



ASEAN SOCIAL WORK JOURNAL

Volume 12, No. 1, June, 2024

ISSN : 2089-1075

e-ISSN : 2963-2404

DOI : <https://doi.org/10.58671/aswj.v12i1.66>
www.aseansocialwork.com

Revisiting Psychiatric Social Work Practice in the Philippines: An Autoethnographic Case

Alain Matteo F. Meneses*

University of the Philippines–Diliman, Philippines

* Correspondence: men.alainmatteo@gmail.com

Received: January 22, 2024 **Accepted:** May 1, 2024 **Published:** June 30, 2024

Abstract

Over the past decades, there has been a gap in literature discussing the field of psychiatric social work in the Philippines. In an attempt to address this, this article describes a case to revisit the practice of psychiatric social work in the Philippine setting. Using an autoethnographic methodology, I recount my experience as a psychiatric social worker at a teaching hospital located in Quezon City, Metro Manila, Philippines, to illustrate the position, its roles and functions, and the common strategies it employs in practice. In discussing my personal experience, I reflect on themes and assert that psychiatric social work remains to have a continuing significance in today's mental health landscape, offering innovative practices in response to newer challenges of helping patients with mental health conditions

Keywords: psychiatric social work, mental health, patients with mental health conditions, psychiatry, autoethnography

Introduction

Since I started my journey as a social worker, I have always had an interest in mental health and working with people experiencing mental health concerns. When I was browsing through the internet to read about mental health social work, I encountered the term “psychiatric social work” which made me very curious. It was highlighted in an online article from an academic institution that discussed the roles of a psychiatric social worker in a hospital. At that time, I got fascinated with the field and continued to look for more information. Little did I know that I would be actually practicing the field sooner in my professional career, and have an opportunity to share my practice experience in this paper.

For a brief review, we know that social workers play an indispensable role in the prevention and treatment of mental health conditions. They are considered valued members of multidisciplinary teams in mental health settings (National Association of Social Workers [NASW], 2011), collaborating with other professionals to address the diverse needs of different clienteles. In the Philippines, social workers often deal with mental health concerns across all settings, and have been noted to be vastly improving and developing in practice (Patricio & Verdeprado, 2020). Over the past years, they have also become more responsive to mental health and psychosocial needs, using social technologies to offer various forms of support (e.g., Cinco, 2021; Cudis, 2021). As such, a significant legislation known as Republic Act 11036 (or the Mental Health Act of 2018) recognizes social workers as qualified “mental health professionals” who are trained to provide a wide array of services to individuals, families, and groups, as well as to communities and organizations at large.

Throughout history, social work and mental health have been inextricably intertwined (University of Nevada, Reno, n.d.). Bamford (2013) explains this relationship by underscoring the important part that social work plays in engaging in broader societal issues—such as inadequate housing, unemployment, food insecurity, and poverty—that cause deplorable consequences on psychological well-being. While social workers of every type are concerned with mental health, some roles come with specialized requirements. An example of this role is the specialty area of psychiatric social work, which

is referred to as the application of social work methods and techniques in the field of psychiatry (Rajalingam, 2019). As Sathyamurthi (2020) elaborates:

“Psychiatric social work is a specialized branch of social work that is concerned with [the] theoretical as well as practical aspects of clinical work practice with any individuals, groups and community having difficulty in dealing with their psychological, emotional and intellectual problems by themselves” (p. 16).

Psychiatric social work was first practiced in the United States in 1907 when the Massachusetts General Hospital began to provide social services in a neurologic clinic (Stuart, 1997). During this time, a shift from institutional management to mental hygiene was observed, highlighting the significance of community care in treating those with mental health conditions. However, Black (1991) notes that earlier psychiatric social workers seemingly functioned as “aides” to the psychiatrists, with some stereotypically calling them as mere ‘errand girls’ attached to the clinic (Stuart, 1997). In their quest for professional status, psychiatric social workers, led by the pioneer of the specialty, Mary C. Jarrett (1922), aspired to provide direct treatment, and thus pursued a more ‘psychological turn’ in their function. Unfortunately, the blurring distinction between the roles of a psychiatrist and those of a psychiatric social worker impeded this quest, causing psychiatric social work to remain a marginal specialty until 1940 (Grob, 1983).

In the Philippines, psychiatric social work was first introduced in child-rearing institutions in Welfareville, Mandaluyong City. Palma (2015) notes that Dr. Jose Vergara, then the superintendent of the Associated Charities of Manila, appreciated the value of psychiatric social work in the United States in 1941, inspiring him to employ social workers to cater to the needs of children and the youth. In 1948, a psychiatric social worker was also engaged under the supervision of the renowned clinical psychologist, Estafania Aldaba-Lim, at the Institute of Human Relations of the Philippine Women’s University, to assist in the provision of clinical services to schools and communities, along with a counselor and psychiatric consultants (Melgar, 2013). Meanwhile, the Department of Health (2010) narrates that a nurse supervisor in the former Psychopathic Hospital (now known as the National Center for Mental Health or “NCMH”) was appointed to function as a social worker to prepare social case histories and facilitate referrals. This set the preliminary standards for performing case management with patients with mental health conditions (referred to as “PMHCs” hereinafter) in hospital settings.

During its early development in the United States, the function of psychiatric social work was considered “fluid” rather than fixed (Grob, 1983). Some of its earliest activities include obtaining information regarding a patient’s environment through home visits, performing clerical and administrative duties, offering support and encouragement, and in some instances, doing ‘social manipulation’ (that is, finding jobs and boarding homes, tapping needed services, and explaining to the patients’ families the psychiatrist’s recommendations). In recent years, major developments have been gradually observed in the role, with later generations of psychiatric social workers adopting counseling, crisis intervention, and certain models of psychotherapy in their work (Shah, 1996). This trend carried on until the present time, especially in many industrialized societies such as the United States and the United Kingdom where mental health continues to be a priority concern (Bamford, 2013). Interestingly, the same trend is occurring in India where the practice and education of psychiatric social work are much more advanced than the ones in other developing countries (Rajalingam, 2019).

