

THE SOCIAL PARADIGM IN PSYCHIATRY AS A LINK BETWEEN SOCIAL WORK AND PSYCHIATRY IN THEORY AND PRACTICE

ABSTRACT

Social paradigm in psychiatry serves to encompass the definition of an individual as a psycho-social being in this branch of medicine. The “social revolution” in psychiatry has sparked interest in social vectors affecting the aetiology of mental illnesses, as well as rehabilitation and treatment success among psychiatric patients. In line with numerous innovations introduced by the social model in psychiatry, social workers have been integrated into multidisciplinary teams working with psychiatric patients. The social model has underscored the need to view and process the socio-economic and interpersonal aspects of functioning among psychiatric patients, while the methods and theories of social work have become inevitable factors in planning activities directed towards prevention and treatment of mental illnesses. This paper analyses important characteristics of the social paradigm in psychiatry that has facilitated

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the process of drawing psychiatry and social work closer together. A comparison between practical implications of the three great paradigms in psychiatry is given, followed by an indication of theoretical specificities of social work that has enabled bidirectional interaction between the two related scientific areas. The paper provides an overview of activities that are seen as duties of social workers within multidisciplinary teams who work with psychiatric patients, and that represent a legacy of the convergence between social work and psychiatry.

INTRODUCTION

Various methodological approaches stemming from several scientific areas can be applied to exploring issues related to the aetiology, development and treatment of mental disorders. For several decades, these issues have been addressed by psychiatrists and experts in the field of medical psychology, social work, sociology of mental disorders, and psychiatric sociology. Given the complexity of the individual's mental life and organism, and the stratification of the socio-political stratum¹ as the environment in which the individual lives and evolves, epistemological diversity in the study of the aetiology of mental disorders is both expected and necessary.

Despite the fact that the aforementioned epistemological pluralism is evident in the area of studies of mental disorders, it is also clear that interest in those aspects of mental disorders that are not exclusively medical or medical-psychological, is a legacy of recent developments in psychiatry, i.e. a result of its merging with social and humanistic sciences. Monographs discussing the history of psychiatry indicate the fact that intensive permeation of psychiatry into non-medical disciplines in both research and practice occurred only after World War II. This convergence of various fields of science resulted in the creation of an **interdisciplinary approach** to matters related to mental health, a versatile model of study of the aetiology of mental disorders, and consequently to **multidisciplinary treatment** of psychiatric patients. Previous discoveries in the area of aetiology of mental disorders and psychopathology indicate that studies of factors that contribute to causing mental disorders cannot be reduced to a single, homogenous dimension that would be investigated with a unidisciplinary approach. Consequently, complete and good quality treatment of psychiatric patients cannot be carried out without active involvement of experts in different scientific areas².

¹ *In contemporary psychiatry, the individual is defined as a bio-psycho-social being who, according to Munjiza "is born, lives and dies inside the community," and represents "a part of the social environment" (Munjiza, 2012: 20, our translation).*

² *Munjiza asserts that, since research and clinical experiences constantly widen our scope of knowledge, "we*

Multidisciplinary teams in psychiatric services are enabled by the members who represent the models that shaped psychiatric theories and practices in the 20th century: **biological, psychological and social** models. Namely, **psychiatrists, psychologists and social workers** use distinct methods in approaching the patient, which renders the treatment of the patient all-encompassing, covering all the important dimensions of the patient's functioning, with respect to the definition of the individual as a being conditioned by **biological, psychological, and social** factors.

As the domination of the social model in psychiatric theory and practice marked the beginning of the convergence of various previously (paradigmatically and methodically) unaffiliated interdependent disciplines³, the following question emerges: which premises of the social model in psychiatry have contributed to merging psychiatry with social work and some of the aspects of social policies? This paper presents and analyses rudimental theoretical and practical discoveries brought about by the social revolution, primarily in the field of psychiatry, social work, and social policies in the area of mental health care. It also indicates practical and theoretical specificities of social work that render this discipline indispensable in the process of treatment of psychiatric patients, covering the social aspects of their functioning, in line with the aforementioned three-partite psychiatric-anthropological definition of the individual.

INFLOW OF SOCIAL THEORY INTO PSYCHIATRY

The social paradigm was chronologically introduced in psychiatry as the third large model (immediately following the biological and psychological models), which shaped the direction of both research and practice in the field of psychiatry. This fact should be considered when reviewing the relationship between the biological and the social approach to mental health/illness. Medical advances that detached psychiatry from the medieval "demonic" approach to mental disorders, which ultimately resulted in the formation of contemporary psychiatry, find their origins in the **biological/biologicistic** model. In the second half of the 19th century, rapid development of certain (predominantly non-medical)⁴ scientific disciplines

must introduce changes in treatment through therapy with modern medication and expansion of the methods of medical care and rehabilitation" (Munjiza, 2012: 6). Such a holistic approach represents the framework of modern, interdisciplinary theory and practice in psychiatry, which encourages psychiatrists to engage in intensive cooperation with social workers and psychologists in organising preventive and remedial activities.

³ *The issue at hand refers to bringing the medical model of patient treatment closer to certain aspects of the public health policy, and social work, which will be discussed in the core of this paper.*

⁴ *Kecmanović posits that at the time "it was of crucial importance for scientific development that all life phenomena could be described and understood by chemical and physical determinants," and that "this premise quickly became dominant in medicine" (Kecmanović, 1978: 87, our translation).*

provided empirical confirmation of the theses suggesting that mental illness is an “epiphenomenon of biological processes” (Woolfolk, 2005). This progress in the area of research of biological correlations to mental disorders was so significant that monographs on history of psychiatry mark it as **revolutionary** (Munjiza, 2011: 89).

The domination of the biological model was followed by a period in which, according to Munjiza, psychiatry was unequivocally governed by the theory and practice of **psychoanalysis** (Munjiza, 2011). This dissociation from the biological paradigm, followed by a turn towards psychology, already indicated that psychiatry had evolved to the point of realisation that the individual's life, along with its aberrational forms, must be examined from various perspectives with the aim of understanding its totality.⁵ Around 1940, psychoanalysis managed to suppress biological psychiatry, and it remained dominant in the field of psychiatric medicine until the early 1990s. Simultaneously (and not incidentally), psychoanalysis started to overwhelm the practice of social work to the point when this period of the field's development is referred to as the “psychiatric flood” (Howe, 1997: 36, our translation). The acceptance of psychoanalysis and absorbing Freud's doctrine on behalf of social work⁶ represented the beginning of convergence between these two interdependent scientific disciplines, which would later on be crowned by co-opting social workers in psychiatric teams.

