

Changing conceptualizations of mental health and mental illness: Implications for “brain disease” and “behavioral health” for social work.

By: Melissa Floyd Taylor and Kia J. Bentley

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Abstract:

Conceptualizations of mental health and mental illness continue to be an important influence in shaping social work practice and education. By critically analyzing the emergence of the current concepts of “brain disease” and “behavioral health,” we are able to better understand the stakeholders in this renaming process. The inherent assumptions and the sociopolitical aspects of these two concepts are analyzed. Recommendations for social work practitioners and educators in preparing for a future in which they will participate more fully in the professional dialog about changes in the vocabulary of mental illness and thus more meaningfully shape the service delivery system in general, and the social work domain, in particular, are offered.

Keywords: mental illness | brain disease | behavioral health | conceptualizations of mental illness | mental health | social work

Article:

Social worker and well-known critic of the concept of “mental disorder,” Jerome Wakefield (1992, 1993) called for renewed discussion and critical analysis of the changing concepts we use in mental health practice. Kutchins and Kirk (1997), Caplan (1995), Chamberlin (1998) and Valenstein (1998) have also significantly contributed to the ongoing dialog about the meaning of language and labels in mental health and psychiatry. Such analyses are important because throughout history, shifts in the field’s lexicon and the concomitant conceptualizations of mental health and mental illness, have had significant impact on the nature and structure of mental health service delivery. Given our own professional prominence in that field (O’Neill, 1999), these ideas are a major influence on social work practice and education.

This paper offers a critical analysis of the concepts of “brain disease” and “behavioral health” in particular, both important contemporary exemplars of this conceptual evolution. Our analytical template consists of two dimensions. First, we will examine the *inherent assumptions* of each term, or the implications for etiology, personal responsibility, and self-determination, which

seem to underlie or be associated with each concept. Second, we will examine what we are calling *sociopolitical aspects* of both “brain disease” and “behavioral health.” Here we will address who “wins” and who “loses” in the rivalry among providers for control or dominance in the mental health field and what are the implications for families and consumers as important stakeholders in these conceptualizations. Both dimensions of analysis provide insight into how the use of these concepts helps to define specifically who should deliver services, who should receive them, what those services should look like, and where and under what conditions they should be delivered. Finally, we offer some recommendations for social work practitioners and educators in preparing for the future in which they will participate more fully in the professional dialog about changes in the vocabulary of mental illness and thus more meaningfully shape the service delivery system in general, and the social work domain in particular.

This paper has grown out of a desire to stimulate social workers’ criticism of emergent conceptualizations with an eye toward the implications for their practice and professional development. It is not our desire to draw final conclusions about the merit or utility of “brain disease” and “behavioral health.” Both can be seen as less problematic than older concepts of mental illness as “possession” or as a result of “schizophrenogenic mothering.” However, it is our premise that the meanings, assumptions and ideas that underlie the professional lexicon should be more fully and openly excavated, explored, and debated.

ANALYSIS OF BRAIN DISEASE AND BEHAVIORAL HEALTH

Brain Disease

In psychiatric circles and increasingly in the public eye, it seems a foregone conclusion that most of the mental disorders thought of as “mental illnesses” are related to abnormalities or dysfunction in the brain, such as dysregulation of neurotransmitters, the presence of large frontal lobes, lack of integrating functions in the central nervous system, or decreased blood flow or metabolism in certain regions of the brain. The list of disorders thought to be connected to such brain abnormalities seems to grow every day. While there is still lively debate, these include at the very least, schizophrenia, bipolar disorder, clinical depression, obsessive-compulsive disorder, and panic disorder. This emergence of “brain disease” to describe the most serious mental illnesses represents the convergence of several interrelated factors, including both planned and serendipitous discoveries about the efficacy of psychotropic medications. Additionally, it is likely also related to significant increases in resources for brain research and especially the improvement in technological sophistication for brain imaging. Research using such tools has uncovered much about brain chemistry, structure, and function and its relationship to behavioral functioning. Also essential to understanding the conceptualization of mental illness as “brain disease” is the disillusionment with theories of etiology that emphasized family interaction. These theories often assumed an otherwise normal child was somehow made to go “crazy” as a result of parental bungling. The full rejection of the older “family blaming” theories of the etiology of serious mental illness in favor of neurobiological explanations is certainly

within sight. Questions still remain about ultimate causes (genetic, viral, environmental, physiological) of the biological correlates of mental illness.

