SOS: a relational orientation towards social inclusion

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Abstract

Purpose – *Relational approaches have become fashionable in a variety of areas from organisational to clinical interventions, however the practical implications of such approaches are still misunderstood. This paper aims to define what we mean by "relational" and explores how understanding and practising a specific type of relational approach is necessary to truly promote social inclusion and recovery.*

Design/methodology/approach – *A hypothetical case study is described giving a practical illustration of how a relational approach would be used in the context of the provision of socially inclusive mental health services.*

Findings – *The paper makes the case for a relational and socially inclusive approach to change. A three-pronged "SOS" model calling attention to the exploration of Self, Other and Situation is outlined. Most importantly, the model attempts to balance the complex and varying needs of clients, others and the wider situation/community/organisation, as opposed to primarily focussing on individual "fault/lack".*

Research limitations/implications – *The paper relies on self-report methods from a relatively small number of individuals.*

Originality/value – *The paper challenges a still predominant individualistic paradigm to change. Instead it suggests the need to redirect attention to clients' existing relational supports to effect quicker and more sustainable change.*

Keywords *Relational, SOS model, Mental health, Social inclusion, Marginalization, Mental health services*

Paper type *Case study*

"Relational" approaches are certainly fashionable and one could easily be forgiven for thinking they are now a preferred way to understand and interact with almost anything. A quick "Google" search reveals relational approaches to leadership, coaching, databases, quantum physics, ethics and psychotherapy amongst other things. But what exactly does "relational" mean in any specific context, including mental health services? Is it a word that in attempting to mean so many things has become diluted and an almost meaningless prefix? We think not, and in this brief paper want to define more precisely what we mean by "relational" and how understanding and practicing a specific type of relational approach is necessary to truly promote social inclusion and recovery.

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Definition

The Concise Oxford English Dictionary (2008), defines "relational" as:

> The way in which two or more people or things are connected or related.

We find this a useful starting point and way of introducing a key post-modern concept: the idea that rather than individual things or people being the main, sometimes only, focus of attention, it is the relationships existing between or amongst them that offers maximum possibility for change. In some discourses, this can be expressed as a move away from "fixing, treating and curing" the "lone hero" individual (be they a patient, coachee, team or organisation), to focus

instead on the relationships, or "social capital" they possess. This can be equated to a leadership programme or coaching intervention focused on developing strengths as opposed to "upskilling" to counteract weaknesses. Within mental health services, we suggest that uptake of a relational approach is the antidote to the social exclusion of individuals and marginalised communities that prevent them from full participation in economic, social and political life.

Brooks (2011, p. 43), states:

> People don't develop first and create relationships. People are born into relationships – with parents, with ancestors, – and those relationships create people.

In other words, the quality of our relationships powerfully define and create the quality of us as individuals (be that individual people, teams, organisations or communities). Indeed, recent neurobiological research (e.g. Siegel, 2007), reveals that our developing brains, although genetically informed, are very heavily influenced by our relationships with others throughout our lives. Similarly, it is well documented that the web of relationships and interactions within an organisation determines the sense of culture and identity, and has a profound impact on productivity and performance (e.g. Kotter and Heskett, 1992; Truskie, 1999; Alvesson, 2002).

Other people, our context, relational situation and degree of social inclusion are thus all vitally important in determining how, and how well, we function. Indeed, we would propose that these contexts (both developmental/historical and social/present centred), are generally more important than individual character/personality in predicting and determining functioning. It follows therefore, that alongside models of individual pathology (e.g. ICD 10 or DSM IV-R), we need tools and models that attend to nets of connectivity and inter-relatedness that support (or do not), our clients and service users to function at their best. Indeed, some theorists examining the phenomena of social exclusion argue that mental health workers must appreciate marginalisation as a socially systemic problem and not the "fault" of the individual (Mulally, 2007; Sakamoto and Pitner, 2005). Accordingly, communities and contexts must feature largely in models of "treatment" and recovery.

We judge that it is clear from the work of a whole range of researchers that with support, collaboration and co-operation, many more of us can benefit from being "full" members of society and thrive (see, e.g. Department of Work, and Pensions, 2008; Spretnak, 2011; Institute for Public Policy Research (IPPR), 2012, for fuller discussion)

The SOS model

Having considerable experience of working in the National Health Service, we were aware of this rapidly growing range of compelling research, and equally of the seeming resistance of services to grasp the relational/social inclusion paradigm and resultant "treatment" issues. Instead, we seemed to "diagnose, medicate and treat" ever larger numbers of individuals, many initially presenting with issues of life (parenting, ageing, work stress, bereavement, family problems, bullying, etc.), rather than compromised mental health. We wondered why this might be, and thought the difficulty of applying existing relational/inclusive models (e.g. Fiske, 1992), might be one issue.