Within the context of the youngest among paradigms – the **social paradigm**, it is particularly interesting to note that the period of domination of psychoanalysis in psychiatry was marked by the maturation of the idea that “psychiatric disorders cannot be explained solely through the medical model of the illness, which is why psychogenic and sociogenic models were developed as well” (Peković, 2010: 30, our translation). Another characteristic of this period is the “immense progress of social psychiatry, which assumes a respectable place in psychiatry” (Peković, 2010: 210, our translation). The aforementioned thesis that the overlap of the strongest influence of psychoanalysis with the beginning of emancipation of social psychiatry was not a coincidence must be underlined. In fact, the absorption of psychoanalysis by psychiatry⁷ as a complex conceptual system with an advanced

⁵ At this point, it is good to draw attention to the neo-analytical theory and its leading representatives, such as Karen Honay, Henry Sullivan and Erich Fromm, whose works clearly state that the development of the personality cannot be analysed outside of the social and interpersonal context.

⁶ The impact of psychoanalysis on social work was so great that a new model was developed within the discipline, called psycho-social work (Knežević, Miljenović, & Branica, 2013: 121). Payne states that the disputes within schools of psychoanalysis affected the theory and practice of social work, which resulted in a division into functional and diagnostic psychodynamic social work (Payne, 2001). Howe writes about the same issue, emphasising that the representatives of the functional school were followers of Otto Rank (Howe, 1997: 37).

⁷ In this context, the contribution of post-Freudian neo-analysis is particularly important as it underscored the significance of social factors in the psychoplasty of the personality. Jakovljević (1969) states that neo-analytical approaches were “socio-cultural” and that they “transformed classical, bio-psychologically oriented psychoanalytical theory based on its socio-psychological qualities” (Jakovljević, 1969: 65, our translation).

method for analysis of the individual, characterised by a dialectical overview of the **interpersonal** and **intrapsychic** processes, has cleared the way for the **sociogenic** model of interpretation of psychiatric disorders; **socio-dynamic** practice; and the rise of social psychiatry in general⁸. Within that context, it is possible to identify the psychological/psychoanalytical paradigm in psychiatry as transitional, implying that it is the **only possible** framework for examination of mental health/disorders, given the knowledge and the intellectual climate in the field. Seen from a present day perspective, that framework has consequently (and inevitably) initiated the rise of the **social movement**⁹ in psychiatry. In the second half of the 20th century, this movement would mark the completion of convergence of psychiatry and social work, initiated by the absorption of psychodynamic theory by both of the aforementioned disciplines. Another moment that enabled progress in the practice of social psychiatry was the interest expressed by the representatives of these disciplines in the intangible, healthy segments of the personality of mentally ill individuals, once again in line with the premise that “there is no illness, only an ill person”. Consequently, the reductionist medical focus on illness, which involved symptom elimination in practice, has been replaced by contriving programmes with the aim of **reintegrating** the ill individual into the society, by the use of his/her remaining capacities, and the therapeutic aspects of the **community** and **group processes**. These factors enabled the expansion of working within communities, and the rise of sociodynamic thought in psychiatry and the correlating socio-therapeutic practice, which is mostly conducted by psychiatric social workers in psychiatric institutions.

DEFINING SOCIAL PARADIGM IN PSYCHIATRY

The term **paradigm** was the focus of epistemological research in social sciences ever since Thomas Kuhn’s book *The Structure of Scientific Revolutions* was published in 1962. Kuhn asserted that scientific progress is not spontaneous or linear – it is not an accumulation of empirical evidence in support of theory, but a collection of “scientific revolutions”, which are radical and marked by “shifts of paradigms”. According to Kuhn, the new paradigm, once canonised in science, does not only give different **meaning** to accumulated facts, but also provides a new

⁸ Similarly, Kecmanović reflects that “it is hard to imagine that psychiatry could have served as a basis for socio-dynamic orientation without cognition, i.e. without results of psychodynamic psychiatric orientation, not only due to the logics of temporal succession of psychoanalysis and socio-dynamically oriented psychiatry, but also due to the logics of conditionality and superintendence of their cognitions and conceptions” (Kecmanović, 1975: 47, our translation).

⁹ It is interesting to note that Elmer Southard, who was the first man to use the term “social psychiatry” in 1917, held his initial scientific lectures on that topic to social workers. It was in 1918, at the Boston School of Social Work. Southard was a doctor and director of the Boston Psychopathic Hospital (Kecmanović, 1975).

method, derived from the related paradigm, which is used for studying scientific problems, as well as distinct practical implications relying on that new paradigm. Given that a particular research method always belongs to the referent paradigm (more precisely, it is derived from that paradigm), the **instruments** used by researchers are constructed in such a manner that they either validate the paradigm, or at least single out complex units that are being studied, and select the elements and relationships between them that are encompassed by the relational paradigm¹⁰. In the context of psychiatry, it is worth mentioning that, apart from the fact that the three paradigms have their own research methods in the field of aetiology and phenomenology of mental disorders, every model also proposes a specific method of operation with psychiatric patients in health and care services. Methodological and methodical differences between paradigms in psychiatry can also be presented in a table:

Table 1. Methodological approaches to the examined matter in psychiatric practice – within paradigms

Paradigm	Biological	Psychological	Social
Team expert	Doctor – psychiatrist	Clinical psychologist	Social worker
Period of domination	End of the 19 th century, re-emerging by the end of the 20 th century	First half of the 20 th century	Second half of the 20 th century
Research method	Clinical, directed towards neurochemical changes	Clinical, directed towards the experiential and developmental axes of the patient; projective tests, personality tests	Mostly quantitative and nomothetic, directed towards the community, the interpersonal, the social; qualitative analysis of the narrative
Methods, techniques and means in remedial work	Pharmacotherapy: antipsychotics, antidepressants, anxiolytics, psychostabilisers and other psycho-pharmaca	Psychotherapy: starting from psychodynamic, over behavioural, humanist/existentialist, to cognitive-behavioural	Socio-therapy; work in large groups, occupational therapy, tertiary prevention, community work

Based on the characteristics presented in Table 1, we will, from now on, refer to the social model in psychiatry as a separate *paradigm* in psychiatry. In an effort

¹⁰ For more information on this matter, see: Kuhn, 2013.

to determine the coordinates of social theory in psychiatry as precisely as possible, we will enumerate its specificities. Furthermore, as much as the scope allows us, we will present the practical implications of this model, which has made social workers important members of multidisciplinary teams in psychiatric practice.