Inherent Assumptions. Thinking of mental illness as “brain disease” seems to fit squarely in what has been called the “medical model.” This model is often understood to mean that dysfunction, with whatever manifestation, is related to some physiological problem which can be accurately diagnosed by an expert who examines the “patient” objectively, and can then in turn prescribe some curative or restorative remedy, typically a medication. The medical model of treatment, despite having made tremendous contributions in the study and treatment of mental illness, has been criticized by proponents of the strengths perspective and empowerment approaches to practice (e.g., Rapp, 1998; Saleeby, 1996) because it traditionally relies on the assumption of a relatively passive patient who yields to the authority of a professional provider/physician in complying with whatever treatment is prescribed to treat the symptoms of the disorder.

Interestingly, mental illness as “brain disease” is reminiscent, theoretically, of the early definitions of schizophrenia as “dementia praecox,” where mentally ill people were also seen as suffering from a disease of the brain (Kaplan & Sadock, 1998). In these cases, psychosis was seen as having been caused by some known (like syphilis) or unknown virus or infection. An important difference between today’s conceptualization of mental illness as “brain disease,” and similar ones a hundred years ago, is around the notion of hope. In the dementia praecox days, mental illness as “brain disease” was associated with despair and professional impotence—a feeling that “there’s nothing we can do.” Indeed, part of the massive appeal of Freud’s psychosexual theories of etiology were related to inherent promises that disorders of the “mind” could be treated with psychological means. If one simply got enough analysis of the right kind, one could get better. In stark contrast, it is now the conceptualizations of mental illness as “brain disease” that seem to be associated with tremendous hope, this time for an eventual medical cure of mental illness. It seems the more “biological” a disorder is now thought to be, the more treatable it is seen to be, and thus the greater hope there is for a positive course or outcome, presuming the “patient” is “compliant” with treatment. On the other hand, severe emotional difficulties and personality disorders, still largely thought to be primarily psychological in origin, seem now to be associated with bleaker prognoses and poorer treatment success than biological disorders such as bipolar disorder, obsessive compulsive disorder, or Tourette’s Syndrome, all thought to be treated effectively with medication.

While self-determination and free will are complex issues and should not be oversimplified into polarities, it is our position that the conceptualizations of mental illness as “brain disease” and “behavioral health” *do* impact notions of personal responsibility that are interesting to explore. For example, mental illness as a “brain disease” does not require the person experiencing its manifestation to feel personally responsible for the actual *presence* of the problem, even if they may still be responsible for aspects of their recovery. An event or events outside the person’s conscious control and admittedly not fully understood has occurred due to chance or genetics, in much the same way pancreatic cancer, heart disease or multiple sclerosis strikes. Additionally,

mental illness as “brain disease” does not require the person’s family to take any blame for the illness of their offspring, except for the culpability of passing on a genetic predisposition. Thus, the increased acknowledgement of mental illness as brain disease may be due in part to the strong appeal this conceptualization has for families and consumers, especially when contrasted with older theories.

A darker aspect of the “brain disease” conceptualization is seen through this very notion of consumers not being able to “help” having a disease being equated with an inability to have insight into their current symptoms or circumstances. The model has been used to call into question a consumer’s capacity, through no fault of his or her own, to make decisions or govern his or her own actions, especially if “noncompliant” with medical treatment (Torrey, 1997). This aspect of mental illness as “brain disease” is especially complicated for social work, with its emphasis on self-determination. An important dialog among social workers about the intersection between self-determination and disease models has already begun and passions are high on both sides. Many speak out for the consumer’s right to refuse treatment unless the consumer is adjudicated incompetent and even then for substitute decision-makers to honor prior choices when possible (Bentley, 1993; Chamberlin, 1998). The emphasis is on the consumer’s basic human dignity and right to make decisions even if their decisions are symptomatic of mental illness. Others invoke beneficence, or acting for the good of an impaired consumer (Murdach, 1996; Rosenson, 1993), arguing essentially that “coercive treatment is better than benign neglect” (Valiant, 1997, p. 286). Often included in the beneficence camp are family members and advocates who specifically argue that *because* mental illness is a brain disease it must *therefore* affect mental and cognitive functions such as judgment and recall, and *therefore*, a consumer’s rights should be tempered with paternalism (Rosenson, 1993; Torrey, 1997). It may be that this equation of “brain disease,” with lack of insight and capacity, added to the increasing public fear of nonmedicated consumers, has led to the expansion of laws to mandate outpatient treatment (e.g., Kendra’s Law in New York) and to liberalize commitment standards to include the “gravely disabled” in addition to those who are an imminent danger to self or others (Bentley & Taylor, 2002, b).

