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Psychology, Mental Health and Distress

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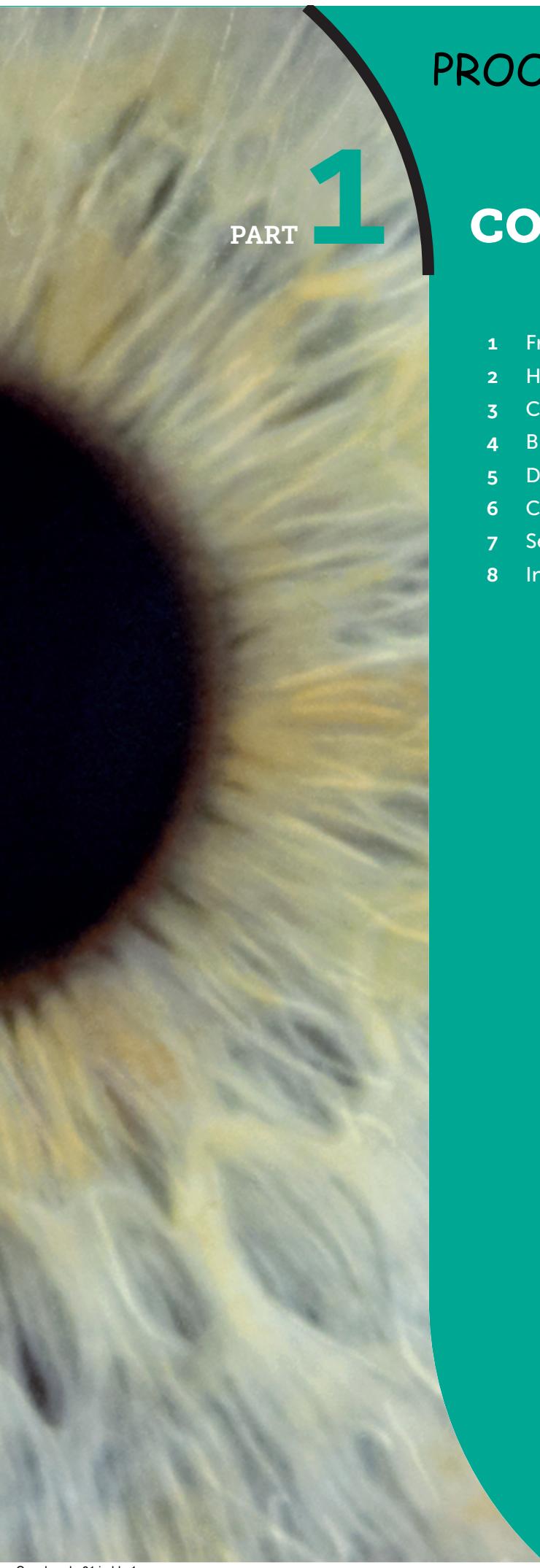


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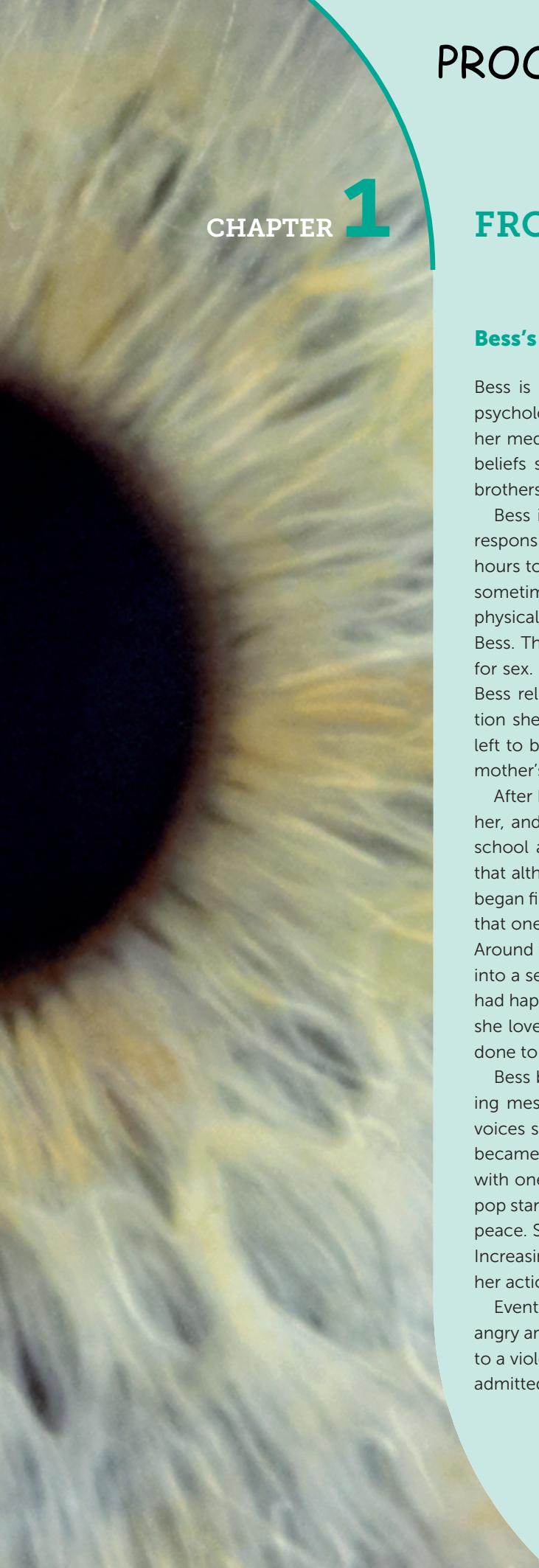
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CHAPTER 1