Important features of the social paradigm in psychiatry are as follows:

1) In the field of **research**, the interest in social phenomena that are related to mental illness and psychiatric patients is significantly emphasised. Among the great deal of research (especially research dating back to the last two decades of the 20th century) that was conducted with the intention of finding the relation between social determinants and mental illness (and psychiatric patients), it is possible to single out two large sub-groups of research, on the basis of how the research problems were defined:

a) Research dealing with the social dimension of the aetiology of mental disorders: this group of research focuses on linking **socio-economic variables** (as predictor variable) with mental disorders (as the criterion variable). In other words, it studies the **sociogenesis** of mental disorders. The predictor variables explored in this group of research are: class, nationality, education, economic status, sudden changes in the society, marital dysfunctions and disorganisation, migration, exile, and stress. The contribution of social work to this derivation of socio-psychiatric thought is twofold. Social work has a distinct methodological approach to the individual and the environment (social anamnesis, house visits), which provides experts with data that is treated as **predictor variables** in later research. In the theoretic realm, the **systems perspective** that dominated over the theory of social work in the second half of the 20th century (Howe, 1979: 39), and that became an indispensable segment of this discipline (Knežević, Miljenović & Branica, 2003; Payne, 2001) enabled the process of linking heterogeneous factors, which act in different strata that surround the individual, and that lead to mental disorders. Psychiatrists accept that constant observation of the **dynamic interaction** between an individual and their environment (both natural and social) is "an orientation which serves as the basis for the most progressive approaches in all areas of preventive and remedial medicine in psychiatry and socio-dynamically oriented psychiatry" (Munjiza, 2011: 193, our translation).

b) Research that does not deal with the social dimension of the aetiology of mental disorders in particular, but with the analysis of the **relationship** between the mentally ill, on the one hand, and the society on the other, i.e. the reactions of the society to the role of the "mentally ill". More precisely, research belonging to this group delves into issues such as: the social role of the mentally ill; attitudes and prejudice towards psychiatric patients; labelling of the mentally ill; and society's control over them. This group of research is closer to sociological analyses, which

is why Opalić defined it as **psychiatric sociology** (Opalić, 2008). In part, the group resembles quantitative methods and techniques of social work, such as **narrative analysis**.¹¹

2) The **method** used in the aforementioned research is primarily nomothetic, and based on quantitative analysis, correlation, and other statistical techniques that enable examination of relations between predictor and criterion variables on **large samples**. This is a methodological specificum of the social paradigm in comparison with the other two paradigms in psychiatry, where methods incline towards clinical and idiographic research. The social model also encompasses qualitative research, including the forms that were drawn closer to the area of social work in the previous two decades, such as narrative analysis. Hence, the social paradigm in psychiatry has contributed to a more holistic view of not only the socio-economic axis of the aetiology of mental disorders, but also the **meaning of experience** of mentally ill individuals.

3) In the field of **practice**, there is prevailing intent to mould preventive and remedial work with psychiatric patients into activities that rely on principles of group functioning and other social entities that draw their healing from the **interpersonal**, rather than **intrapsychic** sphere. Research in the area of group functioning and group dynamics is significant in this context, along with meticulous insight provided by psychoanalysis, contributed to the formation of the opinion that mental illness is an aetiologically **relational** phenomenon. Various types of group work with psychiatric patients that rely on the laws of group dynamics as catalysers of the healing process are encompassed by the term **socio-dynamically oriented psychiatry**. The contribution of social work is invaluable, since representatives of this discipline explore the methods of working in communities during their undergraduate studies, which is highly relevant in organising preventive activities in the field of mental health, and in the process of rehabilitation. The specificities of studying the methods of social work in undergraduate studies entail mastering the theory and basic principles of the functioning of group dynamics, which is especially significant for working with groups in infirmaries, including socio-therapeutic activities.

As the aim of this paper is to point out the dialogue between the theoretical-research background of the social paradigm in psychiatry and practical activities which are the duties of social workers in the service of mental health, we will focus on providing basic information on these activities, aiming at providing a link between them and the facts presented thus far. Simultaneously, we will ensure bi-

¹¹ Narrative analysis, as a qualitative research technique in social work, is particularly suitable for reviewing experiences of mentally ill individuals from more than one conceptual framework (for example Sosulski, 2010).

directional flow of communication between theory and practice, thus underlining that the inclusion of social work in psychiatric practice was not a mere one-sided consequence of the “social revolution” in psychiatry; in fact, the discipline of social work has been reciprocally shaping social thought in psychiatry ever since it was integrated in the field of mental health, thus providing psychiatry with a valuable empirical knowledge from its own perspective.

SOCIAL WORK AND PSYCHIATRY ON THE SAME MISSION

By the beginning of the second half of the 20th century, medicine started to open up towards the area of social sciences, incited by, as Kecmanović states, efforts to increase its therapeutic efficiency (Kecmanović, 1978: 118). The same process was taking place in psychiatry, which led to an increase of interest in certain aspects of the social problematics that might be related to mental disorders. Kecmanović points out that “social-psychiatric orientation is the psychiatric *double* and equivalent to the *socio-medical approach* and orientation in non-psychiatric medical branches” (Kecmanović, 1978: 121, our translation).

As the social paradigm in psychiatry led to the recognition of the significant role of social components in the genesis of mental disorders, and the remedial potential of interpersonal and group processes in the treatment of the mentally ill, it has made room for the integration of social workers into multidisciplinary psychiatric teams¹² as their equal members. The method of social work (clinical social work in particular) is specific for its use of concrete methods and techniques in working with psychiatric patients, their family and the community, thus creating multidisciplinary teams that render treatment of psychiatric patients complete. Therefore, this interest in the social sphere of the patient’s functioning, which underlies social work, concludes the tripartite (bio-psycho-social) conditioning scheme of the individual, still present in psychiatry today.