We started searching for an easily graspable way of explaining the paradigm shift from "individualistic" to "relational": moving from diagnosing individual pathology to considering relational supports and social/situational contexts. We wanted a practical model that quickly and effectively conveyed the importance of a sense of interconnectedness, alongside the need for collaboration and assistance.

After several attempts, collegial discussions and "framings", our explicitly simple "SOS" model emerged. We were fully aware that SOS is the commonly used description for the International Morse Code distress signal. In popular usage, SOS is therefore associated with such phrases as "save our souls", "save our ship" and "send out succor". These all convey a sense of need, urgency and request for help that we believed were inherent in embracing a more socially inclusive, relational world view: "I need more than myself to thrive".

In the SOS model, we therefore use the letters to refer to a threefold consideration of "Self, Other and Situation" (Figure 1). We propose that each of these elements requires exploration, and possible intervention, in any change process. More specifically, this relational orientation means finding an optimal balance between three interrelated elements:

- self; which can be seen as either the individual, group, community or organisation;
- other; as the "other" in the relationship at any given moment; and
- situation or overall context/culture in which we the issues are embedded.

Each of these three elements requires complex and detailed analysis, often requiring multiple skills of clinician, social/community worker and organisational consultant.

Vitally, we also use the model to convey a "felt sense" of the socio-political ethic inherent in a socially inclusive relational paradigm: we are all ultimately interconnected and interdependent. As such, collaboration, co-operation and supportive environments become foundational pre-requisites for thriving and flourishing individuals, teams, organisations and communities. We necessarily therefore seek to expand and include all the diverse elements of any presenting issue, believing this brings the most stable, sustainable and nourishing solutions.

We will now illustrate with a simple example how the SOS model can, and we believe should, be used in the context of the provision of inclusive mental health services.

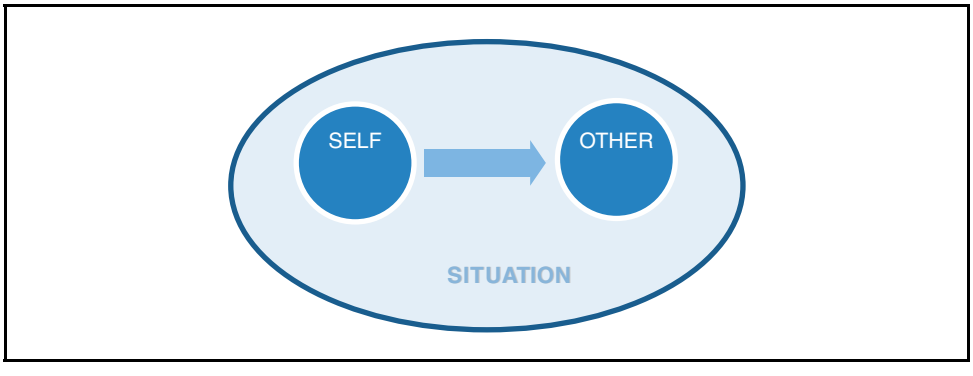
A case study

If we imagine an individual presenting for help (probably to her GP), saying she feels bullied by her boss, it is still most likely that she will be diagnosed with anxiety and/or depression, and offered some medication and/or psychological "treatment". Fortunately, NICE treatment guidelines (e.g. CG90, October, 2009, Depression in Adults), do emphasise the importance of addressing issues of possible stigma and discrimination associated with depression, the power of culture and ethnicity, the need for "watchful waiting" and the importance of families/carers and a carer's assessment. Anxiety guidance offers similar explicit advice.

One might reasonably expect therefore that increasingly, a socially inclusive paradigm and recovery focused intervention would be the usual outcome of help-seeking, with heavily individualised treatments (such as an individual taking medication or being the sole recipient of "treatment"), being reserved for particularly "individualised" presentations. Sadly, however, experience (and statistics), demonstrate this is not the case. Instead, individual prescriptions and referrals for individual treatments (such as cognitive behavioural therapy) are rapidly increasing, while genuinely socially inclusive, community based interventions and supports are struggling to survive, let alone expand. This is in spite of the genuinely innovative, inclusive and relational policies and projects described and explicitly recommended in "Working Together" (2008).

We deeply regret this, and would argue that there is an immediate and powerful advantage to a relational analysis using the SOS model of assessment prior to diagnosis or treatment. It enables us to explore with the presenting individual not only their own mental state and circumstances,

Figure 1



but necessarily also involves a focus on the behaviour of the key other (in our example, the boss), and also the cultural context (work), within which the complaint arises. Combining these three factors provides a much richer analysis of the issue, and is likely to more effectively target inclusive solutions than retreat to an individualistic formulation of the problem (be it bra.in chemistry, thinking style, developmental history or a combination of all of these).