At present, there is limited data available on the current application of psychiatric social work in the Philippine setting. In fact, there is no literature that directly discusses psychiatric social work in the country when searched through the Google Scholar engine. I recount, however, during our agency visit at the NCMH in 2018, that social workers were mostly engaged in the socio-economic evaluation and classification of PMHCs entering the institution, as well as in the delivery of case management (i.e. facilitating referrals) for those presenting any psychosocial problems. In addition, I recall that the same activities were carried out by the social worker at the Department of Psychiatry and Behavioral Medicine of the Philippine General Hospital (PGH) during my field practicum in 2019. As Mendoza (2008) states in her famous book *Social Welfare and Social Work*, social workers in psychiatric units of hospitals and mental health agencies generally have the same functions as medical social workers in health facilities, except that they deal with those experiencing mental health conditions. This is also affirmed by an old definition I found from de Guzman’s (1988) local social work dictionary, which describes the specialty as “social work practice in a medical/clinical setting which deals with mental/behavioral problems of patients” (p. 57). However, I find Morales’ and Sheafor’s description of psychiatric social work in the Department of Health’s (2010) manual compelling, since they argue that “psychiatric social workers perform a distinct function compared to their colleagues” as they:

1. Address the social and psychological factors that contribute to the psychiatric condition that must be dealt with to facilitate recovery and prevent occurrences of nonfunctional dependence
2. Help them learn to cope with problems in their social functioning, and
3. At the same time, work to change factors in their environment to promote better mental health or eliminate social conditions that have a negative effect on their functioning” (p. 317).

Since decades have already passed, I recognize that there is a need to revisit and provide a description of the current practice of psychiatric social work in the Philippine setting. Drucker (1977) notes from his decades-old paper on psychiatric social work that a vast area of research needs to be undertaken by psychiatric social workers in developing countries to adequately describe the social aspects of their working situation. To reiterate, local literature on the specialty remains scarce, and is seemingly limited to a few excerpts in select outdated books. This is probably because the specialty area of “psychiatric social work has been neglected and misunderstood by contemporary writers” (Stuart, 1997, p. 26). Another explanation that may be attributed to this gap is the reality that Filipino social workers are not afforded the luxury of time to document their practice experiences, mainly because of the massive amount of caseloads they are managing.

In an attempt to contribute to addressing the literature gap, I intend to highlight and discuss my personal experience as a psychiatric social worker in the Philippines. In doing so, I express no intent of representing other existing practices in the country, but rather focus on providing a personal account alone. Nonetheless, I hope this paper serves as a valuable contribution to the small body of literature on Philippine psychiatric social work, which I deem to be useful for teaching and further research. Drawing data from my personal account, I intend to: (1) describe the position of the psychiatric social worker; (2) identify its roles and functions; (3) specify its strategies of intervention; and (4) discuss relevant themes pertinent to the experience in line with the existing literature.

Methodology

I utilize an autoethnographic case study approach to illustrate an account of psychiatric social work in the Philippines. Using a descriptive format, I present the data drawn from my engagement as a psychiatric social worker at a teaching hospital¹ (referred to as the “East Hospital” hereinafter) located in Quezon City, Metro Manila, Philippines, which lasted for a year and three months. According to Poulos (2021), autoethnography is a qualitative research approach that draws findings from the researcher’s personal experiences to describe “beliefs, practices, and experiences” (p. 4). Currently, it is an emerging method of inquiry in social work that offers a “way of addressing the ‘oft-chagrined’ practice-research gap” (Witkin, 2022, p. 29). This is also being applied in other related areas of social work as exhibited in some local articles published over the past years (e.g., Abenir, 2010; Barrameda, 2006).

Understanding the possible implications of using a ‘subjective voice’ in the paper, I maintain an objective and analytical stance in delving into the subject to create a balance between my personal experiences and the actual world (Keles, 2022). To augment my autoethnographic account, I utilize other data-gathering methods such as participant observation, desk review, and conversations with three (3) former psychiatric social workers and the medical social workers of the East Hospital. Lastly, I discuss the case using a narrative thematic analysis in line with Gibbs’ (2015) framework to look for relevant accounts and experiences, identify and code thematic ideas, and develop connections (mostly theoretical) with the literature. In doing so, I utilize an analytic autoethnographic stance (Anderson, 2006) to link and contrast my personal account as a psychiatric social worker with existing research, to reach a scholarly analysis and support theory-building.

Results

About the Position

The East Hospital is a private teaching medical center that provides opportunities for beginning physicians, nurses, and other allied medical professionals to develop their clinical competencies in their respective disciplines by directly engaging in the assessment and treatment of patients. The Hospital is known for its various services, and is considered to be one of the few healthcare facilities in the country that cater to PMHCs through its Psychiatry Department, which is an accredited training institution for physicians planning to specialize in the psychiatric field.

At the East Hospital, there was only one position allotted for the psychiatric social worker. I was the fifth worker to assume the role; and during the onboarding process, I remember being told by my former colleagues that the position is “*iba*” (different) from the other social work positions. First, it was

¹ For ethical considerations, the real name of the hospital is substituted for “East Hospital.”

narrated to me that the position was not intended as an additional staff for the Hospital's Social Service Unit, unlike in many government-run psychiatric institutions in the country. Rather, it was instituted for the purpose of complying with the accreditation requirements of the Psychiatry Department back in 2018, to remain as an accredited training institution. However, I recall being confused when I was briefed about the affiliation of the position since it was placed under the organizational structure of the Social Service Unit. As I understand it, the position remains distinct, as it is more attached to the operations of the Psychiatry Department. Although it is interesting that the official set of qualifications for my position were the exact same as those of a medical social worker.