From a chronological perspective, professional activities that can be defined as **social work in the mental health field** started to form between the two World Wars, according to Miković (2007). The need to involve social workers in the field of mental health was first voiced in England, where the vocation of the **psychiatric social worker** was “associated with the work of the first therapeutic community founded by Maxwell Jones” (Miković, 2007: 153, our translation). Thanks to V. Hurdolin, a Croatian author and practitioner, the concept of therapeutic community

¹² Similar to the thesis of this paper are Munjiza’s observations that “team work in psychiatry developed under the auspices of the therapeutic community and the social dimension in psychiatry” (Munjiza, 2012: 106, our translation). Incidentally, the meaning that the author ascribes to the term “social dimension in psychiatry” in the text matches the context in which the term “social paradigm in psychiatry” is used in this paper.

has in due time been integrated into the psychiatric practice in the former Yugoslavia, which has consequently enabled the process of co-opting social workers in the field of mental health (Lazić, 1999: 26). In summarizing the practical contribution of social workers to psychiatric activities, some authors have claimed that the shared property of different methods and techniques applied by social workers in their activities with individuals with mental disorders is that the practical applications of the theories of human behaviour leads to interventions in situations where interaction between the individual and their surroundings has been interrupted (Miković, 2007), which corresponds with the systemic theory background of social work (Payne, 2001).

Kecmanović encompasses all the various practical activities developed under the influence of social thought in psychiatry, and at present practiced mainly by social workers with one term - **socio-psychiatric orientation in psychiatry** (Kecmanović, 1978). According to monographs in the area of social psychiatry, these activities can be sorted into two large groups:

1) **Prevention-oriented psychiatry**, where the objectives and method are directed at **preventing** mental disorders, i.e. towards preventing complications and the spreading of disorders;

2) **Socio-dynamically oriented psychiatry**, which is mostly remedial, and intervention is mostly directed at the patient's **environment**, i.e. their **interpersonal surroundings**.

We will now provide an overview of the social aspects of these psychiatric orientations, accentuating the role of social workers in activities that can be sorted under the two aforementioned orientations.

PREVENTION – ORIENTED PSYCHIATRY AND SOCIAL WORK

Under the influence of the socio-medical views on health/illness, there is a growing tendency in medicine to observe health issues as a problem that concerns the social community, and not just the individual. In the past few decades, particular attention was paid to redefining the organisation of health protection, thus shifting the focus from illness to health. This resulted in increased interest in preventive activities, especially in primary levels of prevention (Munjiza, 2012). Prevention-oriented psychiatry is a psychiatric derivation of the aforementioned tendencies in medicine.

According to Kecmanović, prevention-oriented psychiatry encompasses:¹³

¹³ The division of prevention-oriented activities in psychiatry was first suggested by Kecmanović (Kecmanović, 1975). Although this nomenclature is older, it was proposed in the period when psychiatric practice inspired

a) Preventive psychiatry **in the narrow sense** – encompassing activities of primary, secondary and tertiary prevention;

b) **Epidemiology of mental disorders** – which deals with studying widespread mental disorders, and represents the diagnostic method of prevention-oriented psychiatry;

c) **Psychiatry in the community** – which can be defined as the application of the principles of prevention-oriented psychiatry in the narrow sense inside the community.

Prevention-oriented psychiatric activities started evolving after World War II, as a result of the growing need, recognised in the period marked by the rise of the social paradigm in psychiatry, to bring psychiatry closer to users of medical services, i.e. to act preventively where, seen from the social and etiological standpoints, the disorder manifests itself – **within the community**. The result of such an approach is a type of psychiatric practice in which the staff leaves the premises of mental institutions to, as Kecmanović explains “experience the life situation of potential, and so-called declared patients”, which occurs “with close cooperation with relevant social services and institutions responsible for making decisions of general interest” (Kecmanović, 1978: 123, our translation). Preventive psychiatry is, as Kecmanović elaborates “a complement to the medical public health model” (Kecmanović, 1978: 123). Similarly, Miković observes that mental health is “an area in which **health and social protection** are interwoven and permeate each other to the highest degree, as the majority of issues studied in the area of mental health – the causes, prevention, therapy and rehabilitation, can also be viewed from the **social aspect**” (Miković, 2007: 193, our translation). On the grounds of the concept of **Community Psychiatry**, an original form of protection and promotion of mental health has been developed in former Yugoslavia thanks to Hudolin, and implemented at the municipal and state level (Lazić, 1999). In line with the fact that mental health is at present no longer defined as an absence of disorders, but as an **affirmation of mental health**, which is another consequence of the process of integration of the social model in psychiatric discourse, psychiatrists from these regions underscore that their profession must be aligned with “all other disciplines that deal with this issue, such as public health, psychology and social work” (Štrkalj et al, 2010, pp. 38-39, our translation).

Apart from the quotes containing explicitly emphasised significance of **social protection services** in the preventive-psychiatric activities, we must also address the facts that underscore the significance of social workers in preventive-psychiat-

by the social paradigm reached its peak, so the aforementioned division has remained in existence until this day, albeit with certain corrections, in modern literature on social aspects of mental health (example: Munjiza, 2012; Bukelić, 2004).

ric practice. Above all, in the area of **primary prevention**, methodical complexes of social work, such as group work and (especially) community work which constitute the basic part of the academic curriculum in social work studies, are adapted to activities in the area of prevention outside the hospital environment. These approaches have significant potential to contribute to systemic education of the population on aetiology, clinical picture, the flow and prognosis of mental disorders, as well as the social aspects of these disorders, i.e. the aetiological factors of mental disorders that are active in the social sphere. Miković states that **protective factors** active in the social stratum ought to be strengthened (Miković, 2007), as they are related to family cohesion, according to research results, as well as to the social–financial status of the individual and groups, and matters of (un)employment – problems normally dealt with by social workers. Social work has particular potential in the prevention of the schizophrenic disorder, which is also referred to as the **true disability of the soul** (Ostojić, 2012: 54). This assertion is made due to the fact that schizophrenia is a progressive chronic disorder, which is harder to control in the case of late detection. Underscoring the role of the social workers in early detection of the schizophrenia, Ostojić asserts that changes emerging in the prodromal phase that can be observed by social workers encompass: social seclusion, passivity, loss of interest for usual activities, sudden decline of quality in academic or professional activities, and consumption of alcohol and psychoactive substances (Ostojić, 2012: 62). The author adds that the role of the social workers is significant at all stages of treatment of the schizophrenic patient (Ostojić, 2012: 62).

