phenomenon, instead considering individualized perceptions of it. Modernism celebrates the outside observer–scientist as an expert on truth, whereas postmodernism embraces the multiplicity of various internal and subjective worldviews. Postmodernism replaced linear, logical, reductionistic thinking, hallmarks of modern science and philosophy, with systemic, subjective and holistic thinking. As it developed, postmodernism looked at language, or discourse, and systemic interactions in new ways: Language is viewed as a tool of oppression, such as, for example, those who do not speak the language of a culture but live within it are—quite simply—oppressed.

Sigmund Freud's was a voice of modernism: He listened for an individual's narrative and then assumed an expert role to interpret this narrative within the "truth" of the psychoanalytic paradigm. As Parry and Doan (1994) put it, "What Freud gave with one hand he took back with the other, and virtually the entire succeeding field of psychotherapy followed him. The therapist became the expert on each client" (p. 8). Psychotherapy followed the examples set by psychiatry and medicine in this respect, subjugating the client's voice to that of the expert. (At the same time, ironically, Einstein's theory of relativity and Heisenberg's uncertainty principle cast doubt on the very possibility of scientific objectivity.) Family therapy, developing in the mid-20th century, used a systemic perspective, but it remained firmly modernist until Maturana's biologic notion of structural coupling was introduced through his work's influence on Tomm, among others. White and Epston (1989) took this further and incorporated Foucault's ideas about power as ubiquitous in human interaction into family therapy (Parry & Doan, 1994). With this final step, the narrative approach to family therapy moved into postmodernism and developed a capacity to identify and respect a multiplicity of differing individual narratives within a family. Strengths-based

family-centered social work practices also have this potential (e.g., Pennell & Anderson, 2005; Petr, 2004), as do solution-focused therapy approaches (Becvar & Becvar, 2006).

THE LANGUAGE OF NARRATIVE THERAPY AND ALTERNATIVE DISCOURSE

White and Epston (1989) presented language as power, emphasizing that individual narratives can be and often are "subjugated to serve the dominant discourse, which comes to define a culture and maintain a status quo" (Parry & Doan, 1994, p. 17). In the context of science, Kuhn (1996) noted: "Sometimes a normal problem, one that ought to be solvable by known rules and procedures, resists the reiterated onslaught of the ablest members of the group within whose competence is falls" (p. 5). This is generally the case with the culturally dominant discourses that may be considered "grand narratives" or even "meta-narratives." Meta-narratives provide commonalities across cultures that may be found, for example, in narratives of religious traditions and scientific paradigms. Familial and culturally dominant discourses can combine and reinforce one another to constrain alternative individual narratives, such that the development and/or emergence of these narratives are inhibited or even prevented.

The first step in breaking the constraints of familial and/or culturally dominant discourses, according to narrative therapy, is to "externalize" the problem. Separating an individual (often identified as "the problem") from an actual problem in this way allows investigation of *unique outcomes* defined as "hitherto neglected or overlooked events or experiences in which the problem has not dominated the person" (Parry & Doan, 1994, p. 17). (These unique outcomes in narrative therapy are similar to the "exceptions" emphasized in solution-focused therapy, which has postmodern components.) Unique outcomes, once identified, can be supported and enhanced to recursively allow individuals and families to escape from dominant discourses that define people as the problem, rather than allowing consideration of the problem as the problem.

This is analogous to the situation mental health practitioners now face in the context of the medical model of "mental illness." The medical model is an extremely influential dominant discourse and can be considered a meta-narrative, as previously described. Within the medical model, people are frequently identified or defined as problems. This often occurs through labeling; for example, professionals when writing or speaking may refer to a person as "a schizophrenic" or "a borderline." Culturally dominant medical model discourse combines and reinforces individual professional narratives in psychiatry and medicine that tend to silence, or subvert the development of, alternative narratives both within and without these disciplines.