FROM DISORDER TO EXPERIENCE

Bess's story

Bess is a 19 year old African Caribbean woman. She was referred to clinical psychology services after being admitted to a psychiatric hospital, because her medication had not lessened the voices she heard nor altered the unusual beliefs she held. Before her admission she had been living with her mother, brothers and sisters in a large industrial town.

Bess is the oldest of four children. Since the age of 9 she had been largely responsible for taking care of her siblings, whilst her mother worked long hours to support the family. Nevertheless, Bess did well at school, although she sometimes experienced racist bullying. Often, her father drank heavily and was physically and verbally abusive – towards his wife, but occasionally towards Bess. Then, when Bess was 12, her father came home drunk and pressured her for sex. He threatened to hurt her brothers and sisters if she didn't comply, and Bess reluctantly agreed. She hated the sexual contact, but relished the affection she received from him. After two years of this sexual abuse, Bess's father left to begin a new relationship. Bess was devastated. She deeply resented her mother's anguish at losing him, and their relationship deteriorated.

After her father left, Bess was confused. She resented the way he had treated her, and wondered why he didn't contact her. She continued to work hard at school and did extremely well in her exams. When she was 16, Bess noticed that although the bullying had mostly stopped she still felt like an outsider. She began finding it difficult to concentrate, and became preoccupied with the belief that one day she would meet someone who would take her away to a new life. Around this time she had a new boyfriend who wanted to turn their relationship into a sexual one, but Bess refused. When she eventually explained to him what had happened with her father, he ended the relationship. Bess felt that everyone she loved would abandon her. She was deeply shamed by what her father had done to her, judging it to be her own fault.

Bess began to spend more time alone, praying. She believed she was receiving messages from God, and began listening to loud music to block out the voices she increasingly heard. She drank large quantities of alcohol, and slowly became convinced she had a personal relationship – with sexual overtones – with one of the pop stars she listened to. This made her feel ashamed, but the pop star told her that one day he would take her to heaven where she would find peace. She heard his voice often, especially when she felt lonely and miserable. Increasingly, though, she also heard her father's voice, commenting critically on her actions and morals.

Eventually, Bess told her mother about these experiences. Her mother became angry and contacted a doctor, who referred Bess to psychiatric services. This led to a violent confrontation between Bess and her mother; Bess was then forcibly admitted to hospital.

Learning outcomes

After you have read this chapter, you will be able to:

- 1 Explain why terminology is especially important in relation to mental health
- 2 Explain what is meant in this book by 'distress'
- 3 Describe some of the problems associated with everyday definitions of normality
- 4 Explain the problem of thresholds in relation to psychiatric diagnosis
- 5 Define key terms, including: service user, distress, madness, psychosis, neurosis, hallucination and delusion

Introduction

This book is about people like Bess. People distressed by life, their relationships, and their position in the social world. It is clear from Bess's story that her distress is far from straightforward. Do her difficulties arise from her unstable relationships, from the way she thinks about the world, or the ways in which she has learned to cope? Whilst there are no easy answers to these questions, we hope that this book will provide some ways of thinking psychologically about the kinds of issues facing Bess and others who have had experiences like hers.

In this chapter, we first of all explain what is distinctive about this book and why we approached this topic in the way that we did. We discuss the importance of terminology and describe why language is important: both because it provides the concepts we use when thinking, and because of its links to stigma and discrimination. We explain how in this book we will focus on **distress** (which for now you can simply read as meaning 'mental illness' or 'psychopathology'), and how we will treat distress as a form of **experience** – something that happens within the life and the subjective awareness of a person – rather than as a form of illness.

Then we give some of the reasons why we decided not to call this a book about 'abnormal psychology'. Approaches to mental health and illness that do not endorse simple notions of abnormality are often described as **anti-psychiatry**: this is the collective term for a set of disparate work, published mostly in the 1960s, which rejected the view that mental health problems are illnesses or diseases. We explain why we do not call our approach anti-psychiatry; consider the issues raised by a focus on distress as something that is perhaps 'in the mind'; and briefly describe some of the ways in which mental health professionals have modelled and conceptualized their field.

These discussions are followed by a short overview of the rest of the book, and a guide explaining how to get the most out of reading it.

Guiding questions

As you read this chapter, you should bear in mind these two questions:

- 1 Why might we question the notion of abnormal psychology?
- 2 What are the implications of rejecting psychiatric diagnoses in mental health?