Most importantly, by using SOS we stop signalling that the individual either is, or now has, the problem (depression) and that it is down to them individually to resolve it. Instead, the issue is spread more widely across the three SOS elements with responsibility for improvement being shared and distributed between stakeholders: in this case, the presenting individual employee, the boss and the employing organisation. A range of evidence suggests that this sharing, as opposed to individual "blaming", is highly effective in decreasing levels of depression (and other mental health problems), while promoting individual well-being, productivity and sustainability at work (see, e.g. AstraZeneca case study in the report by the Department of Health *et al.*, 2005, p. 15 on health, work and well-being).

Many in mental health services will argue that multi-dimensional assessments and interventions such as SOS happen routinely due to the influence of bio-psycho-social approaches. We would, however, counter by saying that the insistence on individual identified patients carrying diagnoses and receiving treatments (be they pharmacological, social or psychological), means it either does not, or is generally tokenistic. The radical difference a socially inclusive relational paradigm can offer has not yet been realised, largely we believe, due to delivery often being embedded within traditional specialist mental health service providers.

Individuals still matter

It is important to emphasise that, by advocating for SOS, we are not ruling out an individual being, or becoming, the main focus of attention: there are circumstances where that will be both important and necessary. What we are arguing for, however, is a radical paradigm shift so that this individual focus is not automatically the outcome of contact with mental health services, including counselling/psychotherapy services. Indeed, there are many instances where the latter are prime examples of the dominance of an individualistic, exclusive culture, whereby an individual's thinking, behaviour or feeling state is identified as the target for change, as opposed to targeting the relational context and culture where the issues arose.

For example, and returning to our case study, by exploring the client's history, we may discover a long-standing pattern of this individual person feeling bullied in many relationships, alongside a lack of any identifiable signs that this is currently the case with their boss. As such, we may offer an intervention to this individual aimed at teaching skills and behaviours that lead to a sense of empowerment and confidence and improved ability to work with her boss. We would judge this as helpful and a vital element of intervening options.

Alternatively, the client may tell us a story indicating that she clearly is being bullied, in which case completely different actions may be required; such as talking with the boss, seeing the client and boss together or, if all else fails, taking human resources advice.

Similarly, it may emerge over time that all our clients from this organisation complain of feeling bullied, in which case a wider, organisational intervention is needed to work with the context and culture.

All of these are intervention options to consider and, vitally, are options that create a sense of shared responsibility and social inclusion rather than individual pathology and marginalisation: the latter often experienced as "go away and deal with your problems and come back when you are fixed".

We would argue that in many cases, however, more than one single element of the SOS model will need to be addressed if the change intervention is to be both successful and enduring, which is our aim. We want an intervention creating sustainable positive change as opposed to chronically managing sub-optimal functioning in difficult circumstances. We would see this aim as radically different to that of some Mental Health specialist teams, where clients are often

monitored for many years: "just in case". The circumstances creating and maintaining distress are not tackled, and instead, symptoms "managed" within the existing context.

Instead (and staying with the above example), by using the SOS model, we have an easily comprehensible, accessible and clear mandate to attend equally to the complaints of the client, the behaviour of the other and the environmental/situational context. As our example shows, it is essential to know if our client is being bullied, before we prescribe that individual an intervention (be it medication, skills training or psychological therapy). The latter all "push" the issue back inside the individual and although they appear supportive, instead they can actively serve to further undermine the individual in the long run: we confirm the problem is "in" them rather than recognise the threefold impact of the SOS variables in both causing and resolving many issues.

Of course, cynically, and according to some of the more political advocates for social inclusion, one could argue that on occasions it suits the more powerful person/group/company, to promote individualism; to leave responsibility for the "problem" with the person or people experiencing it. Evidence would seem to suggest that this is especially likely if the "presenter" is less powerful and more vulnerable therefore, to being marginalised (see, e.g. Department of Health, 2007, for statistics concerning health inequalities and minority groups). We would thus argue that it is essential to address these inequities in considering both aetiology and resolution of issues, and are delighted by an increasing number of practitioners and policy makers advocating for a more relational and socially inclusive approach to how "care" is delivered in the UK (Levitas *et al.*, 2007). SOS is our accessible entry point to working with, and delivering on, this vital agenda.