Given the organizational arrangement, I dealt with the persistent problem of not having a stable work space at the East Hospital. During that time, I had no choice but to transfer from the Social Service Unit to the Out-Patient Psychiatry Clinic, and vice versa, in an effort to manage cases. I knew, however, that I needed to keep myself open for any incoming referrals from the psychiatrists. Similar to other healthcare staff, I was also seen as an 'on-call' worker from the Social Service Unit, who promptly responded to the requests coming from the Psychiatry Department. Until such time, I began to notice that the setup or arrangement for my position was becoming "*magulo*" (or complicated), especially after hearing from former psychiatric social workers that they also encountered the same difficulties during their time.

Exploring Roles and Functions

One of my former colleagues shared with me that the first ever psychiatric social worker of the East Hospital had no clear-cut set of roles and responsibilities. As narrated, this worker mainly performed clerical and administrative duties, rather than engaging in casework activities with PMHCs. When the subsequent psychiatric social worker assumed the position not long after, I was told that more functions were given by the Psychiatry Department, such as the socio-economic profiling of patients, facilitation of referrals to needed resources and services, and the preparation of social case study reports. Eventually, these functions were performed by the successor of the position, with an added activity of conducting intake interviews at the Out-Patient Psychiatry Clinic, following the Department's new standard operating procedure. However, much change was introduced when the fourth psychiatric social worker held the position, becoming a major reference for my own work.

By the time I started working as a psychiatric social worker at the East Hospital, I still carried out much of the tasks being performed in the past (i.e. assessing the socio-economic situations of patients, facilitating referrals, and preparing case study reports); and in the same way as before, I also had no defined set of roles and responsibilities specific to psychiatric social work. I heard, however, that the Psychiatry Department has shown a list of the functions of the psychiatric social worker previously, but this was not confirmed. Since there was no formal training to prepare me for the work, I was finding myself in a constant state of "kalituhan" (confusion), wondering what my roles were and what assistance I needed to give to PMHCs. Although I was committed to enrolling in mental health-related courses and seminars at that time, it was not sufficient to gear me in the position. Further, it was dismaying to know that a training program on psychiatric social work was (and probably still is) generally lacking. Despite these challenges, I strived to adapt to the demands of the position, and carried on in assuming more functions. Among these are:

- *Case Consultation* which I carried out in response to the requests of psychiatrists and other physicians to assess patients in crisis situations, abandoned circumstances, untimely discharge, and probable situations of abuse or neglect;
- *Direct Intervention* in which I performed to deal with the psychosocial problems of PMHCs of all ages (and their families, if applicable), either by performing counseling, family intervention, crisis de-escalation, financial aid, patient advocacy, location service, and linkages;
- *Women and Children Protection* where I was assigned to collaborate with professionals to ensure the protection of patients, most especially women and children, from the risk of abuse, neglect, violence, and exploitation; and
- *Aid to Clinical Instruction* where I assisted in the residency training of beginning psychiatrists by participating in the management of their caseloads and attending their "grand rounds."

In addition, I was also tapped before by the Psychiatry Department to give a short talk on mental health support for PMHCs, in commemoration of the Mental Health Month in October. Unfortunately, this did not push through due to some conflicts in schedule; although it was shared with me that giving talks on mental health-related topics is also one of the psychiatric social worker's main functions before, since raising community awareness is recognized as an important part of its skills set.

Other than the functions I highlighted, I also had a fair share of experience performing the duties of a medical social worker at the Social Service Unit. In general, medical social workers at the East Hospital were responsible for evaluating the financial situation of incoming patients and for facilitating referrals for financial aid. Oftentimes, I was exposed to these tasks when there were no referrals coming from the Psychiatry Department or when the Social Service Unit requested my assistance. Over time, I was faced with the realization that my role was becoming flexible to more and more tasks, which sometimes were beyond the supposed scope of my duties as a psychiatric social worker.

Strategies for Intervention

Direct intervention is an important function of the psychiatric social worker—more so because, in my time, it cuts across other functions, one way or another. Although I did not have enough training in psychiatric social work, I was still able to implement several interventive strategies that aim to address a wide range of concerns among PMHCs (and their families). It was not ideal, but I had no choice but to rely on my generalist skills and acquired knowledge from mental health-related courses and seminars. I also found the practice wisdom of the former psychiatric social workers to be useful in my work. From these existing knowledge bases, I began to develop confidence in utilizing the strategies below.

Social Work Counseling. When I was being informed of the usual activities of the psychiatric social worker, I remember hearing the word “nagka-counseling” (or counseling). However, this activity—or interventive strategy—was only implemented during the COVID-19 pandemic, when the fourth psychiatric social worker made an initiative to assist in the treatment of mental health concerns among PMHCs. In my time, I considered counseling as a core intervention, primarily because the patients’ needs are psychological in nature. However, there were limits in providing this intervention, recognizing that PMHCs are already getting treatment with their respective psychiatrists. From that recognition, I then decided to develop and offer a supportive form of counseling that has two goals: 1) building the coping capacities of PMHCs; and 2) increasing adherence to their prescribed treatment. In providing this, I utilized social work counseling techniques (e.g. catharsis, reflection of current and past factors, sustaining remarks, etc.) and drew insights from other evidence-based methods (e.g. Dialectical Behavior Therapy, Cognitive-Behavioral Therapy, and Eye Movement Desensitization Reprocessing).

From my practice experience, social work counseling can either be a stand-alone intervention or an adjunct to other interventive strategies. In many cases, I counseled PMHCs (with or without members of their families) during ‘wellness check-ins’—or what the Psychiatry Department calls “kumustahan”—as part of the aftercare plan (i.e. the recommended treatment for a patient once discharged from the East Hospital). As I conducted it from my experience, the ‘kumustahan’ is a structured session, usually held online using video-conferencing or other remote platforms. Similar to the concept of telemedicine, the kumustahan serves as a venue for the employment of other interventive strategies, which are relevant to the patients’ situation. Since the East Hospital management discouraged the conduct of home visits in my time, the check-ins have become an alternative for me to meet and interact with PMHCs in their own environments, albeit virtually.