In **secondary prevention**, community work methods allow timely identification and observation of individuals and groups that are, according to the results of sociological research on the aetiology of mental disorders, exposed to risk when it comes to the development of mental disorders within communities.¹⁴ We must again emphasise the significance of research for the aetiology of mental disorders, as good knowledge of precipitous factors of mental disorders can be helpful in the process of formation of preventive programmes on prevention at the social level, especially for better treatment of groups exposed to risk. Knowledge in the area of social axis of aetiology of mental disorders also indicates that, when dealing with this group of disorders, groups exposed to risk are those that social workers mainly work with: children without foster care, the elderly, individuals from incomplete families, the disabled, the unemployed, people living below poverty line, refugees (Munjiza, 2012). It is evident that, in the field of secondary prevention, mental

¹⁴ Research shows that certain social groups like the poor, unemployed, or the socially discriminated are exposed to higher risks when it comes to certain mental disorders, such as depression (Taylor & Turner, 2002; Eaton et al 2001).

health care is closely connected with prevention of **social issues** escalation, which renders the contribution of social workers to preventive care in the area of mental health particularly significant. At this level of prevention, the social work methods act on “suppressing risk factors, and eliminating initial changes that lead to certain disorders” (Miković, 2007: 173, our translation).

Social workers play a significant role in **tertiary prevention**¹⁵, as a large number of psychiatric patients lose their jobs, due to the chronic flow of the illness, which complicates their socio-economic status. Research in this field shows that there is a negative correlation between the frequency of relapses and the financial status of the patients, which makes the engagement of social workers imperative with the aim of finding long-term solutions of social and financial problems of the psychiatric patients and their families. Activities of social workers are equally important for the rehabilitation process during the patients’ reintegration in the community after a period of hospitalisation. Working on suppressing prejudice through group or community work is also imperative. Miković stresses that social work is a practical method of solving various forms of society’s discrimination of those patients that returned to the community, due to the fact that it can be used in both individual and group settings (Miković, 2007).

Within the context of tertiary prevention, we must remember that, even in the Western world, the process of **deinstitutionalisation** exists, which means that there is a tendency to keep the patients in the infirmary as shortly as possible, when hospitalisation is required. This means that an efficient **social network** upon which the patient can rely is required in the community in order for the rehabilitation process to be successful. Miković observes that the “practice of social work is being transferred from mental institutions to the local community”, which is also an effect of deinstitutionalisation (Miković, 2007: 150). The aforementioned trends are followed by a rise of community psychiatry, which calls for engaging a large number of members that do not belong to medical staff, including social workers (Miković, 2007). The main objective of psycho-social rehabilitation of the mentally ill is **strengthening** – developing a feeling in the individual that they can tackle difficulties, thus gaining control over their lives. Miković adds that the strengthening process also implies **social security** among this part of the population, especially in terms of permanent employment and adequate secured housing. Other activities that follow the psychiatric patients’ return to the community, normally managed by social workers are: providing help in exercising certain rights, organising transportation, recreation, social help and medical protection (Miković,

¹⁵ Munjiza states that successful rehabilitation, recovery and improvement of the general quality of life of psychiatric patients are unimaginable without active participation of social workers (Munjiza, 2012: 116).

2007: 171). In addition, at the third level of prevention, the social worker can help in coordinating self-help groups (if such groups exist within the community), and in working with the patient's family. The contribution of the social workers is particularly important in bracing the family for the so-called preparatory weekend, which the hospitalised patients spend with their family, following remission, and prior to definite discharge from the hospital. The fact that individuals who turn to professional help for psychological issues have fewer close friends than mentally healthy individuals, and that those individuals also spend most of their time in the community with their primary group, indicate the growing need for social workers' help in the process of rehabilitation of psychiatric patients (Munjiza, 2012: 219). Since psychiatric patients tend to reduce social communication, it is imperative to work on reaffirming and spreading the social networks of these individuals in the community, and social work has great potential to contribute to that cause. Munjiza asserts that several studies indicate how within the context of tendencies related to **anti-social behaviour** by individuals suffering from schizophrenia, good **cooperation with the family** can be an important component in suppressing such forms of behaviour (Munjiza, 2012: 231).

The significance of **social anamnesis** of the patients must also be emphasised. Shaping the anamnesis falls under the category of obligatory activities conducted by clinical social workers engaged in mental health services. Taking into account previous inferences about the social paradigm in psychiatry, it can be concluded that information regarding the patients' social anamnesis is valuable not only for creating a meticulous plan of treatment of the patients that would encompass the socio-financial dimension of their functioning, but also as a significant base of empirically gathered data on the social and financial background of the patients, which can be used to design research in social aetiology of mental disorders, and the programmes of prevention through work in the community¹⁶.

SOCIO - DYNAMICALLY ORIENTED PSYCHIATRY AND SOCIAL WORK

While the focus of prevention-oriented psychiatry, as the fruit of social thought in psychiatry, concordant with its **preventive** approach, is to hinder the emergence and spread of mental illness, socio-dynamically oriented psychiatry, as the second branch of the applied social paradigm in psychiatry is dominantly **remedial**. In the widest sense of the word, socio-dynamically oriented psychiatry relies on the idea

¹⁶ Research in the field of mental health, conducted from the perspective of the social paradigm (such as the group of research referred to in footnote 19) is mostly based on data collected by social protection services.

that elements of group functioning can have therapeutic effects on psychiatric patients. Kecmanović states that socio-dynamically oriented psychiatry uses “beneficial socio-psychic forms of impact on the individual for diagnostic and therapeutic purposes” (Kecmanović, 1978: 122-123, our translation). The author adds that socio-dynamically oriented psychiatry represents “application of knowledge and methods of social psychology, especially psychology of interpersonal relationships in so-called small groups, in treatment and care of the mentally ill”. Socio-dynamically oriented psychiatry obviously follows the trail of interdisciplinarity, with respect towards the contribution of those disciplines that are not strictly medical. This is the case with concrete activities and suppliers of remedial activities that socio-dynamically oriented psychiatry relies on. Kecmanović underlines that one of the most important characteristics of socio-dynamically oriented psychiatry is that the representatives of **non-medical personnel** are equal partners with psychiatrists, which is not the case in organotherapeutic and psychotherapeutic activities. **Social workers, therapeutic workers and psychologists** are indispensable participants in group work with patients, according to Kecmanović, immediately followed by family members and work colleagues (Kecmanović, 1975).

