

Aina James Bergh and Caroline Jonsson

Ersta Sköndal University College

Institute of social studies, Social work program with an ethics and philosophy of life orientation, 240 ECTS Credits

Bachelor Thesis, 20 ECTS Credits, Spring Term 2013

First cycle (undergraduate)

Supervisor: Johan Gärde

Examiner: Kenneth Sundh

## **Knowledge, contribution and social factors**

**A qualitative study about psychiatric social work in Goa, India**

## **Preface**

The journey towards this final essay has been a real challenge but at the same time a valuable experience. We are grateful to have had the opportunity to travel to India for this purpose. It has been an adventure we will remember for the rest of our lives.

When we started planning our study and our trip to India we knew we wanted to explore an issue in the field of mental health care. After reading a lot of research in mental health we got interested in exploring how mental health care workers in India understood the Bio-psycho-social model of mental illness with focus on how they described the social part. We contacted one Non Governmental Organization (NGO) and one mental health care center that matched our sample criteria. We had one perception of how the NGO worked before we came to India but when we got there we realized that they did not match our sample criteria after all.

At the mental health care center we conducted two interviews before realizing that it would be difficult for us to find enough material for this study in the state of Goa. We realized that answering our research questions would have required a much larger research project than what could fit in the frame of a bachelor thesis and that we needed to rethink and reprocess the purpose of the study. In our present study we explore psychiatric social workers' and psychiatrists' perceptions of social work's unique knowledge and contribution to the field of mental health care in Goa. We also explore psychiatric social workers understanding of the social factors in relation to mental illness.

## **Abstract**

Social work is one of the core mental health professions. With a dominance of a biological model in psychiatry, the scope of social factors has been relatively marginal. Social factors have been argued to be social work's area of expertise. Psychiatric social work is challenged to articulate its unique knowledge and valuable contribution to the field of mental health care since they are coexisting with other more well-established professions. This qualitative study explores how psychiatric social workers and psychiatrists in Goa, India, perceive social work's unique knowledge and its contribution to the field of mental health care. It further explores psychiatric social workers' understanding of social factors in relation to mental illness. The empirical material was collected through twelve semi-structured interviews with ten psychiatric social workers and two psychiatrists working in different mental health care settings in Goa.

The results show that the main psychiatric social work contributions were described as raising awareness about mental illness and their functioning as a bridge between units. The result further shows a difficulty (among psychiatric social workers) to articulate psychiatric social work's unique knowledge, but during the interviews a specific in-depth knowledge emerged as well as a focus on psychiatric knowledge. Our findings showed that psychiatric social workers understood social factors in terms of social relations. The results are analyzed with Foucault's theory of discourse, Polanyi's theory of tacit knowledge and Inglehart's modernization theory.

Key words: Psychiatric social work, mental illness in India, mental illness in Goa, Social factors, Contribution, Knowledge

## Table of contents

<b>1. Introduction.....</b>	<b>6</b>
<b>1.1 Problem statement.....</b>	<b>7</b>
<b>1.2 Purpose .....</b>	<b>7</b>
<b>1.3 Research questions .....</b>	<b>7</b>
<b>1.4 Definitions .....</b>	<b>8</b>
<b>1.5 Outline.....</b>	<b>10</b>
1.5.1 Responsibility distribution.....	10
<b>2. Background.....</b>	<b>10</b>
<b>2.1 Mental health setting in India .....</b>	<b>10</b>
<b>2.3 The mental health setting in Goa.....</b>	<b>12</b>
<b>3. Method.....</b>	<b>12</b>
<b>3.1 A qualitative approach .....</b>	<b>12</b>
<b>3.2 Theory of science.....</b>	<b>13</b>
<b>3.3 Literature search .....</b>	<b>14</b>
<b>3.4 Sampling .....</b>	<b>15</b>
<b>3.5 The interview outcomes and transcriptions .....</b>	<b>16</b>
<b>3.6 The respondents.....</b>	<b>17</b>
<b>3.7 Validity &amp; reliability.....</b>	<b>20</b>
<b>3.8 Method of analysis.....</b>	<b>22</b>
<b>3.9 Methodological considerations .....</b>	<b>23</b>
<b>3.10 Ethical considerations .....</b>	<b>24</b>
3.10.1 Conducting research in a developing country .....	25
<b>4. Previous research.....</b>	<b>26</b>
<b>4.1 Studies from western countries .....</b>	<b>26</b>
4.1.1 Social factors in mental health .....	26
4.1.2 Knowledge articulation .....	28
4.1.3 Social work in mental health – an undervalued profession.....	29
<b>4.2 Studies from India.....</b>	<b>30</b>
4.2.1 The need for psychiatric social work in India.....	30
4.2.2 Psychiatric social work in India .....	31
4.2.2 Potential for social work contribution .....	32
4.2.3 A cross-national exploration of social work .....	33
<b>5. Theoretical framework.....</b>	<b>34</b>
<b>5.1 Foucault’s theory of discourse .....</b>	<b>34</b>
<b>5.2 Tacit knowledge .....</b>	<b>37</b>
<b>5.3 Modernization Theory - Inglehart.....</b>	<b>39</b>
<b>6. Results .....</b>	<b>40</b>
<b>6.1 Knowledge articulation difficulty .....</b>	<b>40</b>
<b>6.2 In depth knowledge .....</b>	<b>42</b>
<b>6.3 Focus on psychiatric knowledge .....</b>	<b>44</b>
<b>6.4 Awareness.....</b>	<b>45</b>
<b>6.5 The psychiatric social worker as a bridge .....</b>	<b>47</b>
<b>6.6 Social relations.....</b>	<b>49</b>
<b>7. Analysis .....</b>	<b>51</b>

**7.1 Knowledge articulation difficulty and in-depth knowledge ..... 51**  
**7.2 Focus on psychiatric knowledge ..... 53**  
**7.3 Awareness..... 55**  
**7.4 The psychiatric social worker as a bridge ..... 56**  
**7.5 Social factors ..... 57**  
**8. Conclusions ..... 58**  
**9. Discussion/inspiration to further research ..... 59**  
**10. References ..... 62**  
**11. Appendix ..... 65**  
**11.1 Appendix 1: Definitions ..... 65**  
**11.2 Appendix 2: Letter of consent..... 66**  
**11.3 Appendix 3: Interview guide Psychiatric social work ..... 67**  
**11.4 Appendix 4: Interview guide Psychiatrists ..... 68**

## 1. Introduction

Psychiatric social work is one of the core mental health professions (Probst, 2012, Proctor, 2004) and makes unique contributions to mental health care (O'Brien & Calderwood, 2010, p. 328-329, Karban, 2003, p. 196-197). The biological revolution in psychiatry, especially during the last two decades, is a factor, which has shaped mental health services. As a result of this, psychiatry paid less attention to social factors in mental health and moved closer to the traditional medicine (Aviram, 2002, p. 625). Social workers can make an important contribution to mental health care as a counterforce to the trend of medicalization (Aviram, 2002, p. 628) since social work as a profession has been encouraged to look beyond illness and treatment to the broader issues linked to the individual such as family, relationships, work and housing (Bland & Renouf, 2001, p. 238).

Psychiatric social workers in India have perceived their primary concerns to be psycho-social problems of mental health patients and affecting changes in their social environment in order to integrate them in society. In spite of this, many psychiatric social workers tend to identify themselves more with psychiatry than with social work (Verma, 1991, p. 15-16). Renouf and Bland (2005, p 421) states that there has been no well-articulated articulation of social work's specific contribution to mental health services but argue that this contribution is the capacity to link the individual experience of mental illness with broader social concerns (Bland & Renouf, 2001, p 238). Another significant contribution made by social workers can be seen as their recognition of disadvantage and discrimination in relation to a multifactorial model of causation of mental health difficulties (Karbon, 2003, p 196). Social workers' knowledge about community factors and skills in intervening in community settings becomes important in a time when the trend is to individualize illness (Aviram, 2002, p 628).

The profession social work is challenged not only to accept the knowledge and values of all disciplines in mental health services but also to articulate social works' uniqueness and valuableness (Renouf & Bland, 2005, p 425). Social workers in mental health settings further face certain challenges due to their inferior position compared to the other health professions (Aviram, 2002, Karban, 2008, O'brien & Calderwood, 2010, McCrae et al., 2004, Renouf & Bland, 2005, Beddoe, 2013). How do psychiatric social workers and psychiatrists in a Non-Western country perceive social work's unique knowledge and contribution to mental health care? And what are their perceptions of social factors in relation to mental illness? These questions lie at the core of our essay. We have chosen to do our field study in Goa, India. Goa is

a tiny state on the Indian western coastline and is one of India's most affluent and literate states (Chinai, 2007, p. 576). A study from Goa shows that 46,5 percent of the attendees of two primary health clinics suffered from common mental disorders, such as depression and anxiety disorders (Patel, 1998, p. 534).

## **1.1 Problem statement**

Psychiatric social work has a history of inferiority to other health professions and of difficulty articulating its knowledge base, which challenges the profession to have the impact on mental health care that it could have. Psychiatry today is still largely built on a biomedical paradigm and it has been argued that in this paradigm, less attention has been paid to the social factors of mental illness, which can be seen as the social workers' area of expertise.

## **1.2 Purpose**

The purpose of our study is to explore psychiatric social workers' and psychiatrists' perceptions of psychiatric social work's unique knowledge and its contribution to the field of mental health care in Goa, India. The purpose is further to explore psychiatric social worker's understanding of social factors in relation to mental illness.

## **1.3 Research questions**

- How do psychiatric social workers and psychiatrists describe psychiatric social worker's unique knowledge?
- How do psychiatric social workers and psychiatrists perceive psychiatric social worker's contribution to the work with mental illness and to the field of mental health care?
- How do psychiatric social workers describe social factors in relation to mental illness?

## 1.4 Definitions

In both quantitative and qualitative social research we connect data to certain concepts. The measurement differs depending on whether data is mainly quantitative or qualitative. In a quantitative study we convert variables into specific concepts in the planning stage while in a qualitative study we often measure while collecting data. Although in a qualitative study we also need clear definitions expressed in words, which are connected to the data (Neuman, 2011, p. 200-205). In this section we will present the key concepts that are important for our essay.

### Knowledge

facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject (knowledge in Oxford dictionaries)

### Social factors

It has been hard for us to find one single definition of social factors related to mental illness. In scientific articles found at Google Scholar, Academic Search Premier and Psych Info, researchers tend not to articulate a specific definition of the concept. Although Kaslow, Bollini, Druss, Glueckauf, Goldfrank, Kelleher & Zeltzer, (2007) describe social factors as:

physical environment, external stressors, family environment, interpersonal relationships, social support and isolation, role models, social expectations, value system, sociocultural factors (e.g., race, ethnicity, socioeconomic status, sexual orientation, religion), school and work history, medical–legal and insurance issues, treatment experience, and culture (Kaslow et al., 2007, s. 280)

For further definitions of relevant concepts from this definition, see appendix 1.

### Mental illness

When we tried to define the construct mental illness we realized that there does not seem to be no universal definition. WHO define mental health as:

a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2011)

We have chosen to use an Indian definition of mental illness from the Ministry of health and family welfare that defines mental illness as:

a disorder of mood, thought, perception, orientation and/or memory which causes significant distress to a person or impairs a person's behavior, judgment and ability to recognize reality or impairs the person's ability

to meet the demands of normal life and includes mental conditions associated with the abuse of alcohol and drugs, but excludes mental retardation (Ministry of Health & Family Welfare Government of India, New Delhi, 2011, p.4)

The above definition is from a draft that the Ministry of health and family welfare released 2011. The old definition of mental illness is from the Indian mental health act from 1987 and defined a mentally ill person as:

a person who is in need of treatment by reason of any mental disorder than mental retardation (Sarkar, 2004, p. 107-108)

This definition has been criticized for being too wide (Sarkar, 2004, Bada & Match, 2011) and in 2010 the work with updating the act began (Narayan, 2011).

### **Psychiatric Social Worker**

means a person with post graduate degree acquired after a minimum two year course in psychiatric social work, or doctorate in the field of psychiatric social work, from any university recognized by the University Grants Commission (UGC) (Ministry of Health & Family Welfare Government of India, New Delhi, 2011, p.3)

### **Mental health care**

When we in this essay refer to mental health care we mean what the Indian Ministry of Health and Family Welfare states as Mental Health Establishment:

Mental Health Establishment means all health establishments called by whatever name, either wholly or partly meant for the care of persons with mental illness, established or maintained by the Central or State Government, Local Authority, Trust (private or public), Corporation, Co-operative Society, Organization or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and/or rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the Central or State Government, Local authority, Trust (private or public), Corporation, Co-operative Society, Organization or any other entity or person; but excludes a family residential place where a person with mental illness resides with his or her relatives or friends (Ministry of Health & Family Welfare Government of India, New Delhi, 2011, p. 3)

## **1.5 Outline**

In chapter one, we began with introducing the study and presenting the purpose and research questions as well as the definitions of our constructs. Chapter two will present background information about the mental health setting in India and Goa and information about social work and psychiatric social work in India. In chapter three we describe the methodological process and address ethical considerations. Chapter four is a review of the previous research we have used and in chapter five we present the theories used to analyze our results. Chapter six presents the results of our study in six themes with quotations from our respondents. In chapter seven we analyze our results with the help from the theories and previous research and in chapter eight and nine we present our conclusions and discuss our findings in relation to our purpose.

### **1.5.1 Responsibility distribution**

Although we have written most of the study together we have divided some parts between us. Caroline has had the main responsibility for the sections Background, Sampling, Ethical considerations and Foucault's theory of discourse and Aina has had the responsibility for the sections Validity and reliability, Method of analysis and Tacit knowledge.

## **2. Background**

This section will give a short introduction to the mental health setting in India, social work education and the current mental health setting in Goa.

### **2.1 Mental health setting in India**

India was a British colony from the year 1859 to 1947. The British built the first mental hospitals during the colonial years, though primarily with ideas and concepts from Europe. At first the hospitals mainly were aimed to treat European patients in India. There are signs of modern medicine and hospitals being brought to Goa by the Portuguese long before the British (Sharma, 2006, p. 112). Goa was a Portuguese colony between the year 1511 and 1961 (Fernandes, 2008, p.151). After the independence from the British rule, psychiatric departments began to move to the general hospitals instead of building more mental hospitals. At this time the government also began to formulate policies for advancement in the field although there is still numerous limitations of the services provided for the people of India (Raney, 2005, p.154).

In India the mental health personnel is quite limited and are mostly located in urban areas (Kandhewal, 2004, p.126). There are only two psychiatrists per one million people and there are 0,2 psychiatric beds per 100 000 people. The number of psychiatric social workers is 1000 for the whole country (Raney, 2005, p.154). The existing facilities in the country fail to meet the required norm and a major share of psychiatric facilities still lie within mental hospitals. The psychiatric facilities are not yet integrated in primary health care settings (Mohandas, 2009, p. 174) but the integration is under development (Kandhewal, 2004, p140).

India is a multicultural society where a lot of people visit religious and traditional healers for mental health related problems. The ancient ayurvedic system of medicine also influences treatment and explanation of such problems (ibid, 2004, p.126).

## **2.2 The development of Social work and psychiatric social work in India**

Social work as a profession was introduced by American educators, who established the first school of social work in Mumbai 1936, now called the Tata Institute of Social Science.