Ethics

It is important to realise that, in balancing the threefold elements of self, other and situation, the focus shifts away from simply prioritising meeting the immediate needs of the client; the issue of impact is also directly addressed. While many mental health practitioners who focus on carer's assessments and family/wider contexts, will be automatically practicing in this more socially inclusive way, many providers of counselling/psychotherapy have been slow to embrace this change. Writing about "Ethical Maturity", Carroll and Shaw (2012), describe this development as attending to the ethical question of:

> How do we balance what we owe ourselves and what we owe others? How do we attend to the development of the Self while staying connected? (p. 108).

In developing the SOS model, we were very aware therefore that an ethical attitude lies at the heart of the approach. It is manifest in the presence of the practitioner and their care for the well-being of a wider system than the individual "signaller" of the problem. In philosophical terms, this means a shift from meeting individual needs, to an emphasis on "the third": an awareness that in meeting my own needs I always have an impact on others (be it in the short- or long-term, directly or indirectly). An individual paradigm cannot address these issues, but a socially inclusive, relational one must balance individual, other and situational needs. As Fairfield and O'Shea (2008), write:

> […]this relational emphasis is actually very interested in the well-being of each individual and how that well-being is so intimately entangled with the well-being of the community to which he or she belongs (p. 26).

It is vital to state that this in no way implies a lack of care for the individual, but instead, a strong conviction that none of us can thrive in isolation. In turn, we believe that it is wider systems, families, communities, organisations and societies that now need targeting for change. Applied to suffering individuals, this relational, socially inclusive perspective means that we look closely at significant relationships and social networks.

In tandem with this, there is urgent and important work to be done at the community/organisational/societal level in order for more of us to recognise that many of life's challenges do not require recourse to a specialist mental health consultation and intense individual attention. Instead, we need to develop a resourced, relational, inclusive support system to draw on in times of need … and invest in at other times. "Relational" therefore means taking and sharing

responsibility, both for my own recovery, and also for my role in others problems and solutions. Indeed, this is the vision we see being articulated in a wide range of recent policy documents such as *The Relational State* (IPPR, 2012), and *Mental Health and Social Inclusion* (Royal College of Psychiatrists, 2009).

It is true of course, that in the short term, I can do very nicely indeed if I view an individual, group or even country as a resource for my growth: a commodity that I can seize to feed myself, or my "tribe", regardless of the effect on them. Many service users who have been the victims of bullying, exploitation or abuse, will recognise this sense of being a "thing" or "commodity" that can be used as a resource for someone else. Increasingly, however, it is becoming clear that many in society will no longer tolerate, or turn a blind eye, to such exploitation and the recent actions by the government to support "whistle blowing" (albeit in the wake of scandals such as the Jimmy Saville case), indicate that moral/ethical considerations are finally being given more attention (see GOV.UK, 2013, for further details).

As positive change agents/facilitators, we do not want a role that principally teaches individuals in unsupportive/harmful contexts a set of skills to tolerate them more. Occasionally, and where contexts are genuinely unable/unwilling to change, such "distress tolerance" skills are very useful in riding out short periods of stress/trauma. As a lifestyle choice, however, we would see this as unsustainable in the longer term, and bound to lead to increasing and chronic symptoms. For that reason, we de-emphasise long-term toleration and highlight instead possibilities, and supports for relational change.

Our belief is that with an easy to grasp, socially inclusive, relational model such as "SOS", service users, providers and wider communities can move to much needed shared ownership of problems and genuinely co-produced, more sustainable, solutions.

Summary and conclusion

We believe that a relational, socially inclusive approach to change is a profoundly useful one, particularly when the relational model used is easy to understand.

In pursuit of this we developed the "SOS" model, with a threefold attention to exploration of self, other and situation. We do not prescribe in any way, where the eventual focus of interventions will be, or what percentage of attention and intervention will ultimately be devoted to each of the three elements: all of those details are revealed in the exploration of each unique situation. What is vital, however, is that the model attempts to balance the complex and varying needs of clients, others and the wider situation/community/organisation, as opposed to primarily focusing on individual "fault/lack".

In this way, and importantly, our SOS model differs from a range of relational models currently used in psychotherapy where (as in classic psychoanalysis), the most important relationship is viewed as being the one manifesting in the room. Instead, we view the site of both exploration and intervention as needing to be wider than this; while the relationship between therapist and client can indeed be a mirror to other relationships, it can also lead to an unhelpful creation of an isolated, though highly supportive dyad. In turn, this is bound to lead to ever increasing numbers of people seeking out, and staying in, some form of mental health service: it becomes the only relational setting in which to reliably gain any support.

Ultimately we believe this to be profoundly unhelpful for suffering clients, families, organisations and wider society. We suggest instead that direct attention to a clients existing relational supports/ "social capital" can effect quicker and more sustainable change. In addition, facilitating socially inclusive community interventions that increase our shared abilities to support each other will ultimately decrease our call on specialist clinical services to deal with ever more of life's challenges.

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