Sociopolitical Issues. Analyzing stakeholders in the conceptualization of mental illness as brain disease essentially asks the question “Who wins and who loses?” Or, in other words, whose social, economic, and political interests are best served by the adoption of the current conceptualization. While stakeholder analysis has largely emerged from the management literature (Elias, Cavana, & Jackson, 2002; Freeman, 1984; Mitchell, Agle, & Wood, 1997), the concept of stakeholder can be applied to many areas. For our purposes, “stakeholder” is defined borrowing from Freeman (1984) and Mitchell et al. (1997) as who or what really counts. In this case, “who or what” relates to the forces that are both forming the concept of “brain disease” (the medical profession, pharmaceutical companies, research-endowing entities), and those affected by the concept (families, consumers, managed care, etc.). Our stakeholder analysis is offered as

an exploration, and is not intended as an indictment of “winners” in the “brain disease” conceptualization.

While very different writers and ideological opposites, the work of both Thomas Szasz (1987, 1994) and E. Fuller Torrey (1988, 1997) offer useful polar perspectives on the sociopolitical implications of mental illness as “brain disease.” For example, Torrey describes brain diseases as essentially neurological diseases and so he suggests they move into the care arena of neurologists, in much the same way as Parkinson’s Disease has done. Torrey supports this transition with several arguments. First, he argues that conceptualizing severe mental illness as brain disease—and not as a behavioral health issue or emotional disorder—is a way of ensuring that these consumers will receive the comprehensive *medical* treatment they deserve, including intensive psychopharmacological and community-based treatments. Torrey also argues that serious mental illnesses are completely different from various types of emotional distress or reactions to trauma and loss, and services should be structured and delivered as such. People suffering from stress in life transitions and accidents, once characterized pejoratively as “the worried well,” should be helped in the social service system and not contribute to the exploding demand for true mental illness insurance coverage. In Torrey’s world, if everyone is considered mentally ill then no one is mentally ill (1997), that is, the concept becomes so watered down it is rendered meaningless.

If Torrey’s argument is accepted, it is clear that physicians (MDs), pharmaceutical companies, and the medical establishment benefit in the conceptualization of mental illness as “brain disease” in terms of establishment of domain. Social workers in so far as they are employed by hospitals or in conjunction with medical practices would also be beneficiaries. Social and economic benefits follow from these benefits such as increased stature, increased scope of practice, and increased research funding. Physicians are seen as the necessary and logical choice for leadership roles in the management of “brain diseases” and “allied” professionals such as psychologists, licensed counselors, and social workers play a smaller or supporting role in the treatment of brain diseases, perhaps even performing only under the direct supervision of a physician.

Families can also be cast as beneficiaries of a brain disease conceptualization of mental illness, as we have implied. Not surprisingly, “blaming the brain” as Valenstein (1998) calls it, is a conceptualization of mental illness that families have embraced because of its stark contrast to “blaming the family” and its virtual elimination of the idea of familial causation beyond genetics. The resulting relief of unnecessary, malignant guilt and remorse for families may be one of the most beneficial implications in the conceptualization of mental illness as brain disease. It may also explain why it has been so staunchly defended by members of family advocacy groups and mental health organizations such as the National Alliance for the Mentally Ill (NAMI) who describe severe mental illness as “known to be treatable brain disorders” (www.nami.org/history, 2003). In fact, a recent on-line survey conducted by NAMI (N= 358) found a sizable majority

(91.34%) endorsing the statement that “genes or inheritance play a role in the development of severe mental disorders” (www.nami.org, 2003).