Specialized courses in various fields were introduced much later and in 1952 the first course in medical and psychiatric social work was introduced at the Tata Institute (Verma, 1999, p 187). The model of psychiatric social work practice in India, like the profession social work, has been borrowed from the United States of America (Verma, 1999, p. 13-14). The training of psychiatric social workers followed a pattern that matched the socio-economic and cultural conditions in the United States of America. In India this created a gap between theoretical knowledge based in a foreign culture (USA) and the Indian social realities (ibid, p. 55-56).

During the past six decades, the number of professional social work educational institutions has multiplied. There are 120 institutions of social work education in India of which as much as 56 are located in the state of Maharashtra (Delhi School of Social Work University of Delhi, 2008, p.2). It is also in the state of Maharashtra that most of the psychiatric social workers are located (Verma, 1999, p 106). At present, 19 schools of social work in India offer a two-year course in medical and psychiatric social work (Verma, 1999, p. 83). Fieldwork is an important part of training programs in most professional courses in social work. Each student is generally expected to spend a minimum of 15 hours a week in the field (ibid, p. 191-194). In India the Bachelor course for general social work is three years and the Master course is two years. A Masters degree of social work has generally been the required degree for entry into the

profession, though this is changing and social workers with a Bachelor degree in social work are now entering the field (Weiss-Gal & Welbourne, 2008 p.286).

### **2.3 The mental health setting in Goa**

In Goa there are two colleges where you can study social work both at a Bachelor level and a Master level; at IGNOU-People's University and at Don Bosco College in Panaji. The Master course of social work started at Don Bosco College in 2012-13 and now 2013-14, for the second year students, there is a specialization in Medical and psychiatric social work. In Goa there are about 50 social workers and 27 of them have specialized in Medical and psychiatric social work (Informative interview, see appendix 5). For working in a psychiatric setting, like an institute or a rehabilitation center, a Master course in medical and psychiatric social work is often required. In Goa there are several NGO's working with mental health in different areas, for example HIV/AIDS and Children and Youth mental health. They are working both at an individual level through counseling and on a societal level through awareness programs. There is one psychiatric institute, IPHB (Institute of Psychiatry and Human Behavior) and two rehabilitation centers, Chaitanya and Our Home.

## **3. Method**

In this section we will describe the theory of science that has guided us during the course of this study. We will further describe our methodological process and reflect over ethical and methodological considerations.

### **3.1 A qualitative approach**

This study is inductive and has a qualitative approach. In an inductive study the researcher measure and create new concepts while gathering data and develop or confirm a theory at the end of the process. The process begins with observing and reflecting on the empirical world and gradually the researcher progress toward thinking in more abstract ways, forming concepts and theoretical relationships (Neumann, 2011, p. 70).

As we wanted to take part of psychiatric social workers' thoughts and subjective experiences a qualitative approach suited our purpose the best (Larsson, Lilja & Mannheimer, 2005, p. 92). In

qualitative studies the researcher is interested in gaining in-depth understanding about specific cases and settings and use methods like interviews, participatory observations and focus groups in order to collect the data which can take many different forms including words, actions, sounds, symbols, physical objects and visual images (Neumann, 2011, p. 421). In this study we have conducted semi-structured interviews since this form of interviewing is flexible. The respondents are able to formulate their answers in their own manner and we, as interviewers, have the possibility to ask follow-up questions during the interview. We chose to use semi-structured interviews instead of unstructured interviews since we have a clear focus in our study and certain themes we wanted to focus on (Bryman, 2011, p. 415, 416).

This study further has an explorative-descriptive approach. Explorative, as the topics we study have been studied to a very limited degree in India and Goa and descriptive, as we want to describe our respondents perceptions about these topics and relate our findings to the previous western research (Neumann, 2011, p. 38-40).

### **3.2 Theory of science**

We, the authors of this study, have an ontological standpoint in social constructionism. Bryman (2011, p. 37) means that social constructionism constitutes an ontological standpoint where social objects and categories are socially constructed. Social constructionism points out that our ways of understanding the world does not come from an objective reality (Burr, 2003, p. 3). The categories and concepts we use to understand the world is historically and culturally created which means that they are in constant revision. It is through daily interaction between people in the course of life that our version of knowledge is created (ibid, 2003, p4).

The perspective of hermeneutics wherein researchers aim to achieve an understanding of a text's meaning has inspired us. In the hermeneutics, the researchers pre-understanding become important (Larsson, Lilja & Mannheimer, 2005, p. 93). When studying the text, the researcher tries to get inside the viewpoint that the text represents and then tries to understand how the parts relate to the whole (Neuman, 2011, p. 101). By revising the pre-understanding through new experiences we gain new pre-understandings and create new meaning (Ödman, 2007, p. 103).

Under the research process we have tried to be aware of our pre-understanding and be open to new understandings. We have acknowledge the fact that the themes in our result may been influenced by our understanding of the interviews in their entirety. The pre-understanding

determines which aspects of the subject that will be studied (Ödman, 2007, p. 102). Even before we conducted this study both of us have had an interest in the subject of psychiatry and how to work with people suffering from mental illnesses. Since this is our subject of interest we are aware that we have gained a type of pre-understanding that could have influenced the interpretation of our data. Our pre-understanding has surely mattered in our choice to conduct this present study.

### **3.3 Literature search**

We began our search for previous research with words like: psychiatric social work+ social work+mental health+mental illness+unique+knowledge+contribution+expertise+India+social factors+social dimension+social domain. We conducted the search in databases like Academic Search Premier, PsychInfo, PubMed, Diva, Google Scholar and Libris. While reviewing previous research we encountered several problems that we had to deal with. The main problem was that there were few research papers from India that suited our purpose. Most of the studies we found were conducted in western countries like England, Australia and Canada. We found some articles regarding psychiatric social work in India and ordered four of them through the library at Ersta Skondal University College since they were not available in full text. Only three of them were available and when we began to review them we realized that unfortunately they were not relevant for our study. We found more research from India regarding social work, although this was regarding social work in other areas like the work with HIV/AIDS, domestic violence, sex workers or poverty.

We have chosen to present four studies related to India which we think are relevant for our study and our purpose. Three of them are conducted in India and one is a cross-cultural study where India is one of the participating countries. The first study is conducted by Mohan in 1970 and does not explore social workers own perception about the possible contribution but we argue for its importance since the study explores the profession psychiatric social work. The second study Verma (1991) is an empirical mapping over the situation of the profession psychiatric social work in 1991 where she also describes the development of the profession. The third study (Kanango, 2008) is an empirical study about the potential contribution of social work in rural health care. Although this study discusses social workers possible, and not actual, contributions the findings are relevant for our purpose.

The final study (Weiss-Gal & Welbourne, 2008) we have chosen to use is a cross-cultural study between ten countries, where India is one of them. This study is relevant because it discusses the profession social work and is quite new in contrast to many other articles found. Besides these studies related to India we have chosen to use previous research from western countries since this research is really close to our study and therefore relevant. We further believe that it is interesting to explore the relation between the findings from western countries with findings from a developing country like India.

### **3.4 Sampling**

Our respondents are divided into two professions; psychiatric social workers and psychiatrists. One part of our purpose is to explore psychiatric social work's unique knowledge and contribution to the field of mental health care. Therefore we believe that it is interesting, besides interviewing psychiatric social workers, to interview psychiatrists since they are a big part of the mental health care setting.

Our criteria for the psychiatric social work respondents were that they should have passed the Master course in Medical and psychiatric social work and work in some way with mental illness in Goa. Our criteria for the psychiatrists were that they should have an education in psychiatry and that they were working with mental illness. In qualitative studies it is rare to sample in order to be able to make generalizations about the entire population. Instead a few cases are sampled to provide insight or understanding about issues in the social world (Neuman, 2011, p. 241). Our aim was not to get cases that could represent all psychiatric social workers and psychiatrists in Goa. Purposive sampling is used when you have a specific purpose in mind (ibid, p. 268). The researcher makes the sampling that is relevant for the research questions (Bryman, 2011, p. 434).

While we still were situated in Sweden, as mentioned in our preface, we got in contact with one mental health care center, Chaitanya, and one NGO. When we made this sampling we had other criteria since we had another purpose. We conducted two interviews at Chaitanya before we changed our purpose and since the respondents still matched the new sample criteria for our new purpose we could still conduct interviews with respondents at this center.

To broaden our study we wanted to reach more psychiatric social workers, other than those working at Chaitayna. Therefore, once we changed our problem statement and research questions to this present one, we googled on the Internet to find additional psychiatric social workers and

psychiatrists with words such as mental hospital+psychiatric hospital+mental health+rehabilitation center+NGO+Goa. This may have limited our sample since we only could find NGOs, rehabilitation centers or hospitals that had a website. We found several NGOs but hardly any of them were working with mental illness. Although, we found one but when calling them we found out that they were not any social workers working there. We also found one psychiatric hospital and two regular hospitals with a psychiatric department. We called the two regular hospitals with a psychiatric department but they did not have any social workers. Finally we called the mental hospital, IPHB, and they had one social worker and several psychiatrists and they referred us to apply for admission to the Dean of the institute to be able to conduct interviews. After we got the admission we could interview the social worker and one psychiatrist.

Snowball sampling is used when you initially get in contact with a group of people and then through them get in contact with other respondents (Bryman, 2011, p.196). This type of sampling fitted us since we did not have any contacts of our own in Goa. The director of Chaitanya mental care center gave us contact information to a psychiatrist whom we called and agreed to participate in our study. We also visited IGNOU-The People's University to ask about information about where we could find psychiatric social workers. They referred us to the Assistant director of the Department of social welfare-welfare of differently abled branch in Goa, Sudesh Gaude. Sudesh had many contacts and arranged four additional interviews with psychiatric social workers and offered to participate himself.

### **3.5 The interview outcomes and transcriptions**

Altogether we have conducted 12 interviews. Initially the plan was to make 14 interviews but two of them we were not able to conduct. For one of the interviews the respondent did not show up at the pronounced time and the other one, we had to interrupt due to the fact that the respondent felt that he had too little experience of work with mental illness. We have been using two different interview guides; one for the psychiatric social workers and one for the psychiatrists since the different professions require different questions (see appendix 3 & 4). We have conducted one informative interview with Sudesh Gaude (see appendix 5) since he has much information about the profession social work in Goa. We found that valuable for our study since there is a lack of this kind of information in previous research.

In all the interviews we left room for individual follow-up questions. The duration of the interviews vary from 34 minutes to 52 minutes. Ten interviews took place at the respondent's workplaces. Two of them took place in one of the respondent's home, although one at a time. The intended plan was that these two interviews would have been conducted at an office but since it turned out that we could not gain access to it, one respondent offered us to conduct the interviews at his home.

We have recorded all the interviews and transcribed them, six interviews each. We have chosen to delete sounds like "eh" and "ah" as well as the sounds of laughter, sighs and coughs since our transcriptions were not aimed for the use of conversation analysis or any detailed linguistic analysis (Kvale, 2009, s. 197-199). Some words, such as missing verbs, have been changed in the result to make it easier to read. We have also left out repetitions of words. Nothing has been changed to alter the content of the interviews.

### **3.6 The respondents**

Altogether we have conducted twelve semi-structured interviews. Ten out of these are conducted with psychiatric social workers and two are conducted with psychiatrists. Below we will introduce the respondents and their workplace to give the reader an idea of the context.

#### **Chaitanya mental health care center**

Chaitanya is a residential mental health care center working with people suffering from chronic mental illness. The first center opened in 1999 in Pune, Maharashtra, where it has its main services. There is also one center in Goa and one in Kerala. Overall, Chaitanya takes care of over 400 patients. At the center in Goa the most common disorder dealt with is schizophrenia and personality disorder, such as bipolar disorder. The patients, who come to Chaitanya, mainly have a manageable and not acute condition. The minimum stay is three months but some patients stay as long as nine months, depending on the patient's condition and the family's cooperation.

Chaitanya offers a wide range of services, for example; individual therapy, group therapy, art therapy, relaxation techniques, music therapy, supervised medical interventions and family therapy. At Chaitanya, Goa, all of the staff are trained psychiatric social workers. In addition to this there is one psychiatrist who comes once a week. We conducted six interviews at Chaitanya. All the respondents have passed the Master course in Medical and psychiatric social work from

Indian universities outside of Goa. Four of them had passed the Bachelor of Social work before that. One respondent had a Bachelor of Arts in economics and another had a Bachelor of Arts in political science. The respondents have been working at Chaitanya between one and five years.

### **Institute of Psychiatry and Human Behavior- IPHB**

IPHB is a psychiatric hospital that provides medical care to patients in Goa and nearby states such as Maharashtra and Karnataka. At present the hospital has 190 beds. The hospital provides both outpatient services and indoor treatment. At an average, 200 patients attend the outpatient department every day. Most diagnoses dealt with are schizophrenia and alcoholic and drug abuse but also different kinds of mood disorders like bipolar disorder, anxiety disorders and depression. Patients who come to IPHB mainly have an acute condition. At this hospital we conducted two interviews, one with a psychiatric social worker and one with a psychiatrist and one with a whom we will introduce below.

The psychiatric social worker has completed a Bachelor degree in Social work as well as the Master course in Medical and psychiatric social work from an Indian university. She has been working at IPHB for two years where her daily tasks are caring for outdoor patients as well as indoor patients. She takes case histories of new cases and gives information about the governmental scheme where the patients can get financial benefits. She also makes home visits to the patients' families to give them awareness about the specific mental illness.

The psychiatrist has completed a Bachelor degree in medicine and a Masters degree in psychiatry from a Goan college and has been working at IPHB for 15 years. He works in a team which meets about 150 patients per day, indoor patients as well as outdoor patients. His daily tasks are basically about clinical assessment and medical treatment.

### **Sudesh Gaude - Assistant Director, Department of social welfare - welfare of differently abled branch**

Sudesh has a Bachelor degree in Social work and a Masters degree in Medical and psychiatric social work from an Indian university outside of Goa. Sudesh has in the past been teaching in subjects like therapeutic work with individuals and families at both Bachelor degree level as well as Masters degree level. He has work experience related to mental illness from several NGO's in Goa. At present he is obtaining his PhD (doctor of philosophy) in social work and at the same

time he is working in the governmental sector. His work is to provide financial assistance to the disabled, which includes the mentally ill.

#### **Psychiatric social worker-SWAPNA**

This psychiatric social worker has Bachelor in social work and after that a Master in Medical and psychiatric social work at an Indian university outside of Goa. He works at an NGO called SWAPNA-Social Workers Association of People in Need. Their main focus is the mental health status of the people of Goa. The NGO works in the communities by conducting different awareness programs where they reach out to families, students and teachers. The goal is to give awareness to people about different mental illnesses so that the communities will accept the mentally ill and not neglect or stigmatize them.

#### **Psychiatric social worker-Sai Life Care**

This social worker has completed a Bachelor in English and a Master of philosophy in Social work. She also has a Masters degree in medical and psychiatric social work. She is working at an NGO called Sai Life Care, which is running twelve projects in a rural area of Goa. The project she is involved in focuses on health and education for adolescents. The project includes ten different schools that receive visits from counselors who identify students with emotional problems. The counselors offer the students counseling and if needed the counselor refers them to a psychiatrist and sometimes they help families to obtain financial support in order to make it possible for the children to finish school. The NGO also conducts different awareness programs about mental health and illness.

#### **Psychiatrist**

This psychiatrist has a Bachelor degree in Medicine and a Masters degree in Psychiatry from an Indian university. He has his own private clinic where he has been working for 15 years. The clinic is an outpatient clinic where he performs clinical assessment but he also refers patients to inpatient services if needed. People come to the clinic with different mental problems such as depression, anxiety disorders or schizophrenia. He see about 20-25 patients per day and is also in charge of a training program at an NGO.