Family Intervention. In the Philippines, one of the main sources of strength and support for PMHCs is their “pamilya” (family). While working as a psychiatric social worker, I bore witness to how important families are in the recovery process; however, I also saw how they can cause extreme distress to PMHCs and, sometimes, “trigger” their mental health concerns. In this regard, it was often a constant effort for me to involve the family as a unit of intervention, in hopes of making them more supportive of PMHCs. If there is one thing that I noticed from families throughout my engagement as a psychiatric social worker, it is that they often find it difficult to accept the patients’ condition because of a lack of “pang-unawa” (or understanding). This explains why family psychoeducation (coupled with counseling) formed a crucial part of my intervention; to foster a more accurate understanding of mental health conditions, as well as to share relevant information on the specific care that PMHCs need.

Besides increasing awareness among families, I also happened to make use of other strategies to help them in their own specific issues. It was an important realization on my end, since nearly all of the cases I handled revealed that individual problems in the family system (e.g. lack of income, personal troubles, workplace concerns, interpersonal conflicts, etc.) still had a significant effect on the PMHC and their recovery process. Hence, it was expected of me to work as well with other members of the family to bring about change in their personal situations, supposing that it would also result in positive outcomes in the condition of their loved ones.

Crisis De-escalation. At first, crisis de-escalation was not part of the usual activities I performed as a psychiatric social worker—probably because crises among PMHCs are deemed to be best handled by other mental health professionals. However, psychiatric emergencies are common at the East Hospital; and although there were on-call psychiatrists assigned in the emergency room, they can only

respond to them, one at a time. This inspired me to implement crisis de-escalation as an interventive strategy to provide immediate support to PMHCs in crisis situations, such as those often described as “sinusumpong” (a Filipino term for the sudden, unpredictable change in mood or behavior, but is often used to refer to a relapse in a patient’s condition). There is a consideration in this strategy, however, in recognition of the psychiatrist’s role to act on these cases.

By building on the insights from the seminars I attended, I was able to use mental health first aid approaches (e.g. Psychological First Aid and Immediate Support Skills for PMHCs) in order to perform crisis de-escalation to offer a safe and non-judgmental space for PMHCs to release pent-up feelings and concerns. Often, these approaches also work for PMHCs with self-harm thoughts or suicidal ideation. Aside from offering them a safe space to discuss their worries, I also provide them with information on existing crisis hotlines and stabilization techniques. Further, it was often delegated to me to inform their family (or other support network) when they did not have any company while experiencing a personal crisis.

Location Service. During psychiatric emergencies, I have encountered many PMHCs going to the East Hospital alone, without any responsible adult accompanying them. Most of these patients had no strong support network (or family accessible to them) whom they could depend on when urgent medical attention was needed. However, there were also those with serious psychotic experiences who unknowingly advanced to the Hospital without their families knowing. In these instances, not only did I use crisis de-escalation to help alleviate existing tensions, but I also performed location services as an interventive strategy to ensure that a responsible adult can accompany the PMHC at the East Hospital. There were times, however, when the PMHCs’ emergency contacts were not reachable by phone. At such moments, I often sought the assistance of the concerned Barangay (the smallest government unit in the country) or the police to locate their whereabouts and inform them of the situation. This procedure was also applied in cases where PMHCs had no identifying information (or “John Doe” as we called it).

Financial Aid. At the East Hospital, financial aid (or “tulong pinansyal” in Filipino) is an important service of a medical social worker. When I had the chance to work at the Social Service Unit, I learned how to navigate what we called the “service jungle” to offer and facilitate the provision of financial assistance to PMHCs (and their families), especially those classified as “indigent.” There were two main options for providing financial aid. These are: 1) conducting an assessment for a patient to avail of the East Hospital’s financial grant to waive certain fees for their needed diagnostic exams and treatment procedures; and 2) endorsing PMHCs to the partner agencies of the Hospital with financial assistance programs, such as the Philippine Charity Sweepstakes Office (PCSO) and the Department of Social Welfare and Development (DSWD).

During my engagement, I made the initiative to explore other agencies to further strengthen the provision of financial aid for PMHCs and other patients at the East Hospital. I compiled the agencies (both government and non-government) altogether in what I referred to as a “resource list,” which is a reference document for prospective referrals. The list incorporated simple details about their programs, including the qualified cases/conditions, requirements, application procedures, and the things to expect (e.g. queuing time, possible interviews, etc.).

Patient Advocacy. Since I started working at the East Hospital, I learned that resources are not immediately granted to patients (or their families)—notwithstanding their efforts—sometimes because of technical, procedural, and other reasons. Such moments often called my attention to “makialam” (intervene) as a patient advocate. As expected, this interventive strategy has become relevant for many of my previous cases, as I often noticed the trend whereby PMHCs get denied in availing services essential to their recovery. I have also used this to help families with their specific concerns. In this strategy, I considered communication and coordination integral, since it pushed me to ensure that the concerned service provider considers and addresses the concern of the PMHC.

In addition, I used patient advocacy by raising the awareness of PMHCs and their families about their rights as service users, and exploring with them available options for proceeding with the treatment. However, I still made sure that there was a common ground between the medical team and the PMHC (and their family) to address concerns—such as a defiance of “paniniwala” (cultural or religious belief), “takot” (fear), and “kawalan ng pera” (lack of finances), among others—with the recommended plans of intervention.

Linkages. As a psychiatric social worker, I have witnessed how frustrating it was for PMHCs and their families to know that certain services were not available at the East Hospital. I recognize the limitations of the institution, but I knew that there were other ways to meet their needs, however, somewhere else. During my engagement, I had developed a practical process for referring PMHCs to important services, where I usually start by gathering the details about the service (like developing the resource list), then providing the PMHC (or their family) with a brief case summary (and a referral letter if needed) and, for ease of doing business, connecting with the concerned service provider by phone.