In the context of the aforementioned inflow of social thought in psychiatry, we reiterate that socio-dynamically oriented psychiatry started being actively used and applied in mental institutions during the 1940s and 1950s, which, as we have seen, overlaps with the period of rise of the social model in psychiatry. In favour of that thesis, we quote Kecmanović in affirming that, in the mentioned period, experts in mental health gradually started to abandon the view that a mentally ill individual “is affected by some organic process, and therefore completely unsusceptible to social impacts” (Kecmanović, 1975: 46). Additionally, the socio-medical stance and the socio-medical tendency are congruent with the primary biological view on illness, with the difference that these approaches “**respect the role of the social aspect** in the complex pattern of the emergence of the illness, as well as the **use of that aspect** in fighting the illness on a wider front” (Kecmanović, 1978: 120, our emphasis and our translation). We appreciate the fact that these quotes emphasise two details that have been stressed in this paper as well. In the first part of the quote, referring to the congruity of different approaches in psychiatry, the inclination to interdisciplinarity has been emphasised; while the second part features two prominent axes of the social-psychiatric paradigm: the society as the possible holder of the key to **aetiology of disorders**, and the society as the possible holder of the key to **preventive and remedial practical activities**. When considered as a whole, these two details constitute the nexus of the social paradigm in psychiatry and co-optation of social workers in psychiatric teams.

Important activities in the socio-dynamic segments of psychiatric practice trusted to social workers are as follows:

1) **Socio-therapy**, which, similarly to group psychotherapy, rests on the laws of group dynamics, and the potential of the group to establish a therapy *setting*, which is methodically rather different from individual work with patients. The difference between psychotherapy and socio-therapy is related to one of the crucial premises of the social paradigm in psychiatry, indicating that a disorder never affects the entire personality – there is always a stable part of the individual that serves as the centre of the healing process (Munjiza, 2012: 170). While the aim of group treatment in psychotherapy (especially psychodynamic/depth treatment), in line with medical regulations, is intrapsychic reorganisation of the personality, achieved through work on those segments of the personality inflicted by the pathological process, socio-therapeutic work is primarily directed towards improving the capacity of the patient to behave in a **socially acceptable manner**. This aim can be achieved through recognition and correction of dysfunctional interpersonal behavioural patterns in the patient (Miković, 2007). Consequently, psychotherapy relies on conscious and **unconscious** functioning mechanisms of the patients, while socio-therapy relies exclusively on conscious, i.e. cognitive mechanisms, such as learning and observing.

The aforementioned distinction is immediately followed by formal differences between psychotherapy and socio-therapy: they refer to concrete interventions of the therapist/leader of group work, since indirect group leadership (which improves the process of transfer) is required for reaching the objectives of group psychotherapy. However, in socio-therapy, the group leader addresses the conscious part of the patient's personality, which renders group-leading more directive. Social workers adopt basic practical skills in the methodical approach to group social works during undergraduate studies, along with knowledge on the theoretical background of socio-therapy, i.e. on the significance of socio-therapy in psychiatric practice. Groups of psychiatric patients in infirmaries that social workers work with can be listed under *large groups* according to the number of members, and as such they have specific dynamics and demand adjusted work. In emphasising the role of the social worker in organising socio-therapeutic activities in psychiatry, a group of authors, Petrović, Sedmak, and Ćorić, state that the socio-therapeutic approach has become the lead method in working with **alcoholics, the elderly, adolescents and addicts**. These are mainly the groups whose social status asks for support from experts who are familiar with the theory and practice of social work, as well as the wider area of social policies (Petrović, Sedmak & Ćorić, 2005).

2) **Therapeutic community** – The first therapeutic community was founded in 1947 in London, in a period overlapping with the interval of rule of social thought

over psychiatry. The basic premise underlying the organisation of the therapeutic community is that the atmosphere in (mental health) hospitals can have a certain therapeutic effect on the mental health of hospitalised patients. Petrović, Sedmak, and Ćorić (2005: 176, our translation) state that the initial idea of the therapeutic community rested on "the belief that the environment can have a therapeutic effect on the patients". This idea was closely connected with the crucial insight that social thought introduced to psychiatry with regards to the aetiology of mental disorders: the cause of the disorder being in the social environment, the society and the family (Munjiza, 2012).

The atmosphere of the therapeutic community rests on mutual respect between the staff and the patients, with the fundamental elements of the community being **freedom, creativity and responsibility**, along with establishing relationships that create possibilities for spontaneous communication between the patients and the staff. It is from these premises that the basic principles of organisation of the therapeutic community are inferred, such as: equality among members (this relates to both the staff and the patients); securing "bidirectional flow" between the personnel and the patients; permissiveness (supporting mutual tolerance among patients, including forms of behaviour that are a reflection of their illness); and therapeutic culture (quotidian examination of problems that emerge in the ward, along with testing of traditional attitudes and beliefs). The previously quoted authors assert that, from its early beginnings, the therapeutic community has grown into a "facility for behaviour modification through group interaction, thus securing an environment for living and learning" (Petrović, Sedmak & Ćorić, 2005: 100, our translation). Similarly, Miković states that the main objective of the therapeutic community is **re-socialisation**, i.e. strengthening social competencies in psychiatric patients, while encouraging them to "accept their role in the community, and not feel as if the role were being imposed or forced upon them" (Miković, 2007: 167, our translation). This is achieved through the establishment of certain social capabilities in the patients, deficient or nonexistent prior to that moment. The patients cannot socialise outside the scope of authentic, realistic relationships with others, and if unwilling to partake in those relationships actively (Munjiza, 2012). As members of the therapeutic community, the patients gain a feeling of belonging, and they acquire communication skills. Social workers are, according to Miković, among the professionals who lead meetings with large groups, in the framework of activities of the therapeutic community (Miković, 2007). The theoretical **background** of the social workers is significant in the context of application of the systemic theory to the extent possible in institutions (Payne, 2001: 108), or in clinical social work (Knežević, Miljenović & Branica 2013: 157).