### **3.7 Validity & reliability**

Validity means truthfulness and refers to whether the researcher observe, identify or measure what she/he personates to measure while reliability refers to the possibility to replicate a study (Neuman, 2011, p. 214). Validity and reliability in qualitative research is perceived and designed in a different way than in quantitative research; there are qualitative researchers who use the same words but pay less attention to measurement, researchers who use the same words but attribute them different meaning and researchers who replace them with other constructs.

There are different aspects of validity and reliability that needs to be paid respect. Internal validity refers to the necessity of a good agreement between the researchers observations and the understandings, ideas and statements produced and that no internal errors has been made in the design that produce false conclusions (ibid, p. 214-217). Internal reliability refers to the agreement among members in a research team about the interpretation of the collected information. External validity discuss the extent to which a study can be generalized and external reliability the extent to which a study can be replicated (ibid,p 214). The relationship between validity and reliability in qualitative research is often that increased validity is gained at the expense of reliability and vice versa. Several methods of measuring increases the probability for getting in-depth information about something but can obstruct reliability and a single measure is easier to replicate but can obstruct the validity (Neuman, 2011, p. 216).

To assure internal reliability we have transcribed the interviews in detail, six each, and where there were difficulty hearing what was said or uncertainty of the meaning of something said, we listened to those parts in each other's interviews. To assure internal validity we have firstly defined the constructs we use. We have then used the same interview guide during all of our interviews and been careful to ask follow-up questions to be certain of what they meant and tried to give an honest and truthful account of the respondents' thoughts in our result. In the final stage of our analysis after the final gathering of our data we went through the transcriptions several times in different stages of reflection and analysis to assure that the themes we put together had a relevant basis in our respondents' descriptions.

Since there are difficulties connected with replication of qualitative studies, due to their unstableness over time and their unique mix of measures (Neuman, 2011, p. 208), some researchers choose to use the term dependability instead of external reliability. Dependability, as used by Guba and Lincoln (1994), refers to creating a complete and available account of all the

phases in the research process, which makes it possible for other researchers to evaluate the quality of the study. Instead of external validity they use the term transferability. They urge researchers to produce what Geertz (1973a) call “thick descriptions” which allows others to evaluate if the results can be transferred to other contexts (Bryman, 2011, p .354-355). This is made by analyzing differences and similarities between the compared situations (Kvale, 2009, p. 282). Additionally Guba and Lincoln use the term confirmability to address the fact that total objectivity is inaccessible in social science and to emphasize the need for the researcher to assure that personal values or theoretical orientation has not consciously influenced the performance and results of a study (Bryman, 2011, p.355-356).

To assure dependability we have tried to account for all the procedures associated with conducting this study as explicitly as possible in order to make the study transparent and possible to evaluate. To assure transferability we have described the Indian context in relation to mental health care, social work and psychiatric social work and described the respondents’ and their workplaces in order to give an account for the context of our study. We have further separated the analysis from the result to make it possible for the reader to discriminate between the result and our interpretation of it. In contrast to quantitative research, validity in qualitative research is not about trying to realize a single truth about something but to offer a fair, honest and balanced account of social life from the respondents’ viewpoint. The word plausible is often used and suggest that the researcher’s truth claim should be reasonable, not exclusive (Neuman, 2011, p. 216).

As the hermeneutic perspective suggests, we are aware that we have a pre-understanding of the studied subject that we cannot escape from but by reflecting on it we have tried to minimize the impact of it on our study. Kvale writes that objectivity in qualitative research is concerning freedom from bias and the researchers commitment to being objective to her/his own subjectivity (Kvale, 2009, p. 260). As qualitative research relies on dependable, credible and trustworthy researchers (Neuman, 2011, p. 168) we have tried to be sensitive to our own views and to recognize how they might influence the study.

### 3.8 Method of analysis

Analysis is the process where the researcher is searching for patterns and relationships among details in the data by organizing, integrating and examining it. This might result in improved understanding, expanded theory and advanced theory (Neuman, 2011, p. 507). The goal is to organize details into a coherent picture or into tightly interlinked concepts. As Neumann puts it: “Qualitative analysis can eliminate an explanation by showing that a wide array of evidence contradicts it” (Neuman, 2011, p. 509). Qualitative research analysis is an ongoing process during the entire study since it requires an interaction between collecting information and reflecting over it or analyzing it. This means that researchers start looking for patterns and relationships while collecting data and might use results from early data analysis to guide the continuing data collection (Neumann, 2011, p. 509).

The qualitative analysis occurs in different steps, commonly described as steps of coding (Bryman, 2011, p.510), but there are no standard methods for text analysis that correspond to the techniques available in quantitative statistical analysis (Kvale 2008). One of the most common terminology of coding originates from Grounded theory (Bryman, 2011, p.510) in which the steps of coding are called *open coding*, *axial coding* and *selective coding* where selective coding is made after the completion of the data collection (Neumann, 2011, p. 514). Grounded theory’s core processes have had a large influence on social science but there are some practical difficulties associated with the use of this method since a complete analysis require going back and forth between data collection and analysis several times. This requires time that researchers often do not have (Bryman, 2011, p. 522-523).

In our study we have used the coding procedure but we have not had the possibility to collect data on different occasions since we made our interviews in India and then returned back to Sweden. After we returned to Sweden and began our final analysis of our material we contacted one respondent that was also our informer respondent and asked clarifying questions about his answers and some further informative questions.

In the initial coding phase we looked for critical terms and located themes. Neumann express this process as bringing “*themes from the surface from deep inside the data*” (Neumann, 2011, p. 511) and describes it as dividing the text into meaning units, condensing them and labeling them with a code. The next step of the coding is to examine the themes; making connections among them, maybe dropping some and examining others more in-depth. One of the requirements for

validation of a study is to build a dense web of support for core themes by finding several instances of empirical evidence and making connections among them (ibid, p. 216). The core themes that we identified were *Knowledge articulating difficulty*, *In-depth knowledge*, *Focus on psychiatric knowledge*, *Awareness*, *The psychiatric social worker as a bridge* and *Social relations*.

We want to emphasize the importance of the social context for the meaning of social action (ibid, p. 175). There has been critique directed against coding since it fragmentize the respondents story and the context around it might get lost (Bryman, 2011, p. 526). We have tried to stay close to the respondent's stories even if we have constructed themes and in a way taken quotes out of their context. We also want to stress that we are aware of the interview never being a totally open and free dialogue since we as researchers set the rules and define what to emphasize in the person's story and what to leave behind (Kvale, 2009, p. 48).

### **3.9 Methodological considerations**

In two of our interviews we recognized limitations in communication due to language barriers. In some parts of the interviews the respondents expressed difficulties expressing words in English. We are aware that this may have affected our result. The result might have turned out differently if they would have had the opportunity to speak their native language. We have chosen to use these interviews anyway since we have been careful to ask follow-up questions to be certain of understanding their answers.

Another thing that can be problematized is the fact that some of our psychiatric social worker respondents worked with more severely mentally ill patients than others. Chaitanya mental health care center and IPHB for example, meet patients with diagnoses such as schizophrenia and other severe conditions. When the respondents talked about their experiences they talked about it in relation to which kinds of mental illnesses they were working with. This may have limited the validity of our study. The best might have been to delimit the criteria of the sample to one specific diagnosis but this would not have been possible in the Goan setting since the psychiatric social workers are very few.

### 3.10 Ethical considerations

Since this study is conducted within a University College education program at a basic level it is not embraced by the Swedish law 2003:460 “concerning ethical considerations when researching on human beings” (Lag (2003:460) om etikprövning av forskning som avser människor). We have followed the ethical principles posed by the Swedish Board of Ethics (Vetenskapsrådet, 2002) which states four ethical principles: *the principle of information*, *the principle of consent*, *the principle of confidentiality* and *the principle of use of material*. (Vetenskapsrådet, 2002, p. 6)

*The principle of information* pose that the concerned persons of a study shall be informed about the purpose of the research, that their participation is voluntary and that they have the right to end their participation. The respondents shall also be informed about how the material will be made public (ibid, p. 7-8). At the beginning of each interview we gave our respondents a letter of consent, which they read and signed. In this letter of consent we stated the purpose of our study, the participant’s rights and how the material will be used (see appendix 2).

*The principle of consent* poses that the respondents are in charge of their participation (ibid, p.9-11). We have, through our letter of consent, informed our participants that their participation is voluntary and that they can interrupt the interviews whenever they want without any reason. We also state that the participants can withdraw their contribution before the final draft of the essay. It can be seen as problematic that we did not ask all our respondents about their participation in first person. At Chaitanya mental health care center the director of the center asked the respondents for participation in our study. Two respondents have been asked for participation through Sudesh.

*The principle of confidentiality* poses that data about the participants shall be given maximum confidentiality and shall be handled in a way that unauthorized person will not be able to take part of the information (ibid, p.12-13). At first we aimed to give the respondents fictional names in order to make them anonymous. After our data collection we realized that it would be difficult to make all the respondents anonymous since some of them worked alone at a certain position. We also understood that there were quite few psychiatric social workers in the mental health care setting in Goa. Therefore we have chosen not to use fictional names and just call them respondents in order to decrease the risk of identification. We have chosen to use the names of the respondents’ workplaces to give context to the interviews. We have chosen to email one of our participants afterwards and ask for permission to use his real name, which he agreed to. If we

named his workplace we felt that it could be a risk that certain data could be derived to him. The interviews have been processed in a way that data that could have been drawn to a specific person has been deleted.

*The principle of data* poses that data about individuals only shall be used for research purpose (ibid, p.14). In our letter of consent we stated the purpose of our study and that the interviews only will be used as a part of our bachelor thesis. We stated that we would transcribe the interviews by ourselves, that we would keep the interviews in a safe manner inaccessible to unauthorized and that we would delete them after the final draft of the essay (see appendix 2).

### 3.10.1 Conducting research in a developing country

This heading was something we considered to be important to add to this section of ethical considerations. Although Goa is one of India's most affluent and literate states, India still counts as a developing country (OECD-DAC list, 2013). Coming from a well-developed country like Sweden to make research in a developing country suggests some challenges. It requires an ability to adopt a sensitive and humble approach towards the people you meet. We, in the more developed countries are not the ones to state what is good or bad, wrong or right, for all people or countries. We think this is something that is important to stress and emphasize when conducting research in developing countries. We have been located in Goa for a relatively short period of time, five weeks.

Although we read a lot about the psychiatric setting in India before we got there, it is impossible for us to fully understand the complexity of the psychiatric context in Goa. It could be seen as problematic that we have chosen to use theories from western countries and apply them on our results based in a different context. One of our chosen theories is Foucault's theory about discourse and we use it in order to problematize that discourses can be valued differently since different kind of knowledge is perceived as more or less legitimate. We use it as criticism of the division of what is perceived as truth, not criticize individuals or the Goan context since we argue for the existence of these divisions even in western contexts. During our research process we have reflected on our privileged position as coming from a well-developed country, which might have given us an interpretative prerogative. Although, we have chosen to use Foucault's theory of discourse since it give us the opportunity to get a deeper understanding of our results.

## **4. Previous research**

In this section we will present our previous research, containing of two parts. First we will present an overview of the literature we use from western countries and secondly we will present three empirical studies made in India and one empirical cross-cultural study.

### **4.1 Studies from western countries**

Many scientists argue that social work is making a significant contribution to the mental health system but that there are things in the way in order for social work to make the contribution they see is possible (Aviram 2002, Karban 2008, O'brien & Calderwood 2010, McCrae et al. 2004, Tew et al. 2012). Below is a review of some of the contributions of social work in mental health and some of the obstacles faced.

#### **4.1.1 Social factors in mental health**

Social factors are important for mental health (Aviram, 2002, p. 625) and opportunities to improve population health have been missed due to the lack of realizing the importance of such factors and of supporting the funding of research about them. The General Social Survey in USA captures a broad scope of information and shows, in comparison to the narrow band of information gotten from major health surveys, how much opportunity have been missed in understanding the social influences on health (Link, 2008, p. 371). Social factors can influence the onset, course, treatment and rehabilitation of mental disorder (Aviram, 2002, p. 625) and Tew et al. (2012) argues that social factors play an important role in recovery of mental health difficulties. In the dominant medical discourses the place of social factors is relatively marginal (Aviram, 2002, p. 625, Renouf & Bland, 2005 p. 422). Many scientists point out that one of social work's contributions to mental health care is its focus on and knowledge about the social aspects of mental illness (Aviram 2002, Karban, 2008, O'brien & Calderwood, 2010, McCrae 2004, Tew et al., 2012).

A study from Canada (2009) was developed in order to address the challenges facing mental health social workers and to explore social workers perceptions of their contribution to the mental health system. 339 social workers responded to an online survey with both open and close-ended questions. One of the results showed that the majority of the mental health social workers

believed that they were making a significant contribution to the mental health system. The mental health care workers described the unique contribution of social work to the mental health field as the client-focused, recovery, human rights, empowerment and person-in-environment perspectives (O'brien & Calderwood, 2010, p. 324-328).

McCrae et al. performed a study 2004 where the two main subjects were the role and status of mental health social workers and the future of social work in an integrated service. The researchers conducted qualitative interviews with two groups; senior mental health service managers (with responsibility for social workers from each of the 33 London boroughs) and senior teaching and research staff of academic institutions (providing social work training in the London area) (ibid, p. 305-308). All participants believed that social workers had an important role in promoting the social model in mental health care (including factors such as family, career and environment) and many also saw the systemic approach of social work and its wider socio-political focus on issues such as race, as beyond the conventional scope of health professions. Their greater awareness of rights and available resources was also acknowledged as valuable (ibid, 2004, p. 310).

Karban (2003) and McCrae et al. (2004) mean that social workers are providing interventions from a humanistic and holistic approach rather than from a treatment paradigm or a medical model (Karban, 2003, p. 191, McCrae et al., p. 308). Social workers also have knowledge of disadvantages and discrimination, which makes them able to critique existing mental health setups (Karban 2003, p.196). Social workers contribute to mental health by helping the individuals to better cope with their problems, adjust to their environment and change social conditions in order to improve the quality of life (Aviram, 2002, p. 627).

Auslander (2001) interviewed 31 experts in the field of social work with different backgrounds (academic, practice and administrative) from six geographical areas (Eastern and western Europe, North America, Australia/South Pacific, Africa and Asia) about what they consider to be the most important accomplishments or achievements of social work in health care during the time they have been involved in it (ibid, p. 202-205). A few top items stood out from the responses. One achievement was described as changing the models of health and medical care, where the incorporation of the bio-psycho-social approach and other holistic approaches in mainstream health care were mentioned. Another achievement they described as establishing

social work as a legitimate discipline in health settings. Finally, knowledge development was seen as one accomplishment of social work in health settings (ibid, 2001, p. 207).

#### 4.1.2 Knowledge articulation

One of the challenges of social work in mental health is to define and articulate its knowledge base (Renouf & Bland, 2005, p 427) as well as its role in mental health (O'Brien & Calderwood, 2010, p. 329).