Often, PMHCs get the service they need through referrals. However, there were also times that I had to be a patient advocate, in order to overcome the barriers hindering their access to the service.

Ever since I started, I was able to facilitate many kinds of referral for PMHCs; most of them were intended to obtain material aid from government agencies (e.g. PCSO and DSWD). However, I also had the opportunity to refer patients to access *rehabilitation services* such as speech therapy or occupational therapy, following the recommendation of the psychiatrist. Although these were readily available at the East Hospital, I saw how difficult it was for them to provide for the corresponding fees. Thus, I often presented them the option of exploring outside groups or clinics that offer services for free or with a minimal charge. Whenever they consent to try this, I usually coordinate the patient with the identified group or clinic to ease the process of availing their service.

Besides this, I also came across PMHCs recommended for *job placement* to help them acquire a source of income. Although my position had its own limitations, I still recall helping PMHCs prepare the necessary job requirements and submit them to the Public Employment Service Office (PESO) to assist them in finding jobs. As a complementary support, I also helped them enroll into the Technical Education and Skills Development Authority (TESDA) Online Program to upscale their employability. Meanwhile, there were also cases wherein PMHCs wished to focus on improving their (or their family's) small-scale business, leading us to apply for livelihood assistance from the Local Social Welfare and Development Office (LSWDO).

I have also facilitated other referrals before, apart from the ones I mentioned. As in the others, these were based on the recommendations of the psychiatrists or the presented needs of PMHCs (or their families). Some of these referrals include being placed in a long-term residential facility, receiving educational assistance, availing a diagnostic test or procedure from another medical institution, seeking spiritual counseling, and many others.

Protective Service. This service was included in my interventive strategies following the key decision of the East Hospital to strengthen its Women and Children Protection program. At that time, there was a surge in cases of abuse against women and children patients being treated in several clinical departments. In addition, the Pediatrics Department is hoping to seek a higher accreditation for its residency training program with the establishment of a Women and Children Protection Unit at the Hospital. As mandated by Republic Acts 7610 (or the Special Protection of Children Against Abuse, Exploitation, and Discrimination Act) and 9262 (Anti-Violence Against Women and Their Children Act), I was entrusted to fulfill the mandate of reporting cases to relevant authorities, and perform both safety assessments to determine the likelihood of re-experiencing abuse, neglect, or other forms of violence. I also carried out other social work-related efforts to support patients, either by conducting counseling through wellness check-ins, family intervention, linkages, or other interventive strategies necessary to their situation.

In the provision of protective service, I had to collaborate with a multidisciplinary team consisting of a pediatrician (regarded as a Women and Children Protection Specialist), a psychiatrist, a social worker from the local government, a police officer, and in some instances, other medical professionals involved in the treatment of a patient. I participated in case conferences, which were initiated to discuss pertinent details regarding a specific case and formulate action plans dedicated to ensuring protection. Based on my practice experience, case conferences also serve as a mechanism for monitoring cases, ensuring that plans are being followed through by each member of the team to achieve overall treatment objectives.

Discussion

The main purpose of this paper is to illustrate my autoethnographic account of psychiatric social work in the Philippine setting. From the start, questions concerning generalisability, validity, and reliability are already raised. However, I intend to reflect on some emerging themes from the narrative; and in line with most autoethnographic social work literature, I leave the above questions to be assessed and judged by the readers themselves.

Critical Involvement in Psychiatric Care

Although the reason for recruiting a psychiatric social worker did not exactly originate from a need to help PMHCs with their respective situations, I find it compelling that there is, at least, recognition from the psychiatric community that social work services are integral to the provision of psychiatric care, being part of the requirements to obtain and, in this case, maintain accreditation. For me, it signifies that social work's "alliance with psychiatry" (Stuart, 1997) has become more apparent, if not well established, over decades of professional collaboration. As Bamford (2013) explains it, interdisciplinary collaboration is widely recognized in mental health care. With the psychiatric social worker involved in the process of managing cases, I believe that the treatment of the mental health condition becomes

more meaningful, as the psychosocial ills precipitating their existence also get targeted for intervention. As Bamford (2013) asserts: "Treatment of mental illness without regard to... wider social problems is unlikely to be wholly effective" (p. 90).

Moreover, Shively and Philipps (1963) state that psychiatric social workers are sporadically employed in psychiatric residency programs as a contribution to the resident's experience of treating patients within the social milieu. Although I am in no position to claim that my work had an impact on the experience of beginning psychiatrists at the East Hospital, the opportunity made me understand how critical it was for them to collaborate with me as a psychiatric social worker, in hopes of controlling the factors beyond their scope affecting the treatment. I have personally seen this during one of their grand rounds, recognizing that "social recovery" (Shively & Philipps, 1963) is also as important as the clinical improvement of PMHCs' psychological manifestations. In this aspect, while it was not the main point for hiring a psychiatric social worker, it became clear to me during my engagement, the creation of the position had still served the purpose of addressing the patients' needs.

Addressing the Social Aspect of Mental Health

According to the World Health Organization (2014), the environment plays an important role in the treatment of mental health conditions. Drawing from my personal account as a psychiatric social worker, it is evident that strategies directed at the PMHCs' environment remain relevant as they set in motion the facilitating factors of their recovery. This evinces that 'social manipulation' is still an important task for the psychiatric social worker. By using strategies such as family intervention, patient advocacy, financial aid, and linkages, a bridge between the healthcare facility—the East Hospital in this case—and the community is being built, addressing potential problems in the social environment (Bamford, 2013). As Stuart (1997) emphasizes, psychiatric social workers often need to manipulate environmental details based on the presenting need and—in consonance with the usual activities indicated from my personal case—this is performed by either replacing existing factors or introducing new ones.