3) **Day hospitals**¹⁷ – represent a type of “partial” hospitalisation with patients dwelling in the hospital during the day, and then spending the night with their family (in a community). Miković highlights that with day hospitals the patient’s family is actively included in the treatment of the ill member by taking responsibility and care of them when the patients are outside the hospital. The author also states that in this manner “family closeness is maintained, and the patient’s reintegration into wider social surroundings is encouraged” (Miković, 2007: 184, our translation). In summarising the qualities of day hospitals, Kecmanović states that the work organisation of day hospitals “compensates for the disadvantages and limitations of treatment in enclosed psychiatric wards, and ambulant treatment of psychiatric patients” (Kecmanović, 1975: 85, our translation). Miković asserts that the organisation of day hospitals today is unimaginable without social worker’s engagement, while adding that the role of social workers in the organisation of day hospitals does not only entail managing socio-therapeutic activities – it also involves “including the entire family in the treatment process, and giving individual protection and help to a number of patients through close cooperation with various types of facilities, such as the centre for social work, work environment, school etc.” (Miković, 2007: 185, our translation).

4) **Therapy in homo-family and hetero-family surroundings** – This model was initially linked with one of the crucial contributions of the social paradigm to psychiatric practice, which relies on the notion that family is “the place for, and the subject of psychiatric treatment” (Kecmanović, 1975: 88, our translation). This notion is a result of not only psycho-dynamic cognition of the impact of the family constellation on the individual (including, in part, the inclination towards psychopathological abreactions), but also of the knowledge that family, as a structured group with its own dynamism and organisation, is one of the most important agents in remedial work with psychiatric patients that the social position in psychiatry can offer. This form of work with the mentally ill is significant in the context of social work as it prepares social workers for activities in the family environment. It should be added that psychiatric services in our environment are organised in such a way that among all the members of multidisciplinary teams working in the field of mental health, only social workers have the legal right to protect the interests and rights of children, and “visit families unannounced and without approval on behalf of the family” (Miković, 2007: 199, our translation).

¹⁷ According to the division of socio-therapeutic activities, proposed by Kecmanović, and adhered to in this paper, the organisation of the day hospital, socio-therapeutic clubs, and therapy in homogenous and heterogeneous family environments fall under socio-therapy in the wider sense (Kecmanović, 1975). Since this paper explores socio-therapeutic activities involving participation of social workers, those activities are presented without any further divisions of socio-therapy, assuming that, for the purpose of this paper, it suffices to observe these activities as one thematic whole.

5) **Work-occupational therapy** aims at strengthening the intangible, creative part of the patients' personality through activation of their creative potential. Occupational activities encourage the feeling of value and competency in patients, thus creating conditions for communication within the group (Munjiza, 2012). The difference between work and occupational therapy is that work therapy rests upon the massive scale unified work done by a large number of individuals, while occupational therapy accentuates the individual approach and encourages optimal development of individual capabilities and preferences. This means that occupational therapy represents a higher degree of therapeutic involvement than work therapy (Kecmanović, 1975). However, the role of the "occupational therapist" is indirect, and consists of, as Kecmanović states, "mediation between patients on one side, and some occupational activity on the other" (Kecmanović, 1975: 78, our translation). Work and occupational therapists in psychiatric institutions are mainly social workers, who undertake additional education for that purpose.

7) **Socio-therapeutic clubs** – as places in which different types of cultural and entertainment activities are being organised with the purpose of gathering psychiatric patients, they can be an "integral part of the health care institutions or an institution on their own" (Kecmanović, 1975: 87, our translation). Inside these socio-therapeutic clubs, psychiatric patients exchange everyday experiences, as well as their views on everyday matters, which do not have to deal with the position of the individual in the community and the society. According to Birer, the role of these clubs is particularly significant in treatment "because they bring patients closer to the reality of everyday lives, which is not the case with any other form of treatment of psychiatric patients" (in Kecmanović, 1975: 87, our translation). Simultaneously, the organisation of these clubs is such that the members, psychiatric patients, create organisational schemes that rely on "self-management and directed democracy" (Kecmanović, 1975: 88, our translation). Another characteristic of socio-therapeutic clubs, which relies on this type of organisation to bring patients closer to conditions of everyday life, is the presence of family members, who can prove to play a significant role in terms of modelling the patients' social behaviour, in line with social community values. As Munjiza observes, it is essential that non-psychiatric team members, such as social workers, be at the patients' disposal (Munjiza, 2012). The author also states that club meetings are often attended by mentally healthy individuals, such as family members and relatives of the ill, or people who remain outside the perimeters of their social environment for objective reasons. The activities of socio-therapeutic clubs evidently contribute to the highly important engagement of social workers, and the clubs themselves have already become part of socio-therapeutic work (for example in treatment of alcoholism) in countries of the former Yugoslavia with outspread socio-therapeutic practice (Miljenović, 2010).

CONCLUSION

The social paradigm introduced some new theoretical, methodological and research impulses in psychiatry, along with innovations in the field of practice of mental health. One of these innovations was the theoretical redefinition of the conceptual framework of psychiatry, i.e. its expansion towards social sciences. Simultaneously, theoretical and methodical specificities of social work converged towards an integration of this discipline in the new currents in psychiatry. Inclusion of social work in the diagnostic activities and treatment of the mentally ill implied completion of the psychiatric-anthropological sketch of the individual as a being that is influenced by a complex constellation of bio-psycho-social factors. In that manner, the framework consisting of the aetiological factors of mental disorders, spreading through the three aforementioned dimensions, and the three different strata of the individual's functioning, which can be used in prevention and treatment of mental disorders, is complete. As a result of drawing psychiatry and social work together in the realm of theory, social work is now richer in psychodynamic perspectives, and psychiatric services have experts that consider the social background of psychiatric patients from a systemic perspective.