The earlier mentioned study from Canada (2010) show that mental health social workers take on a number of different roles such as educators, researchers and professionals in direct practice and that they provide a wide range of services. The findings of the study show that mental health social workers are doing a little bit of everything and that it is hard to discern what they do and do not which calls for a need for social workers to articulate their role in the field of mental health settings (O'Brien & Calderwood, 2010, p. 331-333). Over many decades social workers have built a wealth of experience and expertise that has been undervalued and McCrae et al. (2004) mean that there is an urgent need for mental health social work to assert its achievements (ibid, p. 317). Renouf and Bland (2005) states:

*The profession needs to be able to assert with confidence that the core concerns of social work; human rights, self-determination, family relationship and welfare, employment, housing, community, life change are central to mental health. (Renouf & Bland, 2005, p. 428)*

According to Aviram (2002) social work's knowledge base is rooted in the social behavioral sciences and is representing a bio-psycho-social approach, which makes their view based on a broad concept of person in society (ibid, p. 627). He argues that social work's multi-disciplinary base of knowledge, and specifically their knowledge of social sciences, is valuable when it comes to the occurrence, identification and course of mental illness and to seeking and getting treatment. It also gives them an advantage over other professionals when it comes to source allocation, mobilizing resource and coordinating services for mentally disabled and it is valuable in facilitating the provision of services in the community. Aviram (2002) states that the mental health system differ from other medical services since it must take in account the social implications of illnesses on all levels, individuals, families and communities. Here social workers have an advantage due to their education. Social workers also have skills in group work and

community work, which is essential when working with self-help groups, family members and groups of mental health care consumers (ibid, p. 627-629).

In an article from 2013, Beddoe discuss qualitative data from an earlier study of his from 2010. This study employed 17 semi-structured individual interviews and 6 group interviews involving 40 social workers, professional leaders and managers in health and mental health. The purpose was to study the role of Continuing Professional Education (CPE) for social workers' understandings of the nature of the profession in New Zealand. The study showed that many social workers feel that they have an insecure knowledge claim but that several participants also could identify knowledge and skills (ibid, p. 28-29). Several participants articulated the knowledge and skills of the profession to be the intimate knowledge of the client's world (ibid, p. 34).

#### 4.1.3 Social work in mental health – an undervalued profession

Social workers in mental health settings face certain challenges due to their inferior position compared to the other health professions (Aviram, 2002, Karban, 2003, O'Brien & Calderwood, 2010, McCrae, 2004, Renouf & Bland, 2005, Beddoe, 2013). Participants in McCrae et al.'s study (2004) perceived that social work in integrated teams lack of academic status compared to health professions and McCrae's conclusion is that social work needs to articulate itself more coherently as it coexists with more powerful disciplines (ibid, p. 311-316).

Beddoe's study (2013) show that social work still is marginalized in the institutional health and mental health settings and that social work is lacking independence because of medical and nursing professions' stronger establishment in the health field (ibid, p. 26, 38). The social workers in the study expressed that it was easy to become a part of the clinical system, which might weaken the adherence to the foundational principles of social justice. They described these principles as significant and felt that this part of the social work identity easily became unrealized in a health setting. Some of the participants advocated for social work to provide a challenge to the medical paradigm (ibid, p. 35). Beddoe (2013) argues that there is considerable support for strengthening social workers knowledge claim in multidisciplinary settings in order for them to have a place at the table (ibid, p. 29).

O'Brien and Calderwood (2010) discuss that social workers are challenged to be both clinically relevant and critical. In clinical practice, such as psychotherapy, the focus of change

lies with the individual while critical practice is more focused on the social inequities that contribute to mental illness. The findings of the current study indicate that the Canadian social workers are not being compelled to choose one focus over the other (ibid, p. 330). Another challenge recognized is that other professions collaborating with social workers have a clearly defined practice embedded in law, which legitimizes their entitlement to perform certain tasks, while social work's practice is of the kind that other professions might perform some of it too. This may lead to the undervaluation of the profession and show the need for social work to more clearly articulate its role (ibid, 2010, p. 328-329).

Aviram (2002) states that social work in the field of mental health has not challenged the dominance of the psychiatric profession, which has put social work in a position that has limited the profession from contributing fully to the field (ibid, p. 618). Finally McCrae et al. (2004) argue that social work, unlike other health professions, have failed to develop a strong professional voice to influence policy and practice and that social work, despite a history of innovative practices, has contributed relatively marginal to the mental health knowledge base. (ibid, p. 316-317)

## **4.2 Studies from India**

Here we will present three studies from India and one cross-cultural study.

### **4.2.1 The need for psychiatric social work in India**

Mohan (1970) wanted to examine the role of the social worker in the institutional process and highlight the profession psychiatric social work's present position and future horizon. Mohan claims that social work services for psychiatric patients at this time (1970) were almost nonexistent and he estimated the number of psychiatric social workers in the whole country to 300. Mohan interviewed patients, relatives and doctors at all three mental hospitals in the state of Uttar Pradesh (ibid, p. 12-15). In his study, the author examines and discusses the social workers possible contribution in different stages of the institutional process. Mohan found that there are several areas where social workers can make important contributions. First he argues that it is hard to recover from a mental illness if the patients do not have the family's support and sometimes, the direct cause of the patients psychiatric condition may lie in familial problems.

Working with families and solving this kind of family issues is one important area where the social workers can make a valuable contribution (ibid, p. 13).

Another area where social workers could make a contribution is regarding diagnosis, participating in giving a more dynamic diagnosis to the patient. Mohan states that the social workers can gather all kind of data regarding the patient's socio-psycho-physical situation since the mental illness only can be understood by studying the patient in his totality. He further states that social work can make a significant contribution when it comes to adjusting the patients back to the world outside of the hospital. Mohan found that patients, after a release, found it hard to resume their role and status in the community. A release requires a careful analysis and planning in order to help the patients adjust back to the community, which is something social workers could do (ibid, p. 14). Finally, Mohan means that medieval beliefs and attitudes towards the mentally ill exist in the society and that there are wide misconceptions of the cause of mental illness. He argues that social workers would be the best agents to perform educational programs to reduce the ignorance and prejudice towards the mentally ill (ibid, p. 16).

#### 4.2.2 Psychiatric social work in India

Verma (1991) explored psychiatric social work in three traditional psychiatric settings; psychiatric institutions, psychiatric departments of general and teaching hospitals and child guidance clinics. Altogether 151 psychiatric social worker's were interviewed in these different settings from all over the country (ibid, p. 21-31). The study is mapping the current situation of the profession with facts like the geographic location of the psychiatric social workers, age, sex, educational background, working condition and function (ibid, p. 124-196). The study showed that psychiatric social worker's function included a wide range of services. It included working with families for the purpose of rehabilitation of the patient, writing social histories of new cases, organizing group activities, individual counseling, follow-up work, referral work, home visits, mobilizing voluntary organizations to provide supportive services for the mentally ill and training programs for non-professionals and volunteers (ibid, p. 151-185). Verma's study (1991) further found that nearly two-thirds of the respondents were involved in assisting the mental health team in diagnostic functions and that psychiatric social workers shared and exchanged their views to assist in the formulation of diagnosis at case conferences (ibid, p. 167).

Verma states that psychiatric social workers have taken an active part in the work with decentralization of the mental health care to the communities. Their specific contributions have been promoting community action and participation, dealing with the psychosocial aspects of care, developing social support systems and networking with welfare and social service organizations and community leaders. Verma makes the conclusion that psychiatric social work has to encounter some basic issues. In order to acquire a distinct status as specialists in the mental health team, social workers have to develop and expand their skills and knowledge within the broad objectives of their profession and relate it to the field of mental health (ibid, p. 219-225).

Verma states that social work developed as an auxiliary service to psychiatry and has often been described as a secondary setting of the medical profession. When psychiatric social work was introduced it did not have a firm knowledge base, which the practice could be based on. Verma argues that psychiatry has gained authority in the field of mental health through its association with science and medicine. Working closely with psychiatrists in a psychiatric setting, the psychiatric social work profession incorporated the psychiatric ideology and perspective with the social work practice. The medical model strengthened their knowledge base, which helped the social workers to base their practice on scientific knowledge and principles. Verma means that this close association with psychiatry and the opportunity of utilizing the knowledge of psychiatry enabled them to claim higher professional status compared to social workers in other settings. Psychiatric social workers have been aware of their auxiliary nature and this has led to an effort to define their role more precisely in order to establish their independent identity in mental health.

Over the years, psychiatric social workers have perceived their primary concerns to be the psychosocial problems of mental health patients such as helping patients meeting their social needs and affecting changes in their social environment in order to rehabilitate and integrate them back in society. In spite of this, many psychiatric social workers tend to identify themselves more with psychiatry than with social work (ibid, p. 14-16).

#### 4.2.2 Potential for social work contribution

In a study Kanango conducted in the rural area of the state West Bengal in 2004, the researchers explored people's (villagers, health personnel of a primary health center, patients) perception of the health services provided by the state. The study was conducted through both interviews and

observations. The result pointed out several difficulties about the health services provided (ibid, p. 104-105). The referral work was restrained, as the doctors were not available most of the time. Villagers mostly did not follow the course treatment prescribed and often expected immediate results. When the illness persisted they fell back on folk remedy. Patients tended to seek help when the illness had become serious and not in the initially state, this especially applied to women. The researcher discusses the results in the way that social work has to have a crucial role in this area, although social workers are very negligible in terms of number (ibid, p. 104-112).

The second area where social workers have to have a vital role is regarding information about the availability of services, about the outcome of various types of treatment and about the importance to follow the treatment fully. The right to information, when a specific treatment is prescribed, has to be ensured by the social workers since the medical professions rarely recognize this. Health education and awareness interventions are a vital area where social workers have a significant role to play since it can prevent a lot of the illnesses. Finally, the researcher argues that there is a need for counseling and guidance which the social worker has to provide since the other professions in the health team have little desire and time to provide that (ibid, p. 114-115).

#### 4.2.3 A cross-national exploration of social work

In an article from 2008, Weiss-Gal & Welbourne compare the professional features of social work in ten countries: Chile, Germany, Hungary, India, Mexico, South Africa, Spain, Sweden, the UK and the USA. The cross-cultural study is based on detailed descriptions and analyses prepared by country experts, established social work educators and academics, during 2005 and the aim of the article is to compare the professional features of social work in ten diverse countries and discuss social work in these countries in terms of eight characteristics of profession: public recognition, monopoly over types of work, professional autonomy, the knowledge base, the professional education, the professional organizations, the existence of codified ethical standards and the prestige and remuneration of social work (ibid, p. 281-283).

The information about India that is relevant for this study is presented below. The status and prestige of social work in the ten countries studied is generally low and in half of the countries (Germany, Hungary, India, Mexico, Spain), the status is particularly low compared to other helping professions. In India this is explained by the broad and non-specific definition of social work and the fact that people without social work training may call themselves social workers

and are employed as such (ibid, p. 284). In addition to this, in India, as well as in five other countries, the salaries are generally lower than in other helping professions due to insufficient awareness that social work requires professional training and expertise. India is the only country out of the ten countries studied that lack state-level salary directives for social workers (ibid, p. 288). The degree of professional autonomy in most of the countries varies with the social worker's position, skills and with the field of practice and sector. In India most social workers have little professional autonomy but in medical or psychiatric settings it is possible for social workers to negotiate greater professional authority for themselves (ibid, p. 285).

## **5. Theoretical framework**

In this section we will present the theoretical framework for our study. The theories used are Foucault's theory of discourse (1993), Inglehart's theory of modernization (1997) and Polanyi's theory of tacit knowledge interpreted by Rolf (1991). In addition to Polanyi's theory we use Olsson (2009) and Bergmark (1998) to understand tacit knowledge. Each one will be described below. In our section of analysis we will relate our results to these theories.

### **5.1 Foucault's theory of discourse**

We have mainly proceeded from Foucault's original text translated into Swedish, "Diskursens ordning, en installationsföreläsning vid Collège de France" (Discourse on Language, Inaugural Lecture at the Collège de France, 1970). This text is quite hard to permeate and we are aware of the fact that Foucault can be interpreted in several ways. We would like to stress that it is our interpretation and understanding of Foucault that will lie at the core of this section and that we do not claim that it is a rightful truth about Foucault's theory of discourse.

A discourse regulates what can be said, who can say it and how and what can be legitimized as the truth (Foucault, 1993). A discourse shall not be considered simply as all the things you say or the way it is said. Foucault puts it: "The discourse is as much in what not being said, or in what marks of gestures, attitudes, ways to be, codes of behavior and spatial dispositions" (Foucault, 2008, p.181, the authors translation).

Foucault mentions three rules of exclusion that regulate the discourse. The most obvious and familiar one is what is *prohibited*. We know perfectly what can be said, when it can be said and finally who is legitimized to say it (Foucault, 1993, p. 7). Another principle of exclusion is about

*division and rejection* where some discourses are not being seen as legitimate. Foucault exemplifies this through division of reason and madness, a division, which is common in modern sciences. What is being seen as reason is created in the discourse through its opposite, the madness. A madman's speech is viewed as non-existing, without either truth or meaning, worthless as evidence which leads to the rejection of the discourse of madness. It is the reasonable's discourse that has been allowed to exist in the sciences (ibid, p. 8-9). This division between madness and reason can legitimize and enable practices that can lead to people being powerfully affected. This has enabled practices that classify people as criminal and abnormal. Foucault mainly writes about this in his work, "Discipline and Punishment: The birth of prison, 2003" (Övervakning och Straff: fängelsets födelse, 2003).

The third principle of exclusion Foucault is talking about is the *opposition between the truth and the false*. What is perceived as the truth is established historically and is inconstant over time. The "truth" get support by a system of institutions that maintains it. With the modern science in the 17th century we got a new will to truth that created lenses that determined truth as what could be observable and measurable. This new will to truth forced the knowing subject (the researcher) to a position with a certain viewpoint that the knowledge should aim to be verifiable and useful (Foucault, 1993, p. 10-15). The will to truth exerts pressure and a power of constraint over other discourses. Foucault exemplifies:

*I am thinking of the way Western literature has, for centuries been forced to base itself in nature, the plausible, the sincerity and in science, in short, upon the true discourse (Foucault, 1993, p. 14, the authors translation).*

The truth of science will emerge to us as universal and as a truth that seems to contain of wealth and power. This makes it hard for us to see how this will to truth works, how it creates procedures of exclusion and specific discursive lenses (ibid, p. 15).

Besides these exterior procedures of exclusion Foucault points at another system where the discourse regulates itself, *internal procedures*. The first, he calls the commentary. Foucault talks about discourses on different levels, where some discourses are more permanent than others. Examples of more permanent discourses can be the religious and scientific ones. A commentary to a religious text, for example, makes it possible to create a new discourse and to say something new and different from the original text. But the commentary always has to relate to the original text, it always has to relate to what already has been said which results in a repetition of what

already has been said. In that way the commentary reproduce and maintain the discourse that is seen as the truth (ibid, p. 16-19).