Through my personal case, it is explicitly shown that the role still taps the "environmental and sociological emphases" of social work (Jarrett, 1921 as cited in Stuart, 1997, p. 33) to provide a holistic service to PMHCs confronting a myriad of social problems. It is what enables the position to "deal with the personality of the patient... as intelligently and constructively as the psychiatrist deals with it" (p. 34). However, there is an apparent constraint in the account considering that the distinctive task of visiting patients in their own homes is discouraged by the management. This could have been an excellent opportunity to understand the patients' situation further and deliver more appropriate interventions. Also, it raises critical points on the exercise of professional autonomy. Regardless, it is important to note how the wellness check-ins have served as an enabling mechanism to observe and interact with PMHCs in their natural environments to some extent, and offer relevant support. The check-ins ('kumustahan'), as highlighted, can be considered as a psychosocial intervention that addresses what Morales and Sheafor indicate as "the social and psychological factors that contribute to the psychiatric condition" (as cited in Department of Health, 2010).

Furthermore, a clearer relationship can be seen between mental health issues and adverse life experiences from my personal experience. Pritchard (2005) states that child protection is an important concept in modern psychiatric social work; yet, these fields have often been separated in practice (at least as observed in the Philippine setting) since protective service usually requires a full amount of time and attention. However, it seems reasonable, to say the least, that the psychiatric social worker as highlighted from my account was entrusted with the mandate of responding to cases of abuse or violence, recognizing that severe mental health concerns among PMHCs (especially women and children) essentially stemmed from troubled homes. As Dr. Romeo Enriquez, former President of the Philippine Psychiatric Association, elaborates in an article by Crisostomo (2012): "For Filipinos, the heaviest [source of stress and cause of mental health condition] is having a dysfunctional family." In my perspective, this is one crucial, if not the most important service function that I assumed at the East Hospital, which helped establish my professional role further.

Delivery of Mental Health Interventions to PMHCs

Counseling is an essential skill that social workers need to "possess and master" (Department of Health, 2022, p. 120). However, there has been a contention on whether social workers are capable and qualified to provide counseling, along with other mental health interventions (Suarez, 2019). My practice experience affirms the justification for the use of counseling in social work practice; and it squarely fits in the interventive framework of psychiatric social work. One can also say that it has been my approach to the delivery of the casework method. Supporting this practice, Suarez (2019) stresses that "social work counseling is a major component of direct service intervention." From my personal account, social work counseling has become complementary to the psychiatrists' therapeutic efforts,

rather than contributing to “role blurring” which endangers professional collaboration (Grumet & Trachtman, 1976). It resonates more with Jarrett's (1923) pioneering work of encouraging patients “to maintain proper mental habits” (p. 417), which, I have observed, is slowly gaining prominence in the Philippines, especially in many workplace mental health programs. As I have applied it, the counseling intervention of the psychiatric social worker at the East Hospital is more promotional and preventative. It is geared towards building PMHCs’ capacities for better coping and compliance with their recommended treatment. If we consider it, it is an appropriate response to the common finding from Crisostomo’s (2012) article that “adherence is a big problem... [that results in] multiple relapses.”

Another intervention that I want to highlight is the application of crisis de-escalation in response to psychiatric emergencies. Grumet and Trachtman (1976) argue that social workers are uniquely well-equipped to respond to psychiatric emergencies because of their sufficient training, non-intimidating presence, wide resource base, and their ability to remain in an ‘established role’ with patients. However, as I have mentioned before, psychiatric emergencies in the Philippines conventionally call for the expert intervention of other mental health professionals (e.g. psychologists and psychiatrists) since they are more trained in dealing with PMHCs (Suarez, 2019). There are also no existing passages on crisis intervention in the current guidelines of the Department of Health (2010) for managing cases of PMHCs. My practice experience proves otherwise, as I believe that crisis-oriented techniques are still within the repertoire of interventive strategies of a social worker, and that they are capable of contributing to the dispensing of mental health care, particularly of psychiatric treatment. Although additional training is needed, I see it as a replicable step towards further strengthening the country’s mental health sector, given the severe shortage of Filipino psychiatrists who can handle heightened mental health concerns (Lally et al., 2019).

In general, it is important to note that parallel to the developments seen in the field from other countries, my personal account as a psychiatric social worker exhibits the value of integrating mental health interventions in the work with PMHCs in the Philippine setting. It further echoes and avows the character of the social work profession as a legitimate mental health profession, as recognized and stipulated by the Philippines’ Mental Health Act. Further, it supports a gradual shift from Bamford’s (2013) idea of mental health social work in Asian countries, including the Philippines, where individual mental health work is considered as a rare practice. However, as indicated in my personal case of doing social work counseling and crisis de-escalation, this begins with an initiative to act on present needs, with the primary objective of restoring patients’ “psychosocial and biological functioning” (Sathyamurthi, 2020, p. 22).

Perceived Challenges and Limitations

It is apparent that the organizational arrangement narrated in my personal account positions the psychiatric social worker to a volatile situation, and maintains the stereotypical notion that it continues to be ‘an aide attached to the clinic.’ Although it has seemed to move past traditional tasks, I perceive it as a challenge that the role remains to have a ‘fluid’ nature, as it continues to adjust to the “specific behests of the psychiatrists” (French, 1940, p. 203). In my perspective, this fluid nature is perpetuated by the lack of a definitive set of roles and responsibilities, subjecting the psychiatric social worker to a constant state of role confusion (or “kalituhan” as indicated). On top of this dilemma, I also find the absence of a specialty-specific job description as a sort of hindrance for contributing more to the psychiatric treatment of PMHCs. Unsurprisingly, it affirms Mendoza's (2008) earlier account of psychiatric social work to some extent, that is, having overlapping functions with medical social work. A proactive step needs to be in place to avoid falling under what Jessie Taft (as cited in Stuart, 1997) would say about psychiatric social work as “just ordinary social service which only happens to be directed toward the mentally ill” (p. 34).