Thomas Szasz (1994), well known for his scathing critiques of the psychiatric establishment, has long tried to expose what he sees as simply physicians’ self-interest, which he believes is reflected in the movement toward medicalizing mental health problems. He takes the position that an increasingly medical understanding of “mental illness” functions primarily as a justification for the future of a lucrative, dominating profession. Likewise, Valenstein (1998) points out that, while it is more palatable to go from “blaming mother to blaming the brain” (p. 1), there are premature assumptions of the neurobiological etiology of mental illness that are still unproven. He specifically states that the early research findings into the beneficial effects of psychotropic medications have been exaggerated, and that too many negative findings go unreported. He notes that discussions of the “biological etiology” of mental illness reflect an assumption of unidirectionality of causation, that is that physical changes in the brain lead to symptoms of mental illness, period. Medical researchers too often ignore the reality that psychosocial and environmental events can *cause* changes in the brain and thus may play a role in etiology. David Cohen (1988, 1997) offered similar arguments in social work, which have been in turn strongly attacked by Johnson (1989). Bentley and Walsh (2001) have taken what might be called the middle road position: Because one affirms a biological model of mental illness does not mean one must turn a blind eye to the reality of the medical profession’s drive for dominance in treating mental illness and its relationship to the economic aspects of prescription writing, drug-research budgets, and insurance reimbursement regulations.

To the list of winners in the brain disease conceptualization of mental illness, we add many mental health consumers. Many consumers may feel freed by the idea of brain disease as it relieves societal pressure for them to somehow cure themselves by simply adopting a new “attitude” (or cognition) or by pulling themselves up by their bootstraps through sheer will. Also removed is the implication that they somehow contributed to having the disease through poor life skills or an inability to cope with reality. Also a “brain disease” conceptualization might help to yield such benefits as a stronger mandate for life-long comprehensive health or mental health services. In the absence of a “medical cure,” as with cancer, heart disease and AIDS, there may be a growing recognition that “medical management” should entail supportive psychosocial supports and community-based services. It should be noted, however, that in a recent on-line survey conducted by NAMI a “significant minority” of respondents reported fearing advances in mental illness genetics research because of the fact that it could lead to discrimination against people with these disorders (www.nami.org, 2003).

Conspicuously absent from the list of winners in the emergence of “brain disease,” then, is the managed care industry. Because of their emphasis on short-term care, the need for treatment and supports over the entire life span might be a threat to economic solvency. Indeed, so far the industry has largely resisted demands to cover “biologically based” mental illnesses on an equal footing with medical diseases for fear of exploding budgets. Family and consumer advocates, on

the other hand, are pushing hard for insurance “parity.” The managed care industry as stakeholder has a very different outlook in the analysis of “behavioral health” that follows.

Behavioral Health

Another shift in the lexicon of mental health and mental illness is in the growing use of the term “behavioral health.” “Behavioral health” was and is defined as the coalescence of medicine and psychology. While this definition seems to be alive and well in the social and behavioral sciences, the term also seems to have been coopted in recent years, by those in the specialty mental health sector and mental health related managed care companies. It is now frequently used as a shorthand term referring to the overarching topics of mental health and substance abuse services. Agencies, even those connected with hospitals, have changed their names from “mental health center” or “psychiatric unit” to “behavioral health services.” Obviously, the term behavioral health is attractive to agencies and professionals, however, the germane question to this analysis is why? What does “behavioral health” mean? Is it, as skeptics assert, just a new term for brain disease? Or, does it, as supporters argue, represent an inclusion of mind/body whole person awareness to a mostly medical specialty?

In the current analysis, “behavioral health” is not intended as a polar perspective to “brain disease,” indeed, many would argue that the names are used interchangeably to describe a similar conceptualization. For example, it is common to see “behavioral health” described in the professional literature as simply the application of behavioral science knowledge to physical and emotional functioning in humans (e.g., Shueman, Troy, & Mayhugh, 1994; Luiselli, 1994; Freudenheim, 1996). However, an understanding of what “behavioral health” specifically refers to seems to have undergone some transition in the past two decades. Importantly, for our discussion, there appears to be a gap between how behavioral health was first envisioned, and what behavioral health in implementation appears to be. Our analysis of inherent assumptions underlying “behavioral health” is connected with the original or “ideal” view of what “behavioral health” means. By contrast, the analysis of stakeholders deals more with the actual implementation of “behavioral health” in practice today.