The second internal procedure for regulating the discourse is about what Foucault calls *the disciplines*. It can be seen an organ of control of the discourse. Every discipline, for example the science of medicine, use a certain set of concepts and techniques that are changeable over time. Every statement has to fulfill many requirements to be counted as a part of the discourse. If somebody wants to talk about new questions, subjects or concepts that is not already in the discourse that person risk to be placed outside of the discourse and the statement risk to be seen as fantasies or popular conceptions (ibid, p. 22-23). As Foucault states:

*It is always possible one could speak the truth in a void but one would only be in the true, however, if one obeyed the rules of the 'policy' which has to be reactivated every time one spoke (Foucault, 1993 p. 25, the authors translation).*

The last internal procedure is regarding *rarefaction among speaking subjects*. It regulates who is allowed to speak and who is not. Specific requirements are constructed for getting entrance to the discourse where different discourses are easier to get entrance to than others. Different rituals decide which qualifications are needed in order for someone to be allowed to speak. The rituals decide gestures and behaviors that the talking subject must fulfill to gain access to the discourse. Foucault view the educational system as a political instrument to control, maintain or change the appropriation of discourses, as well as the knowledge and power within them (ibid, p. 26-31). In the sciences, the formal requirements and qualifications are very clear. To gain access to the discourse you first have to accept the truths that are created in that discourse. The speaking subjects have to bow to the discourse to get entrance to it (ibid, p. 26-31). But we shall not forget that there exist other discourses. As Foucault states:

*The existence of systems of rarefaction does not imply that, over and beyond them reigns a great, limitless, continuous and silent, repressed and driven back by them, making our task to abolish them and at last to restore it to speech. (Foucault, 1993, p. 37, the authors translation)*

From our understanding of Foucault's thoughts about discourse we argue for the existence of a psychiatric discourse as well as a discourse of social work. They both have their own system of concepts, rules and statements. In our analysis we will put Foucault's theory of discourse in relation to our results and give an account for its significance. After reading and interpreting

Foucault we argue that there exist a psychiatric discourse and a discourse of social work. Both the discourses have principles of exclusions and internal procedures for regulating themselves. But they also differ from each other. For example, the procedure of *rarefaction among subjects* can differ since there are different rules of qualifications in order to get access to the discourses. There can also be differences of how well established the created truths in each discourse are.

## **5.2 Tacit knowledge**

Tacit knowledge is a construct originally coined by the Hungarian philosopher Michael Polanyi. After him it has been interpreted by many researchers and attributed various different meanings. Here we will give a brief account of some of Polanyi's thoughts interpreted by the Swedish philosopher Bertil Rolf (1991) and mention some of the thoughts that has emerged in Sweden about tacit knowledge in relation to caring professions by referring to Olsson (2009) and Bergmark (1998). There are two aspects of tacit knowledge that especially interest us. One is the necessity for social workers' tacit knowledge to become explicit to some extent in order for it to be recognized and valued. The other aspect is that tacit knowledge tends to be less valued than scientific knowledge with the consequence that professions like social work, which to a large extent require tacit knowledge, are devalued. This last part is particularly a challenge for psychiatric social workers since they reside in a context dominated by the more established profession psychiatry.

Polanyi describes four aspects of tacit knowledge; knowledge that does not stand in focus, knowledge that is required in order for us to have other knowledge (surrounding knowledge), clues to the meaning of an entirety and knowledge about the parts that build up the knowledge about the entirety (Rolf, 1991, p. 64). One of the central thoughts behind Polanyi's construct tacit knowledge is a human who is using a tool and identify the tool as a part of herself and thereby expand her boundary towards reality (ibid, p. 62).

Polanyi describes the difference between tacit and explicit knowledge like this:

*The essential logical difference between the two kinds of knowledge lies in the fact that we can reflect critically on what is explicitly presented in a way that we cannot reflect on our silent awareness of an experience. (Polanyi in Rolf, 1991, p. 100)*

He states that it is possible to distance oneself from the tacit knowledge in order to reflect on it and articulate it. Then the tacit knowledge becomes possible to spread, criticize and expand. Tacit knowledge can grow through a learning process that reminds of trial and error, which makes it partly an experience-based knowledge (Rolf, 1991, p.100). Polanyi further argues that language not always is sufficient in order to capture the tacit knowledge. Since the world and the knowledge we build up is complex, the totality of our knowledge is impossible to fit in a language (ibid, p. 29-30).

Polanyi states that in the debate about qualification in society, professional competence is often linked to the scientific language of a profession, a professions symbolic capital or if a profession is built on a theoretical education but mean that education lack sufficiency for creating competence in a profession (ibid, p.126-127). He further link tacit knowledge to professions and professional competence. He argues that professional traditions develop through the interaction between tacit knowledge and social reflection communicated through language. A professional tradition requires a set of rules, a system, that legitimate the content and define social roles. Characteristic for a profession is that one of its members by reflecting on knowledge and giving feedback can influence and change this system. This process is what Polanyi calls professional competence (ibid, p. 161-163). He further argues that a person that somehow gets disconnected from her or his tradition, for example a professional tradition, will lose constructs to think with, a picture of oneself in relation to others and knowledge and values passed down in the tradition (ibid, p. 228).

Olsson (2009) states that the discussion after Polanyi has been characterized by views on the differences between scientific and experience based knowledge and that it especially within caring science has been stressed that certain knowledge only can be gained through experience. This knowledge has not come into existence with the purpose of creating theories about anything and cannot, as opposed to scientific knowledge, easily can be connected to education (ibid, p. 41-47). Bergmark (1998) means that the construct tacit knowledge have been used to refer to social workers' special but unarticulated knowledge and that it has been emphasized in contexts where professions have felt their position threatened or where there has been disagreement about how to evaluate different forms of knowledge. He further expresses a worry that practical, not articulated knowledge may become marginalized as the range and claim of formalized knowledge increase (Bergmark, 1998, p. 49).

Olsson (2009) states that the academic world often nurture a notion that only scientific knowledge can be seen as true, important, valid and reliable but insist that there are other forms of knowledge; practical knowledge that is tied to personal experience (ibid, p. 41-42, 54). This experience-based knowledge is established in numerous problem situations throughout life and becomes especially important when social workers need to make personal choices of action. Olsson further stress the problem concerning this kind of knowledge; since there are no obligations in documenting and publicizing the knowledge, it can neither be reviewed criticized or defended (ibid, 2009, p. 45-54).

### **5.3 Modernization Theory - Inglehart**

Modernization theory has been developing for over a century with advocates like Marx, Weber and Bell (Inglehart, 1997). In 1997 the political scientist Ronald Inglehart put together the results of the World Value surveys from the years 1981 and 1990 and of the Euro-Barometer surveys carried out annually between the years 1970 to 1990 in his book *Modernization and postmodernization*.

One of the main findings in Inglehart's book is that there are coherent and even, to some extent, predictable patterns in the way that economic development, cultural change and political change go together which modernization theory in different shapes has always claimed. On three points however Inglehart differ from earlier claims; he does not believe that change is linear, he does not believe in either economic or cultural determinism but that they are mutually supportive and he reject the ethnocentric perspective of those who equate modernization with westernization, as the rise of the west only was one form of modernization. According to Inglehart (1997) the patterns of economic development, cultural change and political change show where countries lie on a scale between modernization and postmodernization (ibid, p. 5-12). When his study was summarized in 1997 he counted India to be one of the countries in modernization (ibid, p. 93).

We will mainly focus on the part of Inglehart's theory that confirms modernization theory (that there are coherent and predictable patterns) and mainly discuss the area of faith and family. Societies that place strong emphasis on religion also tend to favor large families and view the family as important. Inglehart argues that modernization results in a shift from traditional authority to secular-rational authority, in other words the decline of the sacred or mystical pre-

rational elements of religious faith due to the rise of a scientific worldview (ibid, p. 80-85). Traditional value systems must be changed in order for modern economic development to take place and new forms of social order has to be established. Modernization has major benefits in the form of increased life expectancy why it has been chosen in spite of the costs (ibid, p. 26). Inglehart writes:

*Successful industrialization requires a relatively competitive, impersonal, bureaucratic, achievement-oriented form of social relations that tends to be dehumanizing and stressful (Inglehart, 1997, p. 26).*

Emphasizing competition reduces the risk of starvation but probably also increases psychological stress since warm and personal communal ties and norms of sharing have to give way to an impersonal competitive society adapted to individual achievement (ibid, p. 71). Inglehart states that taking one's world apart and putting it together again is extremely stressful and that one's belief system is important for the sense of security in times of change (ibid, p. 33-40).

## **6. Results**

Out of our three research questions; knowledge, contribution and social factors, we have structured six themes that emerged from the interview answers. The themes connected to knowledge are *knowledge articulation difficulty*, *in-depth knowledge* and *focus on psychiatric knowledge*. The themes connected to contribution are *awareness* and *the psychiatric social worker as a bridge* and the theme connected to social factors is *social relations*. We will present our results under these themes, beginning each theme with the results from the psychiatric social worker respondents and ending it with results from the psychiatrist respondents. We will analyze our results under the headline analysis that follows after this section. We have chosen to use the term patient for the people our respondents work with since it is the construct the majority of the respondents are using.

### **6.1 Knowledge articulation difficulty**

Our main question about knowledge was: *What kind of knowledge do you think you as a social worker have that other professions in mental health care do not have, which is important when*

*working with mental illness?* With questions like this we wanted the respondents to describe the unique knowledge of social work.

Almost all of the social worker respondents had difficulty articulating social work's specific knowledge. Three of them clearly expressed that social workers lack specific knowledge with phrases like: "Actually, it's not the specific. No, not a specific" and "No I don't think so" (that they have unique knowledge). Another respondent expressed it like this:

*I don't think so, that separate knowledge is there for the psychiatric social workers (...) our theoretical background is very limited in the sense, like, only the basic. It's not in detail, because these psychologists study in detail. Their course, I think, are more on mental illness and how to conduct these psychotherapies but ours it's, in India it's very limited, we get only the basic even of mental illness.*

Some of the respondents tended to emphasize what knowledge they did not have. They talked about the specific knowledge that psychiatrists or psychologists have, seemingly unable to articulate social work's specific knowledge:

*I cannot treat the mental case or any abnormal behavior. I cannot treat. (...) as a social worker I have basic knowledge of psychiatric mental illness, mental health care, but I cannot decide the treatment plan. That is psychiatric only who are doing the treatment plan.*

One social worker stood out as an exception from this trend as he had no difficulty at all expressing psychiatric social workers' specific knowledge, for example acknowledging social work's knowledge about the society and social relationships:

*To understand the social factors, the social worker is the best person who can understand the social factors or social status of that particular family. Wherein for other persons it will become difficult because, see, social worker have studied the society in depth, what are the difference, how the society is, okay. When we say the society and the social relationship, how this social relationship take place, that is the social worker is best person who knows about these social relationships as compared to that other professionals. (...) Because, see, the social worker is the best person to know about these social relationship as well as what are the reasons for breakage of this social relationship, what are the factors which are responsible in breakage of social relationship which lead to a mental illness.*

Later on the same respondent also mentioned social workers knowledge about family relations, describing it as one of the strengths of the profession:

*So in order to counsel the family or in order to deal with the family, social workers is the best person as compared to the other professionals because in the regular curriculum they have studied the types of families, what are their relationships with each other, how they relate to each other, how their*

*family disorganizations takes place. All these things we learn in our profession, how to deal with the family, okey. The psychologist might be good at the testing and all that but this is our strength wherein we know the family, the family backgrounds, how to deal with the families.*

The two psychiatrists spoke a lot about what knowledge psychiatric social workers should have instead of what knowledge they believe that they actually have and one of them expressed that since he was a psychiatrist it was difficult for him to answer that question. One of the psychiatrists however expressed that psychiatric social workers have knowledge about integrating mental health patients back to society. The other psychiatrist expressed doubts about the knowledge of psychiatric social workers and talked about missing parts in their understanding of mental health care work:

*See, when I look at it I find that a lot of social workers they see the patients as of today, right now. But when I see a patient I see where I want to send that patient, where I want him to reach. I don't see right now. (...) so that understanding of where to take him is not fully developed.*

He also stated that most people in mental health, including social workers, make the mistake to see the individual in isolation and not as a whole, as an individual who lives in society. Additionally he argued that social workers lack practical knowledge from their education.

## **6.2 In depth knowledge**

As mentioned above, most of the psychiatric social workers had difficulty articulating their unique knowledge. They seldom spoke of knowledge explicitly but by describing parts of their work, specific knowledge came through and the most prominent theme in those descriptions was related to the amount of time the respondents spend with the patients:

*Social work knowledge means handling patients. (...) Psychiatrist sitting there and prescribe some medication first of all. Social worker only one of the person who is dealing with them... who is talking with them, who is handling family, who is given feedback to doctor.*

Another respondent expressed the in depth knowledge about the patient which dealing with the patients results in:

*We have sessions, like family sessions and then we get a better insight about them (...) So I feel in this my particular profession of psychiatric social worker we're doing in this depth field of the particular patient. (...) so we're thinking about the different aspects of their life, not only just from what happened in these past few months in their personal life. Right from their childhood to the other personal life, so we'll be having an overall idea of their different aspects of their life. But as you are asking about*

*different professionals in mental health itself, they're not so much concerned about other aspects, they consider only about medical aspects, what happened particularly with the person clinically, but our profession is to know basically and to make that person reconsider, make that particular person understand about different aspects of their life, so that's what I mean in-depth.*

Working closely with the patient was something that this respondent described. This resulted in a relationship with the patient that she perceived as valuable:

*We are dealing with patients directly. (...) When psychiatrist come he saw the patient for one hour maximum. But we are always with them. (...) We know about the patient, we know about the family, we know about the social atmosphere, what the rituals are. In India there are a lots of, you know, so many gods, religions are there, so what are their religion, they follow some different rituals, their faith are different so we are knowing about it, we need to talk about it with the patient maybe or in the family maybe. (...) So the psychiatrist is also doing the same thing but their time limit is less and their attachment is quite less. But we are doing with them because we know everything about them. (...) You know, so, that makes us different. (...) Ok, psychiatrist, he's giving like, what to say, biological ease to the mentally ill patient, ok. Psychologist, he is analyzing him, doing some test and all. Social worker, he's handling with the patient, family, the community also, society also. (...) This work takes long time, it's quite big process that we are following so I don't think that psychologists or psychiatrists will do the same.*

Another respondent expressed that psychiatric social workers' specific knowledge lies in going out and gathering information about the patient both from the patient but also from relatives and friends in order to get the social history:

*Yeah, they have, we are getting the social history. We are contacting with the psychiatric setting, relatives, friends and all. We are going to relatives, friends. If patient is starting colleges and schools or job place, all social worker can do the most, like, other than the psychologists and the psychiatrists. They are not going out and all. We can go out and gather knowledge, get the history of, so we can do many things other than the psychiatrists and the psychologists. So I feel that social workers can do best, yeah.*

In some of the interviews the respondents used the expression “rapport building” which means “a close and harmonious relationship in which the people or groups concerned understand each other's feelings or ideas and communicate well” (Oxford dictionary). This respondent talked about rapport building in relation to getting information from the patients:

*Every day we have to talk to them, we have to build a rapport with them, because without a rapport you cannot get the proper history and all. That intervention you have to, those tactics you have, social workers have those types of techniques: Empathy, sympathy, non-judgmental attitudes, individualization, these types of techniques you want to get out the history from the patients.*

One of the psychiatrists confirmed that one of psychiatric social workers' contribution in mental health care is working closely with the patients, helping them deal with their lives:

*They are having a very important role in all the rehabilitation of the patients because mental illnesses are long term illnesses. Often some of them are life long, serious illnesses. So cope with that. So it's not just, I mean, medication are important but it do require social workers to help them deal with their lives.*

### **6.3 Focus on psychiatric knowledge**

Several respondents who had difficulties articulating social work's unique knowledge tended to point out the importance of psychiatric knowledge instead. When asked about important knowledge in mental health care, several psychiatric social worker respondents expressed that psychiatric knowledge is the primary knowledge needed. The psychiatric knowledge emerged as the main knowledge needed in both working with the patients insight about their illness and the in the community work. One respondent described the main knowledge when working with mental illness like this: "See, we have to learn all the disorders first. You should know all the disorders, what type of disorders are there." Another respondent talked about the psychiatric knowledge needed in relation to the work with the patient's insight about the illness:

*We have knowledge about mental illness mainly, ok.(...) So if a social worker was there and he give them knowledge that no, this is not because of black magic, it is because of the illness and he or she needs treatment, then we can guide them. He will get treatment there, he will get free medication there.*

Several respondents talked about the importance of the psychiatric knowledge in order for being able to give proper information to the patient and the family. One respondent described the psychiatric knowledge as the primary knowledge needed:

*Psychiatric knowledge we have, must have for working in this field, if we don't have psychiatric knowledge we can't handle patients, we can't give proper information to family and patient, we can't supervise their symptoms so we have to, we have to learn psychiatric first.*

Another respondent referred to the importance of psychiatric knowledge in the work with family and community:

*Normally, basically, is to have the scientific knowledge of psychological problems. So as a social worker, have basic knowledge of psychiatric mental illnesses, mental health care. Having knowledge,*

*basic knowledge, psychological knowledge, psychiatric knowledge helps us to sensitize that particular community, family members and the community and associated people around.*

## **6.4 Awareness**

The most prominent theme that emerged from the questions about social work's contribution was awareness. All of the social worker respondents spoke about awareness, either as the patient's insight about her/his illness or as the surrounding worlds' (family, community and society) awareness about mental illness. The respondents saw awareness as a crucial matter in the work with mental illness and expressed that this was a major part of their contribution to mental health care. Work with awareness could be conducted both as prevention of mental illness and as a step in the recovery process of the patient. One of the respondents described the work with the patients' insight about their illness like this:

*(...) we are trying to help, adjust them to accept the reality, so, it's their illness. And some of them is believing that it's maybe because of the fathers and mothers, they think it's because of their life, that's why it happened, like it's fate, like that. We are trying to convince them to realize that's their illness.*

Another respondent described it similarly and expressed the effort needed in the work with the patients' insight:

*They have no insight about illness so gradewise we have to give them insight only, with sessions. We are providing reading materials, some we do with speeches and counseling, that we are doing. So with that they are knowing about their illness, no? Sometimes they will not accept that 'I'm having some problems', they feel that 'I'm doing well in my career, my family', but since they're having some problems, they are not accepting sometimes, they say that because of others I'm having this sort of thing. They have lots of, lots of excuses so we motivate them to, we make them aware that see you're having the illness and for that you have to deal with it and you have to take the medicines, everything.*

Other respondents talked about the importance of making people aware of the causation of mental illness to decrease the superstition and increase the amount of people getting treatment. One respondent answered the question about what psychiatric social workers can contribute with to the field of mental health care like this:

*A lot, in the sense like we can keep awareness to the society, to the community, can educate the person concerned, who is mentally ill, and then we are often more aware what is mental illness. They all think maybe it's like a curse from god and all this so they don't know this is an illness. So the basic thing is like educating them and giving our awareness to the society people. Especially, once a person is affected with mental illness they ignore them. (...) So they just leave them and*

*sometimes they don't even give treatment so in that way if they understand they will at least take them for the treatment.*

Superstition was mentioned in several interviews as something lingering in the Indian society and was seen as a hindrance for people with mental illness to get proper care and proper treatment by others:

*Ok, social work has a good role, vital role in mental health. We are doing work individually with the patient. Same thing, we have to do some work in society also, community also, like giving them information, we are making them aware that those people who are having mental illness needs treatment. They should not isolate him or they should not behave inhuman with them, no? Like beating or keeping them in a room, tie their hands. (...) We have to do everything, like we have to give them knowledge in society and community, we have to give them knowledge what is mental illness and what are the treatment. (...) now they think that ok, it is because of, you know, black magic, some superstition are still present here. So if a social worker was there and he give them knowledge that no, this is not because of black magic, it is because of the illness and he needs, he or she needs treatment and then we can guide them.*

Other respondents further spoke of awareness as a means to decrease stigma around mental illness.

*(...) if the family member or society, people, are aware of the mental illness then they can support them. They can give more support. They can at least accept them. Like okey, they got mental illness but it's an illness. So if they know that it's an illness surely they won't all the time ignore them or maybe stigmatize them. (...) That they might become a support for them and surely help the mentally ill people to 'okay we are also members of the society, we are also a part of the family', those kind of feelings will come and that surely will help them feel better.*

One of them pointed at the important role social workers have in this consciousness-raising work:

*Basically as I already mentioned our community doesn't accept the people as far as possible. (...) so what I feel is that social workers have an important role here to take care of these issues by convincing, by creating mass awareness among the community that mental health is not a taboo or they should not stigmatize them. Rather they should accept these people.*

One of the psychiatrists described one social worker contribution to be the work they do with the patient's insight about her/his illness.

*Most of our patients are reluctant to take medication; they don't understand that they have a mental illness, that they need treatment. Most mental illnesses are like that. If people don't feel that they are having a problem they refuse to take medication. That's another point where the social worker comes in to help. He goes home, explains it, make sure he takes the medication and all.*

## 6.5 The psychiatric social worker as a bridge

Another prominent theme regarding psychiatric social workers' contribution dealt with the psychiatric social worker as a bridge between different units; between the patient and the family/community and between the patient and the psychiatrist. Several respondents talked about psychiatric social workers as being a bridge between the patient and the community or family and referred to it as integrating the patients back to society. In this process they emphasized helping the patients with their lost skills; basic skills like hygiene, social skills like communication and even job-skills. They also emphasized the importance of working closely with the family in this process. One respondent described it like this: "At the same time I do the counseling for the family, how to manage the patient at home after the rehab, ok." Another respondent talked about rehabilitate the patients so they would be able to take care of themselves and return to a normal life:

*Social worker's objective is like in the mental department, mental setting, is like sending them back, rehabilitate them. At least like make them able to take care of themselves, at least a normal life, without any like support from the family members. If they need too much of support from the family members then they can't be kept in the house. They need institutionalization so I think in that way what we could give them is maybe like basic skills. In that way they will integrate back to the family members.*

One respondent widened the term integrate to involve the community's responsibility in the integration of the former patient:

*What I'm associated with at the moment is basically to see that those who are suffering or having sort of abnormalities, for those people what we can do better to bring them into a mainstream society. That is what we do. We see to it that these people are not neglected or not given any importance in the community so they are given due importance.*

This respondent talked about the norms in society and that the work with integrating the patients back to society could be about educating the patients about these norms:

*So when the person is going to the society, that time we should make him, like, 'see now you have to go to the normal society and see there are some norms, there are some rules and regulation there which you have to follow', ok.*

Giving feedback about the patient to the psychiatrist was something many of the respondents spoke about. This was among other things done in order for the psychiatrist to be able to better

decide what treatments would be suitable. In this way the psychiatric social workers act as a bridge between the patient and the psychiatrists:

*There I have to observe their behavior, then I have to give it back to the doctor, psychiatrist and according to that, doctor will start medication and counseling to the patient and to the families.*

One respondent described this bridge in a similar manner and again mentioned the time psychiatric social workers spend with the patients compared to the psychiatrist:

*Doctors they don't have much time like interview and collect information in detail. So it's better like if psychiatric social workers does all this. Take case history and get information in detail. Then like, give feedback to the doctor, then the doctor have a much more idea to diagnose the kind of mental illness the person is suffering from, then can make a plan accordingly. So in that way social workers are required. Like social workers, actually, they do visiting houses, visiting families.*

Another respondent described psychiatric social workers as a bridge between the patient and the psychiatrist or the patient and the family:

*We will act, as I said, a bridge between psychiatrists to the patients and family to the patients. We are acting as a bridge between, some sort of helping, we will try to understand them and we will give feedback to the doctor, families.*

Some respondents further spoke of the work psychiatric social workers do identifying people with mental illness and referring them to a psychiatrist:

*So sensitizing through awareness programs helps them know the problem, accept the problem and take the case to the hospital, refer to the hospital, take the treatment in time so the problem is not aggregating further. (...) What we are doing is, the role of social worker is very important in this area. To identify these cases one thing, second to refer these cases to the psychiatrists or the hospitals which are taking due care of these sort of people. And do counseling. See identify and referring is not, identifying is maybe an easy job but referring that particular case to the hospital is a big task. We have to convince the patient first. If he is not convinced you have to convince his peers or the family members. That is very important.*

One of the psychiatrists described social work's contribution in a similar way to the psychiatric social workers. He saw integrating the mentally ill to the community as an important task made by the psychiatric social workers.

*There is a special field of training called psychiatric social work where they are trained to handle patients with mental illnesses and integrating them back to society. Because basically what happens is that in mental illness, the person on account of the illness slowly loses its social skills, by and large a*

*lot of that is the ability to communicate, to talk, to share, to be a part of his larger network. He loses that as well as his employment skills, his job skills, he loses a lot of that. Once you treat this person and you want to put him back into this original place where he came from and that is the setting that social workers come in. The bridge back between what we do as treatment and what happens back home. That gap has to be bridged by social workers.*

The other psychiatrist spoke of psychiatric social workers being the profession, which can work in the community in order to reach out to people and to unburden the psychiatrists:

*I think social work becomes the backbone, because you see, the number of clinicians is very few, the number of psychiatrists are very few so social workers can actually go out in the community and get in patients. See, we have to decentralize, see initially everyone is coming to the doctor. (...) we need to go to the community and give the help at the community level, that is the work of the social workers.*

## **6.6 Social relations**

With our questions regarding the respondents thoughts about social factors in relation to causation of and recovery from mental illness we wanted to seize what they see as social factors related to mental illness. We recognized two patterns in their answers; first an emphasis on social relations and secondly the marginal mentioning of sociocultural factors (race, ethnicity, socioeconomic status, sexual orientation, religion; see definition). The majority of the respondents pointed at the importance of social relations in the recovery process of the patient and some mentioned it as a factor in the causation of mental illness. With social relations they referred to a patient's social interactions with family or society and social support:

*If the person is having that social interaction with the society or family. Those who are not having that type of interaction they are in a broader chance to get their illness.*

One respondent talked about the importance of social support in the rehabilitation of the patients and that this support, or lack of support, has consequences for the work of the psychiatric social worker:

*There are some families actually who don't have any social support which makes it very difficult for us to, like, for a person to rehab because we do have our own limitations and there are some times, things happens that people are actually no one to take good care of so the lack of social support is difficult for us, to make them rehab in society again.*

This respondent also spoke about the importance of good social relationships with important people in the surrounding for a patient's recovery process:

*All this, see if there is no social relationship with the people, if they don't have good relationships with each other, there is no good rapport with the people, if there is no good communication with the people, among the family members, definitely it leads to major problems. So these social, as well as psychological factors are very much responsible factors for mental illness. I'd give an example. When the client returns to the family, if the family members have good cordial relationship, they are the people who take responsibility for the client; definitely it becomes a boost for that client to recover at a faster rate. In the same way, even if we are talking about psychological factors also, if the neighbors and the relatives have good relationships or good attitudes towards the mental illness, then definitely it helps the client to give some sort of psychological relief. It doesn't put any burden on him when there is a psychological support from all these people. As well as the environment in which he or she recites.*

Several respondents mentioned a change in society, which they perceived as creating stress. One of the respondents spoke of the changes in the Indian society during the last 20 or 30 years, the transfer from a joint family system to a system built on the nuclear family and a more stressful way of living, and the increased need for counselors to handle the problems coming with it:

*See, nowadays it is more the world is very stressful. Ok, this is one of the reason maybe this mental patient is growing. (...) So maybe that's the reason nowadays the importance of counselor. (...) So everything is fast, ok. Even people are not getting time to solve their problems. (...) because if you think about ancient times and all, there was, I don't know about in your country and all, in India you know it was like joint family system. Ok, this was very helpful. If somebody's having some problem in the home or at home, they can share with a lot of people, ok. Now it is a nuclear family and there is no time to sit with family.*

One of the psychiatrists also spoke about the joint family system and the changes in society.

*If you look at some years back, Indians lived more in joint families, (...) Off course that strata of society is changing, you know, people are living more in nuclear families, either you live alone or you live with your husband or your wife and your children. So initially when Indians, or when the people lived in joint families, it was more protective. Because if someone had a mental illness there were a lot of people to look after that person, you understand? So that people would give him his medication, to check on whether he is brushing his teeth, having his bath, you know, day to day activities. So there was a good monitoring system, it's still a good monitoring system because our family structure is very strong, you know. So that is a protective factor which helps in recovery(...) It's like everyone minding everyone's business, you know, people are too inquisitive but in a way in recovery for people with mental illnesses it helps because the community is supportive, they're checking on the person. Religiously, so you have religious groups coming and praying with that person, you have the priest of the village coming and actually checking on him so this kind of society, of social structure, actually is helpful.*

When asked about social factors in relation to mental illness, not many psychiatric social worker respondents spontaneously answered with describing sociocultural factors such as for example discrimination, disadvantage and socioeconomic factors. A few did:

*Then like sometimes even financial, these things, crisis or maybe like some traditional beliefs and all I hope, those things also is factors for causing mental illness.*

When we asked specifically about these types of factors some started talking about them:

*Yeah socioeconomic also, if you don't find out the financial thing or social, the parents are not educated, they have no financial benefit, so children may turn into mental illness. Because they are not eating proper food, proper education, so then you go other way, like bad things, like alcoholic. They remain uneducated and all. This may cause mental illness.*

Other answered that they do not play a major role in sentences like: “To some extent it does play a role. But to not that large extent as compared to the social factors” and “Rarely, not exactly, rarely. Socioeconomic and other factors, these are not major factors which are affecting this mental health.”

## **7. Analysis**

In this section we will analyze our results in relation to Foucault's theory of discourse (1993), Inglehart's theory of modernization (1997) and Polanyi's theory of tacit knowledge interpreted by Rolf (1991). In addition to Polanyi's theory we use Olsson (2009) and Bergmark (1998) to analyze our results. We will present our analysis in the form of our themes from the result with the exception of merging the first to themes together and renaming the last theme to social factors. Our division will be the following: *Knowledge articulation difficulty and in-depth knowledge, Focus on psychiatric knowledge, Awareness, The psychiatric social worker as a bridge and Social factors.*

### **7.1 Knowledge articulation difficulty and in-depth knowledge**

Our result shows that a majority of the psychiatric social workers have difficulty articulating their unique knowledge. This result is similar to Beddoe's study (2013), which shows an insecure knowledge claim amongst mental health social workers (ibid, p. 28-29). Renouf and Bland (2005) recognize this knowledge articulation as one of the challenges for social work in mental health (ibid, p. 427). This previous research is based in a western context and our findings from Goa show a similar pattern. One of our respondents diverged from the others on this point. Sudesh Gaude explicitly articulated a lot of unique psychiatric social worker knowledge such as knowledge about social factors, society and family, which is similar to the knowledge previous research stress. One of the reasons for this exception might be the fact that Sudesh has worked as

a social worker for a long time in many different kinds of social work settings and that he in addition to this has been teaching social work both at the Bachelor level and on the Master course for Medical and psychiatric social work.