In addition, I noticed that the strategies and functions from the case remain restricted to some degree, since the lack of support for training (as well as the unavailability of a specialty training at large) and supervision rendered me to rely on my generalist background, self-directed learning, and day-to-day experiences in the field. Rajalingam (2019) narrates that the training of psychiatric social workers has often been a challenge even before. Grumet and Trachtman (1976), on the other hand, mentions in their decades-old paper that most of the activities that psychiatric social workers engage in are not directly supervised. Although there are comments supporting the worker’s “independent clinical judgments” while working on cases of PMHCs, I reckon that there should be, at least, consideration given to whomever assumes the position at the Hospital, since it still requires a certain level of specialized knowledge and skills that are often not available in generalist social work education.

Further, I find the strategies directed at the larger systems to be lacking, to say the least, from my personal experience. This is in spite of Drucker’s (1977) proposition that a “psychiatric social worker needs to understand and have skills in sparking off organizational and institutional change” (p. 4). As

might be expected, the absence of macro intervention somehow makes for most of the challenges being confronted by the position at the organizational level, as well as those being faced by PMHCs in their recovery process. However, this probably remains a difficult task for most psychiatric social workers in the country given its non-inclusion in the current guidelines for managing cases of PMHCs (Department of Health, 2010). Regardless of the limitations, I still believe that the position from my personal account, even while perplexed by varying roles and functions, has carried on with its mission to address the transactional deficiencies in the person-in-environment configuration to “deal with the problems of the ‘mind’ and ‘brain’” (Sathyamurthi, 2020, p. 16).

There is a general limitation in my personal experience as a psychiatric social worker, but one way or another, it presents some significance in today's social and psychological milieu. This is not to suggest, however, that my account sets a ‘standard’ for other psychiatric social workers, as there has to be evaluative studies attesting to this. Moreover, there are other practices across the country which might be more advanced than what has been illustrated herein. If there is any implication that I wish to achieve, it is to provide a glimpse on how promising the specialty is in the Philippine setting and what opportunities await for it in the future, especially in taking a much bigger role in the treatment and prevention of mental health conditions in the country.

Conclusion and Suggestions

In the past, psychiatric social work has focused on acting on the specific requests of the psychiatrists to assist in their work. This led to stereotypical notions of the psychiatric social worker's activities, reducing its function to being a mere ‘aide’ and ‘errand girl.’ Much of the activities were also carried out by earlier practitioners of the specialty in the Philippines. Although some of these remain to be noticeable in the present time as illustrated in my personal experience, I put forward that the role was able to assume more functions at the East Hospital, and adopt intervention strategies in response to newer challenges of helping PMHCs in the context of social work. This shows the continuing significance of the field in today's mental health landscape, which is heavily characterized by a multitude of problems arising from the complexities of the person-in-environment interaction. However, I leave, once again, to the reader the task of assessing the validity of this personal account, and hope that they find sense and meaning by engaging in the experience.

In the end, there is still a need to improve the practice of psychiatric social work in my account given the challenges and limitations hindering its fullest potential to be of service to PMHCs and families. It is for this reason that I deem it important for the subsequent psychiatric social worker of the East Hospital to:

1. Recommend a new job description of the position that includes a set of roles and responsibilities specific to psychiatric social work and other important details (e.g. reporting, supervision, and so on), in coordination with the social service unit and the psychiatry department;
2. Create an official manual for the position to standardize processes and activities related to the practice of psychiatric social work at the Hospital;
3. Request funding for training to keep the psychiatric social worker abreast of latest direct treatment strategies that are relevant to the needs of the patients and their families;
4. Explore the applicability of meso- and macro-level strategies (such as group work, community organizing, and so on) to provide a holistic intervention; and
5. Perform evaluative research on the effectiveness of the position in performing its functions at the Hospital.

Meanwhile, I also consider it important to advance the competencies of all the psychiatric social workers in the Philippines, as well as promote the specialty at large. In particular, it is recommended for concerned social work practitioners and organizations in the country to:

1. Conduct a study with a wider scope to survey, document, and examine the current practices and experiences of psychiatric social workers across the country;
2. Clarify the definition of psychiatric social work and craft a specialty training (with aspects of women and children protection) to prepare beginning social workers to practice as psychiatric social workers in mental health facilities;
3. Establish standards and guidelines for the practice of psychiatric social work in the Philippines, complementing the existing Department of Health (DOH) standards on conducting case management for PMHCs; and
4. Call for the integration of psychiatric social work as a topic in select courses in the Philippine social work curriculum.

Acknowledgement.

The author extends its sincerest gratitude to Ms. Tracey Jayne L. Molina for giving her valuable time to run through, review, and provide comments on the earlier versions of this article. Without her support and encouragement, finishing this article would not be possible.

Author/Authors Brief Bio

Alain Matteo F. Meneses is a registered social worker in the Philippines with over two years of practice experience in the field of mental health and psychosocial support. He graduated from the University of the Philippines–Diliman with a bachelor's degree in social work. Currently, he works as a program coordinator under a mental health-focused non-government organization (NGO) based in Metro Manila, and is undergoing training on clinical trauma studies. His recent publications (as co-writer) include two handbooks on psychosocial support and volunteerism, respectively.