At present, it is clear that the aetiology of mental disorders is partially determined by socio-economic factors, while health care services in the Western culture are undergoing the process of deinstitutionalisation. Consequently, it is to be expected that social workers will continue to contribute to the theory and practice of mental health. Following the domination of the social paradigm in psychiatry during the second half of the 20th century, biological psychiatry has regained influence in recent years, with a change in terms of taking into account the individual's psychological and social functioning, thus enabling future development of psychiatric theory and practice in accordance with the principles of interdisciplinarity and multidisciplinary. These tendencies point to the fact that the time of absolute domination of individual paradigms is past. Consequently, the three great paradigms that marked the development of modern psychiatry will not only coexist, but also contribute to the convergence of related disciplines in the area of mental health while respecting individual research and practical contributions. Social workers will play a significant role in that process, especially if we take into account the fact that, along with socio-therapy and psychotherapy, as two central axes of preventive and remedial activities, work with psychiatric patients now involves members of non-medical related disciplines.

REFERENCES

1. Bukelić, J. (2004). **Socijalna psihijatrija**. Beograd: Zavod za udžbenike i nastavna sredstva.
2. Eaton, W., Muntaner, C., Bovasso, G. & Smith, C. (2001). Socioeconomic status and depressive syndrome: The role of inter - and intra - generational mobility, government assistance, and work environment. **Journal of Health and Social Behavior**, 42 (3), 277 – 294.
3. Howe, D. (1997). **Uvod u teoriju socijalnog rada**. Beograd: Naučno - istraživački centar za socijalni rad i socijalnu politiku FPN.
4. Jakovljević, V. (1969). **Psihoanaliza i antropologija**. Beograd: Kultura.
5. Kecmanović, D. (1975). **Socijalna psihijatrija sa psihijatrijskom sociologijom**. Sarajevo: Svjetlost.
6. Kecmanović, D. (1978). **Društveni korijeni psihijatrije**. Beograd: Nolit.
7. Knežević, M., Miljenović, A. & Branica, V. (2013). **Teorija socijalnog rada**. Zagreb: Sveučilište u Zagrebu Pravni fakultet, Biblioteka socijalnog rada.
8. Kuhn, T. (2013). **Struktura znanstvenih revolucija**. Zagreb: Jasenski i Turk.
9. Lazić, N. (1999). Vladimir Hudolin i socijalna psihijatrija. U: Wofl, D. (ur.), **Vladimir Hudolin i njegovo djelo**. Rijeka: Sveučilišna knjižnica Rijeka, 20 – 28.
10. Miković, M. (2007). **Socijalni rad i mentalno zdravlje**. Sarajevo: Fakultet političkih nauka.
11. Miljenović, A. (2010). Psihosocijalni pristup i alkoholizam: Iskustvo rada u klubovima liječenih alkoholičara. **Ljetopis socijalnog rada**, 17 (2), 281 – 294.
12. Munjiza, M. (2011). **Istorijski razvoj psihijatrije**. Beograd: Službeni glasnik.
13. Munjiza, M. (2012). **Zdravstvena nega u psihijatriji**. Beograd: Velarta.
14. Opalić, P. (2008). **Psihiatrijska sociologija**. Beograd: Zavod za udžbenike.
15. Ostojić, D. (2012). Prva epizoda shizofrenije - važnost ranog otkrivanja bolesti. **Ljetopis socijalnog rada**, 19 (1), 53 – 72.
16. Payne, M. (2001). **Savremena teorija socijalnog rada**. Banja Luka: Filozofski fakultet.
17. Peković, M. (2010). **Psihiatrija**. Podgorica: Univerzitet Crne Gore.
18. Petrović, P., Sedmak, T. & Ćorić, B. (2005). **Metode grupnog socijalnog rada**. Beograd: Autorsko izdanje.
19. Sosulski, M. (2010). Life history and narrative analysis: Feminist methodologies contextualizing black women's experiences with severe mental illness. **Journal of Sociology & Social Welfare**, 37 (3), 29 – 57.
20. Štrkalj Ivezić, S., Jukić, V., Hotujac, L., Kušan Jukić, M. & Tikvica, A. (2010). Organizacija zaštite mentalnog zdravlja u zajednici. **Liječnički vjesnik**, 132 (1-2), 38 – 42.

21. Taylor, J. & Turner, J. (2002). Perceived discrimination, social stress and depression in the transition to adulthood: Racial contrasts. **Social Psychology Quarterly**, 65 (3), 213 – 225.
22. Woolfolk R. (2001). The concept of mental illness: An analysis of four pivotal issues. **The Journal of Mind and Behavior**, 22 (2), 161 – 178.

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SOCIJALNA PARADIGMA U PSIHIJATRIJI KAO POVEZNICA IZMEĐU SOCIJALNOG RADA I PSIHIJATRIJE U TEORIJI I PRAKSI

Socijalna paradigma u psihijatriji služi kako bi se obuhvatila definicija pojedinca kao psihosocijalnog bića u ovoj grani medicine. "Socijalna revolucija" u psihijatriji pobudila je zanimanje za socijalne čimbenike koji utječu na etiologiju mentalnih bolesti, kao i na uspješnost rehabilitacije i liječenja psihijatrijskih pacijenata. U skladu s brojnim inovacijama koje je u psihijatriju unio socijalni model, socijalni radnici čine dio multidisciplinarnih timova koji rade s psihijatrijskim pacijentima. Socijalni model istaknuo je potrebu da se prepoznaju i analiziraju socioekonomski i interpersonalni aspekti funkcioniranja psihijatrijskih pacijenata, dok su metode i teorije iz socijalnog rada postale neizbježni čimbenici u planiranju aktivnosti namijenjenih sprječavanju i liječenju mentalnih bolesti. U radu se analiziraju važne značajke socijalne paradigme u psihijatriji koje su pojednostavile proces približavanja psihijatrije i socijalnog rada. Navodi se usporedba između praktičnih implikacija tri velike paradigme u psihijatriji te teoretske specifičnosti socijalnog rada koje su omogućile dvosmjernu interakciju između ove dvije povezane znanstvene discipline. U radu je naveden kratak pregled aktivnosti koje se smatraju obvezama socijalnih radnika unutar multidisciplinarnih timova koji rade s psihijatrijskim pacijentima, nastale kao plod konvergencije socijalnog rada i psihijatrije.

Ključne riječi: paradigma, socijalna revolucija, socijalni rad psihijatrije, multidisciplinarnost.