Instead of directly articulating their unique knowledge, many of the psychiatric social workers spoke about what they do practically with the patients and described that they spend a lot of time with them and their families and get to know them very well. Although the psychiatric social workers did not express this as a unique knowledge we interpret it as an expression of an in-depth knowledge emerging from their experience. This kind of knowledge is referred to in Beddoes's study, which showed that several social workers articulated their knowledge and skills to be the intimate knowledge about the client's world. One of the respondents identified the "tactics" and "techniques" required for this in-depth work with patients as things like rapport building, empathy, sympathy and non-judgmental attitudes. "Rapport building" was an expression that several respondents mentioned during the interviews and since it means the building of close relationships where mutual trust and communication is crucial, we recognize it as one of the core skills required when meeting the patient. One of the psychiatrists mentioned a contribution made by psychiatric social workers as working closely to the patient in order to help them deal with their lives.

Both the experience based in-depth knowledge gained from working closely with the patients and the knowledge required for rapport building can be understood with the construct tacit knowledge, as can even the fact that the psychiatric social workers have difficulty articulating their unique knowledge. Olsson (2009) means that this kind of knowledge, as opposed to scientific knowledge, not easily can be connected to education and that it has not come into existence with the purpose of creating theories about anything (ibid, p. 41-47). As a result, this knowledge is not made explicit as self-evidently as scientific knowledge. In addition to this, Polanyi means that language is not always sufficient in order to capture the tacit knowledge (Rolf, 1991, p. 29-30). According to Bergmark (1998), knowledge tied to personal experiences is valuable but not given due importance compared to scientific knowledge (ibid, p. 49). This makes it even more important for psychiatric social workers to recognize it as knowledge and articulate it.

The psychiatrists either talked about what knowledge psychiatric social workers should have (and not what they actually have) or expressed doubts about social work's knowledge. This can

be understood with the argument that psychiatric social workers' knowledge to a larger extent consists of tacit knowledge which could be harder to make explicit. Either this knowledge is not seen by the psychiatrist, or it is devalued when made explicit.

Another way of understanding this result is by using the reasoning of Foucault. According to Foucault (1993) a new will to truth emerged in the 17th century and truths were created through what could be measurable, observable and useful. This new scientific knowledge emerged to us as the legitimate truth (ibid, p. 10-15). The psychiatric discourse is associated with the field of medicine where the possibility to measure generally has been high, which makes this knowledge perceived as true. Foucault (1993) states that this new will to truth exerts pressure and power over other discourses since less measurable knowledge is seen as less legitimate (ibid, p. 14). We interpret that the social work discourse, especially in a psychiatric setting, could be one of these repressed discourses. Due to this, statements from a social work discourse, which are expressed in a psychiatric discourse, may not be seen as legitimate and true. Foucault (1993) argues that if someone inside a discourse expresses statements that historically are not a part of that discourse, this statement risk to be rejected and the person expressing it risk to be placed outside of the discourse (ibid, p. 22-25). This could mean that a social worker in a psychiatric discourse would be less prone to articulate statements that are foreign to this discourse.

## **7.2 Focus on psychiatric knowledge**

Some of the psychiatric social workers did not express any specific psychiatric social work knowledge and when we asked specifically about it they rejected the idea of such knowledge. Others tended to emphasize the importance of psychiatric knowledge over knowledge normally related to social work.

As mentioned above the new will to truth created the notion that the truths emerging from knowledge that is measurable are more legitimate than others. The new will to truth makes it hard for us to look beyond the knowledge created by it since this knowledge emerges to us as powerful and wealthy truths (Foucault 1993, p. 10-15). This could mean that truth and knowledge, created in the psychiatric discourse is seen as the legitimate truth by the psychiatric social workers. Foucault (1993) further argues that in order to gain access to a discourse you need to accept and bow to the truths that are created in that discourse which he calls *rarefaction among speaking subjects*. In order for psychiatric social workers to work in a psychiatric setting it is necessary for

them to accept and adjust to the truths that are created in a psychiatric discourse (ibid, p. 26-31). This might be one possible reason why the psychiatric social workers tended to emphasize psychiatric knowledge rather than knowledge related to social work.

Polanyi argues that if you get cut off from a tradition, for example your professional tradition, you lose constructs to help you think, a picture of yourself in relation to others and knowledge and values passed down in the tradition (Rolf, 1991, p. 228). When a psychiatric social worker is working in a psychiatric setting they might need to adjust to the psychiatric discourse, which could result in placing less focus on knowledge and values from the social worker discourse.

The findings from Beddoes's study (2013, p. 35) showed that social workers perceived parts of their social work identity as being unrealized in a health setting and that it was easy to become a part of the clinical system. Verma (1991) means that psychiatric social work in India developed as an auxiliary service to psychiatry and argues that working closely with psychiatrists in a psychiatric setting made the psychiatric social work profession incorporated in the psychiatric ideology. She also states that psychiatric social workers tend to identify themselves with psychiatry rather than with social work (ibid, p. 14-15). This historical development of the profession psychiatric social work in India could be a contributive factor for the emphasis on psychiatric knowledge among our respondents.

Psychiatric social workers have been aware of their auxiliary nature which has led to an effort to define their role more precisely in order to establish their independent identity in mental health (Verma, 1991, p. 15). The fact that they in spite of this tend to identify themselves with psychiatry could be an indication of the need to adjust to the psychiatric discourse in order to work in it.

Another condition that could play a role in why the respondents tended to focus on psychiatric knowledge is the disposition of the education. Psychiatric social workers in India undergo a two year Master course in Medical and psychiatric social work. Foucault (1993) states that the system of education is an institution, which regulates the access to discourses (ibid, p. 26-31). Education can regulate the discourse regarding how you should work, think and speak in a psychiatric setting. In Goa a Masters degree in medical and psychiatric social work is typically required in order to work as a social worker in psychiatric settings. With a Foucauldian interpretation this could mean a maintenance of the psychiatric discourse, possibly at the expense of a social work discourse; a discourse containing knowledge which Aviram (2002), McCrae et al. (2004), Karban

(2003), O'Brien & Calderwood (2010) and Renouf & Bland (2005) regards as important for the psychiatric setting.

### **7.3 Awareness**

One of the major results concerning psychiatric social work's contribution was that a majority of the psychiatric social worker respondents mentioned work with awareness as one of their core contributions. This is similar to Mohan's (1970) findings about what psychiatric social work could contribute with. He states that there are widespread misconceptions about causation and treatment of mental illnesses (ibid, p. 16). Descriptions of these kind of misconceptions emerge from our findings as well. Because of the common notions that mental illness is derived from for example actions in past lives, black magic or are curses from God, the respondents described the necessity to inform people that mental illness is not caused by such things. According to the respondents these notions result in unacceptable behavior towards the mentally ill, stigmatization and unwillingness to refer mentally ill persons to mental health care where they can get suitable treatment in time.

Inglehart (1997) argues that modernization results in a shift from traditional authority to secular-rational authority, in other words the decline of the sacred or mystical pre-rational elements of religious faith due to the rise of a scientific worldview. In order for modernization to occur, traditional value systems have to be changed (ibid, p. 80-85). Our respondents described creating awareness as one of their major contributions to mental health care which can be understood by the modernization process India still partly is going through. At the same time Inglehart (1997) recognizes faith as something that gives security in times of change and that rapid changes in the way of living are extremely stressful to people (ibid, p. 33-40). One respondent talked about the need for her, as a psychiatric social worker, to know about the faith and rituals of her patients and their families since it was an important issue for them.

The respondents also spoke about awareness in relation to their work with the patients, giving them insight about their illness in order for them to better cope with their difficulties. Some of the respondents described a set of problems wherein the patients do not accept their illness. They described this in terms of how the patients sometimes had a lot of excuses, that their illness would be derived from things outside of them such as life events or actions in past lives. This was a part of their work, to make the patients aware of their symptoms being derived from an illness

and not from something else. One psychiatrist described it similarly when he described how patients sometimes do not understand that they are having an illness and that the social worker can explain to the patients that they are having an illness and make sure they take their medication. The psychiatric social workers often explained their patients' illness with what might be in line with a psychiatric discourse. This could be understood from Foucault's (1993) earlier mentioned thoughts about *rarefaction among speaking subjects* where he states that in order to gain access to a discourse you have to accept the truths in that discourse (ibid, p. 26-31).

Another of Foucault's principles of exclusion, *division and rejection*, could be used for understanding how people with mental illness are met in society. The division between reason and madness is common in modern sciences where reason is created through its opposite, the madness. Foucault (1993) states that the madman's speech is viewed as untrue and without meaning (ibid, p. 8-9). The psychiatric social workers perceive it as crucial for the work with mental illness to create awareness in order for the patients to get proper treatment. At the same time it is important to give voice to, as Foucault puts it, repressed discourses. In a psychiatric discourse there could be hard for other non-psychiatric truths to be acknowledged. This might make it harder for psychiatric social workers to bring up other models of explanations for mental illness than the psychiatric which in turn might lead to the patient's models of explanation getting less scope.

#### **7.4 The psychiatric social worker as a bridge**

Another contribution the psychiatric social workers and one psychiatrist talked about was the work with rehabilitating the patients and integrating them back to society. As stated in previous research, this is a common contribution of psychiatric social workers in mental health care (Aviram 2002, Karban 2003, O'brien & Calderwood, 2010). In the year 1970, Mohan argues that one significant contribution by social work in India could be adjusting patients back to the society (ibid, p. 14). Today, 43 years later, our result shows that this is the case. O'Brien and Calderwood (2010) also talk about psychiatric social workers having a person-in-environment perspective which in our study was reflected in the respondents' descriptions of their work with rehabilitation and integration as they talked a lot about the importance of knowing the family and working together with the family (ibid, p. 324-328).

During the interviews we noticed that many respondents perceived psychiatric social work as a bridge between the patient and the psychiatrist. Several psychiatric social workers and one psychiatrist described the work of referring patients to the psychiatrist as an important psychiatric social worker contribution. Some also spoke of the contribution psychiatric social workers can do reaching out to mentally ill in the communities and thereby unburden the psychiatrists. Kanango (2004) acknowledge that social workers in India have an important role in referring mentally ill persons in order for them to get treatment in time (ibid, p. 104-112).

When the psychiatric social workers talked about the time they spend with the patients it became clear that they also work as a bridge between the patients and the psychiatrist, giving feedback about the patients to the psychiatrists. The psychiatrists then use this information in order to make correct diagnoses and prescribe suitable treatments. This is consistent with Verma's study (1991), which found that nearly two-thirds of the respondents were involved in assisting the mental health team in diagnostic functions and that psychiatric social workers shared and exchanged their views to assist in the formulation of diagnosis at case conferences (ibid, p. 167). Mohan (1970) argues that a significant psychiatric social worker contribution could be participating in giving patients a more dynamic diagnosis since they study the patient in her/his totality and gather data regarding many dimensions including the social, psychological and physical (ibid, p. 14).

## **7.5 Social factors**

Previous research has argued that social workers could be a counterforce to a biological model of disorder in psychiatry because of their knowledge about things like disadvantage, discrimination, community factors, family, relationships, work, housing, employment, career and environment (Karban, 2003, Renouf & Bland, 2005, Aviram, 2002, McCrae 2004). This research originates from western countries and our results differ at some points. When we asked the psychiatric social workers questions about social factors only a few of them spontaneously talked about sociocultural factors (for example disadvantage, discrimination and socioeconomic factors). Some attributed these factors some significance when we asked specifically about them and others did not think that such factors play a major role in relation to mental illness. The majority of our psychiatric social work respondents did not talk about social factors as either their contribution or specific knowledge.

Instead the psychiatric social workers almost exclusively talked about social relations. They mostly talked about the importance of social relations in recovery of mental illness; some however mentioned social relations as a responsible factor for getting mental illness. Two respondents, one psychiatric social worker and one psychiatrist, stressed that changes in society have led to disintegration of traditional family structures which have resulted in family members having less time for each other. One respondent described the joint family structure as containing too much inquisitiveness and social control but at the same time emphasized that it can be protective and supportive for people with mental illness since there are people around who can look after and check on a mentally ill person.

One way to understand the psychiatric social workers perceptions of social factors mainly as social relations is through the thoughts of modernization mentioned earlier. Inglehart (1997) states that traditional value systems must be changed in order for modern economic development to take place and that a new form of social order has to be established (ibid, p. 26). The warm and personal communal ties and norms of sharing have to give way to an impersonal and competitive society as a result of modernization and this shift tends to be stressful (ibid, p. 71). In a society where the family structure is still strong but disintegrated, a focus on social relations is understandable and needed.

## **8. Conclusions**

- There is a need for psychiatric social work in Goa to articulate its unique knowledge.
- Through working closely with the patients the psychiatric social workers gain unique in-depth knowledge, which could be a huge contribution to mental health care.
- The psychiatric social workers perceive that their major contributions are to create awareness about mental illness and integrate patients back to society.
- Social factors are understood by the psychiatric social workers mainly as social relations. Social relations seem to be an important factor in relation to mental illness in a Goan context, which psychiatric social workers perceive and bring into their work with patients.

## **9. Discussion/inspiration to further research**

In this section we will summarize and reflect over our results and relate them to our purpose. One part of the purpose of our study was to explore psychiatric social workers' and psychiatrists' perceptions of psychiatric social work's unique knowledge and its contribution to the field of mental health care in Goa, India.

It has been argued in previous western research that there is a great need for social workers to articulate its knowledge base. According to our findings this seems to be the case in Goa as well since the psychiatric social workers had difficulty articulating their unique knowledge. In order for psychiatric social workers to claim their position in a multi disciplined setting the articulation of their unique knowledge is important. If the psychiatric social workers unique knowledge becomes visible there is a greater possibility for it to become valued and possibly challenge a psychiatric discourse. The core problem as we see it may lie in what Foucault states as the new will to truth. Truths and knowledge derived from what could be measured and verified is emerging to us as the legitimate truth. Discourses that might differ from a measurable science will be undervalued and rejected.

Polanyi argues that in order to articulate tacit knowledge you have to distance yourself from it and reflect on it. One suggestion of future research related to this topic could be research on how this process of reflection can be practiced by social workers/psychiatric social workers in their everyday work. When we urged the psychiatric social workers to articulate their unique knowledge they had difficulty doing so but eventually many of them expressed what we perceived as a unique in-depth knowledge of the patients. Through this knowledge about how to work closely with the patients (rapport building) the psychiatric social workers gain in-depth knowledge and this could be a huge contribution to the mental health care. The fact that the psychiatric social workers act as a bridge between the patients and the psychiatrist also mean that they have space where they could mediate this knowledge. Since our findings show that the psychiatric social workers seems to have been incorporated in the psychiatric discourse to a relatively large extent, the question is if the psychiatric social workers feel free to express their gained knowledge if it is opposed to established psychiatric notions about mental illness.

A suggestion of future research could be to explore power relations between professions in the psychiatric setting. More specific topics could be the cooperation and interaction between psychiatric social workers and psychiatrists, what kind of information is mediated to the

psychiatrists by the psychiatric social workers and how psychiatric social workers perceive their opportunities to influence for example diagnostics and intervention choices.

The psychiatric social workers described their main contributions as creating awareness about mental illness to the public and to the mentally ill, rehabilitating the mentally ill patients and integrating them back to society. Awareness was perceived as crucial to the work with mental illness in Goa since superstition, according to the psychiatric social workers, prevents the mentally ill from getting treatment. They further emphasize the importance of creating awareness in order to counteract and decrease stigmatization of the mentally ill. This is an important contribution made by psychiatric social workers in Goa. The respondents also talked about awareness as giving insight to patients about their illness. Here we perceived a focus on a model of explanation in line with a psychiatric discourse on behalf of other possible models of explanation, which may lead to certain interventions being chosen before other. A suggestion of future research could be making a comparative study in order to see if the different Master courses in social work in India result in different perceptions of for example mental illness.