References

- Abenir, M. A. (2010). A social protection and integration strategy for children of OFWs: A case study on the psycho-social support program of BUNGA Foundation, Inc. *Philippine Journal of Social Development*, 2, pp. 37-58.
- An Act Establishing a National Mental Health Policy for the Purpose of Enhancing the Delivery of Integrated Mental Health Services, Promoting and Protecting the Rights of Persons Utilizing Psychosocial Health Services, Appropriating Funds Therefore and Other Purposes, Rep. Act No. 11036, 4 (m) (June 20, 2018) (Phil.), <https://www.officialgazette.gov.ph/2018/06/20/republic-act-no-11036/>
- Anderson, L. (2006). Analytic autoethnography. *Journal of Contemporary Ethnography*, 35(4), 373-395. <https://doi.org/10.1177/0891241605280449>
- Bamford, T. (2013). Social work and mental health. *Commonwealth Health Partnerships*, pp. 90-92. <https://www.coursesidekick.com/sociology/81852>
- Barrameda, T. (2006). Women taking center stage: Organizing women through community theater. *CSWCD Development Journal*, pp. 98-125.
- Black, W. G., Jr. (1991). Social work in World War I: A method lost. *Social Service Review*, 65(3), pp. 379-402.
- Cinco, R. (2021 April 14). When COVID-19 forced overseas Filipino workers to return home, a collective of volunteer social workers became their lifeline. *Freedom Collaborative*. <https://freedomcollaborative.org/newsletter-archive/when-covid-19-forced-overseas-filipino-workers-to-return-home-a-collective-of-volunteer-social-workers-became-their-lifeline>
- Crisostomo, S. (2012 August 2). 'Family ties usual cause of mental illness among Pinoy's'. *The Philippine Star*. <https://www.philstar.com/headlines/2012/08/02/833977/family-ties-usual-cause>
- Cudis, C. (2021 June 29). DSWD WiSupport helps mental health patients. *Philippines News Agency*. <https://www.pna.gov.ph/articles/1145371>
- de Guzman, L. S. (1988). *Dictionary of social work: Philippine setting*. New Day Publishers.
- Department of Health. (2010). *Manual for medical social workers (6th Ed.)*. Department of Health Health Facility Development Bureau.
- _____. (2022). *Manual for medical social workers (6th Ed.)*. Department of Health Health Facility Development Bureau.
- Drucker, D. (1977). *Role of psychiatric social work in developing countries*. NIMHANS, Bangalore.
- Ellis, C., Adams, T., & Bochner, A. (2011). Autoethnography: An overview. *Forum Qualitative Sozialforschung / Forum Qualitative Social Research*, 12(1), Art. 10. <http://nbn-resolving.de/urn:nbn:de:0114-fqs1101108>
- French, L. M. (1940). *Psychiatric social work*. Commonwealth Fund.
- Gibbs, G. (2008). *Analyzing qualitative data*. SAGE Publications.
- Grob, G. N. (1983). *Mental illness and American society, 1875-1940*. Princeton University Press.
- Grumet, G. W. & Trachtman, D. L. (1976). Psychiatric social workers in the emergency department. *Health & Social Work*, 1(3), pp. 113-131.
- Jarrett, M. C. (1921). The place of psychiatric social work. *Hospital Social Service*, 4, pp. 63-66.
- _____. (1923). The psychiatric social worker in relation to mental hygiene. *American Review*, 1(4), pp. 413-420.

- Jarrett, M.C. & Southard, E. E. (1922). *The kingdom of evils: Psychiatric social work presented in one hundred case histories*. Boston College.
- Keles, U. (2022). Autoethnography as a recent methodology in applied linguistics: A methodological review. *The Qualitative Report*, 22(2), pp. 448-474.
- Lally, J., Tully, J., & Samaniego, R. (2019). Mental health services in the Philippines. *BJPsych International*, 16(3), pp. 62-64. [10.1192/bji.2018.34](https://doi.org/10.1192/bji.2018.34)
- Melgar, M. I. (2013). Counseling and psychotherapy in the Philippines. In R. Moodley, U. Gielen, & R. Wu (Eds.), *Handbook of counseling and psychotherapy in an international context* (pp. 237-246).
- Mendoza, T. L. (2008). *Social welfare and social work* (3rd Ed.). Central Books.
- National Association of Social Workers [NASW]. (2011). Social workers in psychiatric hospitals: Occupational profile. <https://www.socialworkers.org/LinkClick.aspx?fileticket=BKOdAV6QAGo%3D&portalid=0>
- Palma, R. (2015). *Working with individuals* [Class handout]. Sikhay Kilos Development Foundation, Inc.
- Patricio, A. L. & Verdeprado, R. H. (2020). Awareness of Mental Health Law of registered social workers in Negros Occidental. *Philippine Social Science Journal*, 3(2), 169-170.
- Poulos, C. N. (2021). *Essentials of autoethnography*. American Psychological Association.
- Pritchard, C. (2015). Psychiatric social work in the United Kingdom. In J. D. Wright (Ed.), *International Encyclopedia of Social and Behavioral Sciences* (2nd ed., pp. 1-6). DOI:[10.1016/B978-0-08-097086-8.28071-9](https://doi.org/10.1016/B978-0-08-097086-8.28071-9)
- Priya, A. (2020). Case study methodology of qualitative research: Key attributes and navigating the conundrums in its application. *Sociological Bulletin*, 70(1). <https://doi.org/10.1177/0038022920970318>
- Rajalingam, M. (2019). *Psychiatric social work (PSW)* [PowerPoint slides]. Scribd. <https://www.slideshare.net/rajammnraja/psychiatric-social-work-psw>
- Sathyamurthi, K. (2020). Medical and psychiatric social work practice: Glimpses and reflections. In R. Sanjoy (Ed.), *Social work education: Indigenous perspectives* (pp. 15-27). SAGE Publications.
- Shah, H. (1996). Psychiatric social work individual interventions: Recent trends. *NIMHANS Journal*, 14(4), pp. 325-329.
- Stuart, P. H. (1997). Community care and the origins of psychiatric social work. *Social Work in Health Care*, 25(3), pp. 25-36. DOI:[10.1300/J010v25n03_03](https://doi.org/10.1300/J010v25n03_03)
- Suarez, A. G. T. (2019). *Social work counseling: An online lecture for SW Board Review* [PowerPoint slides].
- University of Nevada, Reno (n.d.). Role of social workers in mental health. <https://onlinedegrees.unr.edu/blog/role-of-social-workers-in-mental-health/>
- Witkin, S. L. (2022). Autoethnography and social work: Strange bedfellows or complementary partners. *Social Work & Social Sciences Review*, 23(2), pp. 19-35.
- World Health Organization. (2014). Social determinants of mental health. Geneva, World Health Organization.