The very conceptualization of aspects of culture as dominant discourses, or narratives, that are made up of narratives coexisting within grand narratives or meta-narratives, is something students may not previously have considered. The first step, then, is to present these concepts and constructs in order to provide vocabulary with which to identify and discuss alternative, marginalized, individual and familial narratives or discourses in the context of power. This is relevant in mental health, where the dominant discourse is currently that of biological psychiatry, firmly supported by the meta-narrative of the medical model. In biological psychiatry, the client's voiced narrative may not only be marginalized: It may be discredited and discarded, restoried or rewritten by experts using the language of symptom labels and illness narratives (e.g., the expert often ascribes patient/client disagreement with prescribed treatment to "lack of insight"). To be heard, a narrative must not only manifest—it must be recognized and acknowledged.

The following is an example of a discredited client narrative: An adult mental health consumer told her case manager that her roommate, with whom she was having serious relationship difficulties, had returned to "shooting up." The consumer experienced (and consistently reported) chronic visual and auditory medication-resistant hallucinations. The case manager accepted that the consumer believed what she was saying about her roommate and took it as an example of a paranoid-psychotic thought process, given the roommate had no known history of drug use and staff had reported no behavioral problems other than the consumer's. The consumer's narrative was only recognized and acknowledged after her therapist's intervention, and it developed that the consumer's report was, in fact, correct. Previous allegations by the consumer that she was molested in the bathroom at her boarding home by a male resident had been similarly discounted. At this point, she was relocated to another facility while those allegations were explored (the boarding home closed shortly thereafter, for unrelated reasons). Students need to recognize that attending and responding appropriately to individual narratives is a vital part of the relationship between social worker and client. The dominance of the medical model's narrative in treatment settings must not be allowed to obscure a consumer's own story or silence a consumer's voice.

The medical model's narrative incorporates concepts: In the language of narrative therapy, it "informs stories" that include biogenetically based mental illnesses, symptom-oriented diagnostic categories, and psychopharmacological treatment interventions. Treatment settings frequently teach these stories to consumers and families and discuss story ramifications within the grand narrative of the medical model. Examples of these include the beliefs that (a) severe and persistent mental disorder diagnoses represent biologically based "illnesses," (b) psychotropic medications restore a biochemical imbalance in the brain, and (c) noncompliance with prescribed medication contributes to a deteriorating course of "illness." While each

of these stories has generated professional controversy, they pervade most treatment settings and are widely accepted among consumers and professionals as facts rather than as either myths or hypotheses (see Harding & Zahniser, 1994; Romme & Escher, as cited in Coleman & Smith, 1997, p. iii). Mental health staff and treating practitioners learn these stories through trainings and continuing education programs and then repeat them to mental health consumers and their families. This repetition is often referred to as psychoeducation and can be considered a component of mental health treatment (McFarlane et al., 1993). In effect, this means that psychoeducation propagates and reinforces the medical model as a dominant narrative, allowing the mental health treatment community to maintain and/or perpetuate an organizational status quo.

A practice example of how a postmodern approach to process with a client can potentially change outcome occurred in a weekly support group situated at a psychosocial rehabilitation program serving adults with severe and persistent psychiatric disorders. The group met each Monday for members' to share their weekend experiences and provide and receive friendly support for the upcoming week in program. The psychosocial rehabilitation program used a treatment team approach, and the Monday morning group leader (a clinical social worker) was aware that the program's staff had reported that one of the group members was extremely delusional recently during psychosocial rehabilitation activities, and staff had expressed concerns about his stability. During group, the gentleman (a White Latino in his late 50s who was a devout Catholic) shared about his morning swim and the sunrise over the ocean (the program was located on the East Coast and he lived with family a short distance from the beach). He then began describing the "Angels that came down, in clouds of glory—It was glorious, glorious, they were so beautiful, you could not believe . . ." and continued in this way, gesturing to emphasize the descent of the angelic host. Using a medical model perspective, the group leader might have identified (a) possible noncompliance with medication, and/or (b) the need for a psychiatric evaluation, as concerns. The leader could have acted on this and either inquired about medication compliance, or escorted the group member from the group room, down the hall to the psychiatrist's office by taking a short break from, or subsequent to, the support group.