The other part of our purpose was to explore psychiatric social worker's understanding of social factors in relation to mental illness. Our result show that the psychiatric social workers understood social factors mainly as social relations and that they did not speak about sociocultural factors to a large extent. They talked about the importance of social relations and social support in a changing society and brought that notion into their work with the patients by emphasizing contact and work together with the families. Previous research suggested that social work's unique knowledge about social factors could be a contribution to mental health care by being a counterforce to the biological model of disorder in psychiatry. Our results showed that the psychiatric social workers did not describe knowledge about social factors as one of their main contributions and hardly mentioned sociocultural factors.

The previous research that acknowledge social workers possibility to be a counterforce to psychiatry are all from western countries. In a Goan context, two other areas emerged as the most important psychiatric social work contributions; creating awareness and integrating patients back to society. Social relations also emerged as an important area although they did not talk about it in terms of contribution or knowledge. The psychiatric social workers stress the importance of these areas in the work with mental illness and incorporate them in their work.

Still, we want to emphasize the opportunity for psychiatric social workers to be this counterforce Aviram (2002) is talking about. Psychiatric social workers in Goa are one of the professions in the psychiatric setting in Goa and they are perceived as making a significant contribution to mental health care. Through articulating their unique knowledge, psychiatric social workers can raise questions not normally emphasized in a psychiatric discourse.

## 10. References

- Auslander, G. (2001). Social Work in Health Care What Have We Achieved?. *Journal of Social Work, 1*(2), 201-222.
- Aviram, U. (2002). The changing role of the social worker in the mental health system. *Social Work in Health Care, 35*(1-2), 617-634.
- Math, S. B., Murthy, P., & Chandrashekar, C. R. (2011). Mental Health Act (1987): Need for a paradigm shift from custodial to community care. *The Indian Journal of Medical Research, 133*(3), 246.
- Beddoe, L. (2013). Health social work: Professional identity and knowledge. *Qualitative Social Work, 12*(1), 24-40.
- Bergmark, Å. (1998). *Nyckelbegrepp i socialt arbete*. Lund: Studentlitteratur.
- Bland, R., & Renouf, N. (2001). Social work and the mental health team. *Australasian Psychiatry, 9*(3), 238-241.
- Bryman, A. (2011). *Samhällsvetenskapliga metoder*. (2., [rev.] uppl.) Malmö: Liber
- Burr, V. (2003). *Social constructionism*. (2. ed.) London: Routledge.
- Chinai, R. (2007). Indian paradise takes novel approach to mental health. *Bulletin of the World Health Organization, 85*(8), 576-576.
- Fernandes, A. (2008). Local power in colonial and contemporary Goa. *Lusotopie, 15*(2), 151-173.
- Foucault, M. (1993). *Diskursens ordning: installationsföreläsning vid Collège de France den 2 december 1970*. Stockholm: B. Östlings bokförl. Symposion.
- Foucault, M. (2003). *Övervakning och straff: fängelsets födelse*. (4., översedda uppl.) Lund: Arkiv.
- Foucault, M. (2008). *Diskursernas kamp*. Eslöv: Brutus Östlings bokförlag Symposion
- Inglehart, R. (1997). *Modernization and postmodernization: cultural, economic, and political change in 43 societies*. Princeton, N.J.: Princeton University Press.
- Kanango, S. D. (2004). Community Based Rural Health Care in India: Potential for Social Work Contribution. *Social Work in Mental Health, 2*(2-3), 95-116.
- Karban, K. (2003). Social work education and mental health in a changing world. *Social work education, 22*(2), 191-202.
- Kaslow, N. J., Bollini, A. M., Druss, B., Glueckauf, R. L., Goldfrank, L. R., Kelleher, K. J. & Zeltzer, L. (2007). Health care for the whole person: Research update. *Professional Psychology: Research and Practice, 38*(3), 278.
- Khandelwal, S. K., Jhingan, H. P., Ramesh, S., Gupta, R. K., & Srivastava, V. K. (2004). India mental health country profile. *International Review of Psychiatry, 16*(1-2), 126-141.
- Kvale, S. & Brinkmann, S. (2009). *Den kvalitativa forskningsintervjun*. (2. uppl.) Lund: Studentlitteratur.
- Larsson, S., Lilja, J. & Mannheimer, K. (red.) (2005). *Forskningsmetoder i socialt arbete*. Lund: Studentlitteratur.
- Link, B. G. (2008). Epidemiological sociology and the social shaping of population health. *Journal of Health and Social Behavior, 49*(4), 367-384.
- McCrae, N., Murray, J., Huxley, P., & Evans, S. (2004). Prospects for mental health social work: a qualitative study of attitudes of service managers and academic staff. *Journal of mental health, 13*(3), 305-317.
- Mohan, B. (1970). The need for psychiatric social work in India. *International Social Work, 13*(1), 12-17.

- Mohandas, E. (2009). Roadmap to Indian Psychiatry. *Indian journal of psychiatry*, 51(3), 173.
- Narayan, C, Narayan, M, & Shikha, D. (2011). The ongoing process of amendments in MHA-87 and PWD Act-95 and their implications on mental health care. *Indian journal of psychiatry*, 53(4), 343
- Neuman, W.L. (2011). *Social research methods: qualitative and quantitative approaches*. (7. ed.) Boston, Mass.: Allyn and Bacon.
- O'Brien, A. M., & Calderwood, K. A. (2010). Living in the shadows: A Canadian experience of mental health social work. *Social Work in Mental Health*, 8(4), 319-335.
- Olsson, E. (2009). *Praktisk kunskap i socialt arbete: om naiva teorier i mötet med klienten*. (1. uppl.) Malmö: Gleerup.
- Patel, V., Pereira, J., Coutinho, L., Fernandes, R., Fernandes, J., & Mann, A. (1998). Poverty, psychological disorder and disability in primary care attenders in Goa, India. *The British Journal of Psychiatry*, 172(6), 533-536.
- Probst, B. (2012). Not Quite Colleagues: Issues of Power and Purview between Social Work and Psychiatry. *Social Work in Mental Health*, 10(5), 367-383.
- Proctor, Enola. K 2004 Research to inform the mental health practice: social work's contribution.
- Raney, S., & s, D. C. Ç. (2005). Counseling in developing countries: Turkey and India as examples. *Journal of Mental Health Counseling*, 27(2), 149-160.
- Renouf, N., & Bland, R. (2005). Navigating stormy waters: Challenges and opportunities for social work in mental health. *Australian Social Work*, 58(4), 419-430.
- Rolf, B. (1991). *Profession, tradition och tyst kunskap: en studie i Michael Polanyis teori om den professionella kunskapens tysta dimension*. Nora: Nya Doxa.
- Sarkar, J. (2004). A new mental health act for India: An ethics based approach. *Indian Journal of Psychiatry*, 46(2), 104.
- Sharma, S. (2006). Psychiatry, colonialism and Indian civilization: A historical appraisal. *Indian Journal of Psychiatry*, 48(2), 109.
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*, 42(3), 443-460.
- Verma, R. (1991). *Psychiatric social work in India*. Sage Publications.
- Weiss-Gal, I., & Welbourne, P. (2008). The professionalisation of social work: a cross-national exploration. *International Journal of Social Welfare*, 17(4), 281-290.
- Ödman, P. (2007). *Tolkning, förståelse, vetande: hermeneutik i teori och praktik*. (2., [omarb.] uppl.) Stockholm: Norstedts akademiska förlag.

## Internet resources

- Culture. I *Blackwell Encyclopedia of Sociology Online*. Retrieved may, 19, 2013 from [http://www.sociologyencyclopedia.com/public/tocnode?query=culture&widen=1&result\\_number=1&from=search&id=g9781405124331\\_yr2012\\_chunk\\_g97814051243319\\_ss1-183&type=std&fuzzy=0&slop=1](http://www.sociologyencyclopedia.com/public/tocnode?query=culture&widen=1&result_number=1&from=search&id=g9781405124331_yr2012_chunk_g97814051243319_ss1-183&type=std&fuzzy=0&slop=1)
- Delhi School Of Social Work University Of Delhi, 2008, *Proposed bill for a Maharashtra council for professional social work*. Available at: <http://www.google.se/interstitial?url=http://www.napswionline.org/pdf/MaharashtraCouncilBill.pdf>

- Environment. I *Oxford Dictionaries*. Retrieved may, 19, 2013 from <http://oxforddictionaries.com/definition/english/environment?q=environment>
- Interpersonal relationships. I *Blackwell Encyclopedia of Sociology Online*. Retrieved may, 19, 2013 from [http://www.sociologyencyclopedia.com/public/toctnode?query=interpersonal+relationship&widened=1&result\\_number=1&from=search&id=g9781405124331\\_yr2012\\_chunk\\_g978140512433115\\_ss1-65&type=std&fuzzy=0&slop=1](http://www.sociologyencyclopedia.com/public/toctnode?query=interpersonal+relationship&widened=1&result_number=1&from=search&id=g9781405124331_yr2012_chunk_g978140512433115_ss1-65&type=std&fuzzy=0&slop=1)
- Knowledge. I *Oxford Dictionaries*. Retrieved may, 19, 2013 from <http://oxforddictionaries.com/definition/english/knowledge?q=knowledge>
- Ministry of Health & Family Welfare Government of India New Delhi, *Mental health care bill 2011*. Available: <http://mohfw.nic.in/WriteReadData/1892s/6420662643DRAFT%20THE%20MENTAL%20HEALTH%20CARE%20BILL.pdf>
- OECD-DAC list, *DAC List of ODA Recipients Effective for reporting on 2012 and 2013 flows*. Available at: <http://www.oecd.org/dac/stats/DAC%20List%20used%20for%202012%20and%202013%20flows.pdf>
- WHO, 2011, Available at: [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)
- Rapport. I *Oxford dictionaries*. Retrieved may, 19, 2013 from <http://oxforddictionaries.com/definition/english/rapport?q=rapport>
- Role model. I *Oxford dictionaries*. Retrieved may, 19, 2013 from <http://oxforddictionaries.com/definition/english/role%2Bmodel?q=role+model>
- Social support. I *Blackwell Encyclopedia of Sociology Online*. Retrieved may, 19, 2013 from [http://www.sociologyencyclopedia.com/public/toctnode?query=interpersonal+relationship&widened=1&result\\_number=1&from=search&id=g9781405124331\\_yr2012\\_chunk\\_g978140512433115\\_ss1-65&type=std&fuzzy=0&slop=1](http://www.sociologyencyclopedia.com/public/toctnode?query=interpersonal+relationship&widened=1&result_number=1&from=search&id=g9781405124331_yr2012_chunk_g978140512433115_ss1-65&type=std&fuzzy=0&slop=1)
- Vetenskapsrådet (2002). *Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning*. Stockholm: Vetenskapsrådet. Available at: [http://www.cm.se/webbshop\\_vr/pdf/er/etikreglerhs.pdf](http://www.cm.se/webbshop_vr/pdf/er/etikreglerhs.pdf)

## Section of Swedish law

- Lag (2003:460) om etikprövning av forskning som avser människor. Available at: <http://www.notisum.se/rnp/sls/lag/20030460.htm>

# 11. Appendix

## 11.1 Appendix 1: Definitions

### Interpersonal relationships

*“In any relationship , two participants are interdependent, where the behavior of each affects the outcomes of the other. Additionally, the individuals interact with each other in a series of interactions that are interrelated and affect each other.”* -Blackwell encyclopedia of sociology online.

### Environment

*“the surroundings or conditions in which a person, animal, or plant lives or operates.”* - oxforddictionaires

### Social support

*“Social support” usually refers to a process of interaction or exchange between individuals and significant others. Researchers have examined different types of support (e.g., emotional, informational, instrumental) and different sources of support (e.g., family, friends, neighbors, church members), as well as functional aspects (e.g., emotional support, sense of acceptance or belonging) and structural aspects (e.g., size, density, frequency of contact).- Blackwell encyclopedia of sociology*

### role-model

*“a person looked to by others as an example to be imitated”.* oxforddictionaries

### Culture

*“all the symbols, meanings, and values shared by members of a group, by contrast to other groups”* blackwell encyclopedia of sociology.

## 11.2 Appendix 2: Letter of consent

### Letter of consent

#### Purpose

The purpose of our study is to explore psychiatric social workers' and psychiatrists' perceptions of psychiatric social work's unique knowledge and its contribution to the field of mental health care in Goa, India. The purpose is further to explore psychiatric social worker's understanding of social factors in relation to mental illness.

#### The interviews

We will conduct semi-structured interviews. The interviews are planned to last 60-90. There might be a need for shorter follow-up interviews either in person or my e-mail. The interviews will be recorded and transcribed by us personally. The interviews will be kept in a safe manner inaccessible to unauthorized. When the essay is finished the recorded interviews will be erased.

#### Anonymity and participation

All participants will be anonymous in the final essay. We will use the name of the workplace so there might be a risk that the participants will identify each other. The participants can interrupt the interview whenever they want without explaining why. Participants who regret their contribution can withdraw it before the final draft of the essay.

#### Responsibility

We, Caroline Jonsson and Aina Bergh are students at Ersta Sköndal University Collage in Stockholm, Sweden. These interviews are the basis for our bachelor essay which will be tutored and graded by Ersta Sköndal University College. Questions can be sent to our e-mail addresses.

#### Consent

I have read the information above and agree with the content. I am aware that I participate without any payment in return and give my consent to be part of this research project.

.....  
Date and city

.....  
Signature

## **11.3 Appendix 3: Interview guide Psychiatric social work**

### **Background:**

- Education
- How long?
- Where did you get your education?
- Which subjects did you study?
- Work experience
- Daily tasks/assignments

### **Social work discipline:**

- What knowledge do you think is important to have when working with mental illness in India?
- What kind of knowledge do you think you as a social worker have that other professions in this field do not have that is important when working with mental illness?
- What do you think the profession social work can contribute with in the field of mental health care?
- Why is it important for social workers to work in the field of mental health?
- Are there any interventions or specific parts of the work with mental illness that social workers are especially good at?
- What do you think would be different in mental health care if there were more social workers in this field?

### **Social factors:**

- What are your thoughts about social factors in the causation of mental illness? Which social factors? Examples.
- What are your thoughts about social factors in the recovery of mental illness?
- What are your thoughts about prevention of mental illness?

## 11.4 Appendix 4: Interview guide Psychiatrists

### Background:

- Education
- Where did you get your education?
- Are you specialized within your field?
- Daily tasks/assignments

### Social work discipline:

- What knowledge do you think is important to have when working with mental illness in India?
- Do you feel that you have gained enough knowledge about psychological and social dimensions related to mental illness in your education? If not, have you gained it afterwards and how?
- What kind of knowledge do you think social workers have that other professions do not have that is important when working with mental illness?
- What do you think the profession social work can contribute with in the field of mental illness?
- Why is it important for social workers to work in the field of mental health?
- Are there any interventions or specific parts of the work with mental illness that social workers are especially good at?
- What do you think would be different in mental health care if there were more social workers?

## **11.5 Appendix 5: Informative interview**

- When and where was social work introduced as a profession in India?
- Can you tell us about how the social work education is disposed in India/Goa?
- Can you study social work in Goa? where?
- Where can you study the master course in medical and psychiatric social work?
- Can you study the master course in medical and psychiatric social work in Goa? where?
- How many psychiatric social workers are there in Goa?