Inherent Assumptions. Early definitions defined behavioral health as a subspecialty of behavioral medicine, and dealt mostly with issues of health maintenance and the prevention of illness in healthy people. Relevant topics included physical fitness, nutrition and weight control, smoking and drinking issues, accident prevention and stress management (Matarazzo, 1980). Today, the *Journal of Behavioral Health* publishes on such topics as cultural issues in breast self-exams, smoking and drinking in cancer patients, and pediatric headaches. However, “behavioral health” has come to encompass much more than these early examples represent.

Behavioral health has from its inception been portrayed as a field that would serve to open up whole new opportunities for interdisciplinary research and practice (Luiselli, 1994). Its researchers and scholars promised to move away from a purely biomedical understanding of

health and development to a more integrative biopsychosocial and holistic one. The developing behavioral health field originally held promise to finally acknowledge and even develop the mind-body connections and reciprocal influences. In sharp contrast to the medical model described earlier, Ford (1985, p. 93) said of the behavioral health movement: “it might be thought of as a modern expression of the old public health philosophy.” In other words, what people need to optimally function is knowledge and skills for healthy living in their everyday life. This suggests both public health screening and public education around lifestyle issues such as diet and exercise, self-monitoring, and accident prevention (Luiselli, 1994).

Under the original definition of behavioral health, “mental” and “physical” health concerns of people are not seen as easily separated. “Behavioral health” issues are normalized in that most people are seen as dealing with them throughout the life span on a regular basis. Rather than objective diagnosis and treatment by an expert with a passive “patient,” the emphasis in the “mental health as behavioral health” model is collaborative education and prevention. The person being served must be an active and responsible participant in her or his rehabilitation and does this by embracing new knowledge and skills. The professional provider’s role is as a resource and a coach/trainer. Aspects of this model of behavioral health seem to be reflected in contemporary models of psychiatric rehabilitation and “partnership” practice (Bentley & Walsh, 2001; Anthony, 1993; Corrigan, Liberman, & Engel, 1990). In these models, the emphasis is also on the consumer’s active role in his or her own “recovery.” Psychoeducation and skills training are often at the heart of these approaches.

The shift in labeling to “behavioral health” may also relate to the convenience of a single term to capture the reality of the umbrella administrative structure of service delivery in many settings or organizations. Backlar (1996) argues that “behavioral health” is an appropriately inclusive and overarching term that can rightfully capture many disorders from addictions, serious mental illness, and developmental disabilities to less severe forms of emotional distress and stress management problems. This definition is most often associated with the managed behavioral health care industry, which includes everything from employee assistance programs to private health insurance companies to public mental health, mental retardation, and substance abuse services. The change to “behavioral health” may also reflect a dissatisfaction with the term “mental health” which could be seen as too narrow, delimiting, or even as inaccurate. That is, “behavioral health” is more inclusive than simply “mental” functioning.

Because “behavioral health” as it was initially *conceptualized* places such an emphasis on consumer-involved treatment, in the themes of self-determination and personal responsibility seem solidly present. In terms of etiology, problems with an individual’s behavioral health should, according to the original idealization of the concept, be seen as multi-causal and dynamic, concerning various aspects of the consumer’s life. All in all, there’s not much to dislike about the rise of “behavioral health” *in theory*. The problem occurs when analyzing the actual *implementation* of the concept. Could switching nomenclature to “behavioral health” represent a rhetorical change only, or perhaps a more palatable re-packaging of the medical model?

Sociopolitical Issues. When analyzing stakeholders in a behavioral health conceptualization of mental health and mental illness, the contrast between behavioral health *in theory* and behavioral health *in implementation* is apparent. For example, while early definitions and implementation of behavioral health clearly benefited psychologists as a group, the argument could be made that in the mental health as “behavioral health” model, all providers across disciplines *should* “win” because differing perspectives on assessment are viewed as crucial and comprehensive services seem to be valued. Indeed, almost all of the early writings on behavioral health emphasize how conceptualizations of mental health as “behavioral health” suggest an interdisciplinary and holistic approach to care. Regrettably, however, social workers are rarely, if ever, mentioned in this literature, even though social workers are providing many behavioral health services. Even now, the authors who publish in these journals are usually not identified as social workers. “Behavioral health” seems to be pointing to increasing treatment approaches that are focused on quickly reducing symptoms and building concrete coping skills. In this way, managed behavioral health care companies are clear “winners,” as they have been credited with saving millions of dollars by depending heavily on short-term models of care delivered by nonphysician providers instead of open-ended insight oriented therapies (Findlay, 1999). Again, however, many skeptics note that, in reality, the behavioral health field ignores too many, especially those who don’t fit neatly into a short-term intervention model, like people with serious mental illness. In addition, for most employees with health insurance, their “mental health” services, perhaps called “behavioral health” to make them more palatable, are regularly “carved out” and completely separated from regular primary health care services. In fact, because of its emphasis on fast cures and cost cutting, managed behavioral care companies also generally stress the use of psychiatric medications, a practice seeming more congruent with the “brain disease” conceptualization. So while the managed behavioral health industry has been successful in documenting the reduction of costs, there has been no concomitant demonstration of improvement in the quality or comprehensiveness of care.