Instead, the group leader respectfully interjected: "Excuse me, excuse— If I may ask?" (and "Yes, yes of course," came the response). The group leader subsequently asked, "How is your mother doing?" This was a follow-up to information given to the group the preceding week about the member's concern for his elderly mother with multiple health issues. He responded after a heavy sigh, "Oh, not good, not good. She had to go to the hospital this weekend. But she is home now with a nurse—I will go home early today to see how she is." He continued and articulated the medical problems involved with no further delusional content. In this instance,

the group leader's question loosened the familial constraint against negativity and allowed the member to address the distressing weekend experience. A fellow group member who had noted the group leader's intervention unexpectedly used this intervention 2 weeks later when the Latino gentleman again asserted that all was well and began describing a heavenly vision. The fellow group member's inquiry about the mother's health elicited a parallel response; the program staff reported no further concerns about psychiatric stability.

Deconstructing the medical model narrative into stories allows the stories to be examined and appraised in a relatively detached way. In the example just described, one story might have been that a medication evaluation and possible dosage adjustment were indicated to improve symptom management. The group leader did consider a medication evaluation as an option; instead of pursuing this, however, the leader first intervened to assist the member to examine an alternative story—one involving distress about a family crisis that occurred and the mother's ongoing poor health. This revisioning allowed consideration and construction of a nondominant alternative story or narrative, and a medication evaluation became superfluous.

Students may not previously have considered that organizational culture can endorse a dominant narrative to the exclusion of others, or even that stories exist within such a dominant grand narrative. With the language of narrative therapy, however, students can deconstruct grand narratives (e.g., that of the medical model) and are invited to consider coexisting nondominant narratives and their stories. Assigning students the task of generating examples of possible alternative narratives becomes a further step in the learning process. A wide range of diverging professional and/or individual narratives may result. The latter can include stories of trauma, abuse, and neglect previously discounted or unheard, because they remained unspoken in assessment interviews focusing on symptom presentation rather than on exploration of an individual's own story. They can include stories of exploitation and coercion by people and agencies or organizations possibly still within the individual's social network, including treating physicians, family members, significant others, boarding homes, social service agencies, and/or schools. Often such stories, if shared, are discounted because the teller is psychiatrically labeled and/or considered "crazy."

Class time permitting, material by Laing (1983), who argued the case for a strong environmental component to severely disordered behavior and Szasz (2003), who asserted that mental illness is a myth, can be introduced. More recent work by Mosher and Burti (1994) and Breggin (1991) can be considered, as these perspectives differ substantially from that of neo-Kraepelinian biological psychiatry, where relevant work includes that of Andreason (1984), Torrey (1995), and Torrey, Bowler, Taylor, and Gottesman

(1994). Biological psychiatry's resurgence in the United States followed the introduction of chlorpromazine and other major tranquilizers and culminated with the creation and publication of the *DSM-III* (American Psychological Association, 1980). The use of tranquilizers for restraint in institutional settings preceded federally funded community mental health centers and other federal policies that supported deinstitutionalization. A so-called revolving door of hospitalization, discharge to the community with prescription medication, and rehospitalization has developed and continues today, with supplemental community supports and services available to a greater or lesser extent in any given area; Whitaker (2002) provided an excellent historical overview of this material. Deconstructing the political history of psychiatry in the United States (again, time permitting) can be an instructive project.

Much has been written in support of both sides of the etiological nature versus nurture divide for major mental disorder diagnoses, and students can identify and describe the differing narratives of diagnosis, course, and prognosis that each represents. In this context the stress-vulnerability model (Zubin & Spring, 1977), which incorporated environmental stressors and biological vulnerability in diagramming schizophrenia relapse, can be explored, as can the more broadly applicable social model (Tew, 2002). The Soteria project's treatment of first episode psychosis, postcrisis, with minimal or no antipsychotic medication (Aderhold, Stastny, & Lehmann, 2007; Bellion, 2007; Bola, Mosher, & Cohen, 2005) is an empirically supported alternative approach. Last, the recently developed recovery paradigm (Andresen et al., 2003; Jenkins & Carpenter-Song, 2005; Noordsy et al., 2002) and its current niche in California social work education postlegislative approval of the so-called "millionaires' tax" can be investigated.