The normalization of “behavioral health” issues might hold promise of reducing the stigmas associated with mental illness, making some consumers winners in this conceptualization. Though as Torrey (1997) has so passionately argued, consumers with serious mental illness could end up “losing” in this conceptualization as they may be lumped in with people with less debilitating problems. This could lead to a reduction of specialized services for people with serious mental illness, or decreased acknowledgement of the seriousness of major mental illness and its impact on the consumer.

As for the mental health agencies and programs who have changed their names to reflect a “behavioral health” model, some would argue that they still appear to have largely retained a “brain disease” implementation. For example, about six years ago, one of the authors was working for a large health-care company in their “psychiatric services” department when a market-wide decision was made to change the name to “behavioral health.” Reasons for the switch seemed to reflect a well-intentioned desire to decrease the stigma associated with the

word “psychiatric” in order to normalize the need for mental health treatment and to move toward a more holistic (and contemporary) vision of mental health care. It was acknowledged, though, that the facility was still entrenched in a medical model. Indeed, the day after the change, the doctors still made rounds, medication was still the primary intervention and psychoeducation groups still centered on disease concepts. It seems that changing to the “behavioral health” nomenclature may represent more of a wish for the future rather than a reflection of the current practice environment.

IMPLICATIONS OF CHANGING CONCEPTUALIZATIONS FOR SOCIAL WORK PRACTICE

In order to insure a healthy future for social work, it is essential that social workers be equipped with the requisite knowledge and skills for practice in a changing environment. The first set of skills that stem from a healthy understanding of “brain disease” and “behavioral health” deals with *practice and policy*. There is a demand that needs to be met for increased information on both *neurobiological processes* and *psychotropic medication* (Bentley & Walsh, 2001). Additionally, social workers who understand the sociopolitical dimensions of “brain disease” and “behavioral health” are better able to *negotiate and exploit the system* for the gains of consumers and their families. The evolution of both conceptualizations of mental illness and mental health, “brain disease” and “behavioral health,” also requires social workers to be adept at working within a multidisciplinary team and consistently not only advocating for, but actually demonstrating, the importance and usefulness of a social work role. Increasing educational materials in schools of social work and in continuing education offerings on *interdisciplinary teamwork* and pursuing related field experiences is encouraged. Both conceptualizations call for social workers to continue to move to broader conceptualizations of human problems, recognizing the inherent conflict of a knowledge base that, in contrast to the professional rhetoric, still may place too much emphasis on psychopathology, or on human behavior as a purely psychological phenomenon. Further training and education for social workers is needed on the *role of stress and coping with disease, pain and loss*. This includes a real need for *cross-cultural research* into the epidemiology of disorders and the *influence of difference* on help-seeking and treatment efficacy.

Other skills that are indicated for social workers in mental health to effectively operate in today’s mental health context deal are encompassed under *continuing education*. Social workers may face “*professional dissonance*” (Taylor, 2002) in their practice when traditional social work values collide with real-life mental health treatment interventions that are possibly informed by emerging conceptualizations (such as involuntary outpatient commitment). Thus, social workers need *support and space* for dealing with an *ethically complex mental health context*. There is also a growing call in health care for more attention to the interface between illness and experience and, thus, a need for more qualitative research into *the lived experience* of people with mental illness. When social workers recognize and respond to the implications or the changing lexicon in mental health practice, perhaps then we can more closely approximate what

Bentley and Taylor (2002, a) define as excellent social work in mental health, that is, practice with clients characterized by collaboration, compassion, competence, commitment, and creativity.

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