Pun, Jarrett, McGrath, and Kalyanasundaram's (2005) excellent series of vignettes can be used to compare a service-user empowerment perspective with the medical model approach to treatment in the context of schizophrenia. Pun et al. described how to use the series of vignettes they provide to stimulate discussion across a wide range of ethical and other issues. Originally developed as a training workshop for psychiatric residents hosted by a multidisciplinary panel that includes a mental health service user, the material is also extremely relevant for social workers.

CONCLUSIONS: CULTURAL SENSITIVITY TO NONDOMINANT ALTERNATIVE NARRATIVES

Social work educators must go beyond cultural sensitivity and challenge students (and practitioners) to become aware of the cultural lens through which they themselves view the world. That is, students need to learn to recognize and be aware of both their personal narratives and their cultural narratives.

Once this occurs, much that is initially and unquestioningly accepted as "fact" becomes only one way of looking at the world (e.g., Romme & Escher, 1989, 1996; Coleman & Smith, 1997, on "hearing voices"). The medical model's scientific perspective thereby loses its previously privileged position as the "right" narrative to use in discussing severe and disabling emotional distress. Further, it can be suggested that this model may not be the most helpful, constructive, or empowering narrative to use and it is at this point that alternative narratives can begin to be recognized and acknowledged.

Alternative narratives of mental disorders and associated experiences do not stop with Soteria House or the recovery model, or with service user efforts to avoid somatic treatment interventions. Other narratives, at least for psychotic experiences, include stories of spiritual growth processes, possession, and extrasensory perception or telepathy (Gosden, 2001; Kingdon & Turkington, 2005). These narratives can be grounded in grand narratives of religious, spiritual, and popular culture belief frameworks that students can consider with respect rather than derision or antipathy—working solely within the medical model can result in being told 6 months into therapy that "Of course I don't hear voices; that would be bad. God talks to me every day and helps me out." Remaining focused on the medical model can also result in overlooking alternative approaches to healing in which the service user may participate. These can include herbal remedies, meditation, prayer groups or rituals, and guidance from religious leaders, guides, gurus, or counselors. Religious leaders and counselors can be influential figures in a service user's support network.

Many students in the United States are raised in a predominately Christian culture, and variants of Christianity alone have disparate beliefs and practices about mental health and illness. Coaching and consultation can assist students to develop increased sensitivity towards and respect for disparate beliefs and practices. Discussion of these alternative narratives can and should originate in the classroom. In addition, the persistent tendency to apply an illness label to young people noncompliant with parental/familial values, beliefs, and behaviors is not unique to the United States (Gosden, 2001) and should be carefully considered. Last, competing cultural and religious narratives that can exist even within families need to be examined.

When working within a medical treatment framework, it behooves social workers to maintain an empathic sensitivity towards client narratives and worldviews. Educators can assist students through reading assignments, case examples, and role plays to consider alternative discourses and narratives of self and experience that may lead to recovery rather than maintenance, and empowerment rather than prejudice and stigma. Contextualizing theory and treatment approaches within modernism and postmodernism provides a potential framework for otherwise disparate and sometimes confusing models. Using the language of narrative therapy during class discussions and when exploring case vignettes can assist

students to develop the ability to talk and listen comfortably to different, and sometimes competing, narratives. Such discussions also provide students with practice in nonjudgmentally accepting and acknowledging a variety of narratives.

Social work students and practitioners need education about the shortcomings of both the *DSM* and the dominant medical model that it represents. Until these shortcomings are recognized and acknowledged, funding for debilitating somatic interventions (e.g., neuroleptic medications, electroconvulsive therapy) will continue to take precedence over environmentally supportive approaches (e.g., psychiatric clubhouses with transitional employment programs, the Soteria House model) and consumers will remain open to mistreatment and even abuse, as their voices and stories are subordinated to professional narratives. It behooves social work educators to take the lead in exposing students to alternative ways of thinking about and treating individuals who experience severe emotional distress.

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