What is distinctive about this book?

The approach taken by this book is somewhat different from those of other books in this area. One very obvious difference is that, unlike many others, we do not use the term 'abnormal psychology' to describe what our book is about (later, we offer a detailed explanation for this). But in fact this book has several distinctive features, so it will be useful to emphasize some of them here.

First, in this book we take a *consistently psychological* approach to mental health. Usually, psychology books on mental health are already pre-structured in terms of psychiatric diagnostic manuals such as the Diagnostic and Statistical Manual of the American Psychiatric Association – the **DSM** (see Box 1.1). Chapter titles are usually based upon diagnostic labels, and explanations are typically directed at ideas of mental illness that have already been formulated within psychiatry or medicine. Instead, in this book we offer a perspective that is more suitable for students from non-medical backgrounds who might want to train as (for example) clinical psychologists, social workers or CBT practitioners. We have already suggested that we will do this by starting with experience rather than notions of disorder, and there is more discussion of what this means later in the chapter.

Second, most other books of this kind pay relatively little attention to recent psychological research – much of it from the UK – which has focused on particular kinds of experience, such as 'hearing voices', rather than diagnostic categories, such as schizophrenia. This research has shown that it is possible to make significant progress in understanding and responding to people's difficulties without having to endorse psychiatric diagnoses. Of course, this does not mean that we don't consider psychiatric diagnoses in this book – just that we don't treat them as necessarily explaining people's mental health difficulties.

Third, many other textbooks claim that **dimensional models** are less clinically useful than psychiatric diagnoses. Dimensional models do not presume a sharp dividing line between mental health and mental illness, and recognize that all of us, sometimes, have distressing and unusual experiences in our lives. They are usually contrasted with **categorical models**, where mental illness is clearly distinguished from mental health and is thought to fall into specific, separate categories: psychiatric diagnosis exemplifies this approach. But in the UK, at least, the vast majority of clinical psychologists use dimensional models in their clinical practice, so this book frequently takes a dimensional approach.

Fourth, most other mental health textbooks contain a series of chapters, each focused on a particular psychiatric diagnosis. But although they present extensive information about each diagnosis, they rarely try to explain the associations and connections between them. Typically, textbooks claim to promote a **biopsychosocial model** of mental health – an approach within which biological, psychological and social influences are all considered or modelled together. But because they don't usually contain very much discussion of the links between 'bio', 'psycho' and 'social', the model actually tends to remain relatively obscure. Moreover, because these textbooks are invariably structured around psychiatric diagnoses, they also tend to be **reductive** – in other words, they tend to treat biological influences as foundational, or as more important than others. By contrast, in this book we try to consider the

links between 'bio', 'psycho' and 'social' in a more nuanced and conceptually sophisticated manner.

Finally, in these textbooks, the discussion of critics of psychiatry, and of the controversies associated with its diagnoses and assumptions, almost always seems to stop at the end of the 1960s. If one were to judge by such books, one might almost believe that all of the problems that these critics had raised were now solved. But this is not the case, and in the five decades since the 1960s there have been many more critiques of, and alternatives to, psychiatry. These critiques and alternatives have come from clinical psychologists and from those who use mental health services, as well as from psychiatrists themselves. In recognition of this, our book is also distinctive because it includes a chapter written entirely by mental health service users.

In writing this book we have therefore made a number of assumptions: for example, that psychiatric diagnosis does not necessarily provide the best way to approach mental health problems; that a more sophisticated psychological account of mental health problems will be useful; that mental health service users have valuable things to tell us about mental health difficulties and interventions. All authors have an **assumptive framework** – a worldview within which certain things are implicit and simply taken for granted. These assumptive frameworks are rarely made explicit, but we thought it would be helpful for you to have a sense of our starting points and assumptions so that you can take them into account as you read the book.

Importantly, we have not written this book as a polemic and we accept that you may agree or disagree with some of our judgements. Throughout the book we will be presenting evidence for and against different ways of conceptualizing

mental health and illness, so that you can come to your own conclusions.

Of course, in attempting to write about mental health in a different way we had to think carefully about the language we used. There are many reasons for this, but perhaps the most important is that language contains concepts that structure our thinking. If we use concepts that are inconsistent or unhelpful, our thinking can become muddled. This meant that we needed to ensure that our approach was internally consistent, so it is to the issue of terminology that we turn next.

Terminology

One of the first challenges in learning about the psychology of mental health is the wide variety of terms and concepts used. Like the language used in relation to any other real-world phenomenon, none of these terms is neutral or value-free. All of them seem to imply something about the nature or the causes of the phenomena they describe, and all of them are more closely associated with certain disciplines and perspectives than with others. The term **mental illness**, for example, clearly suggests that our talk will be of matters related to health and sickness, that it will have a medical character but that it will also take a mentalistic or psychological focus. Another widely used term, **psychopathology**, makes exactly the same assumption because it adds the concept of disease – pathology – to the prefix 'psycho-' which is short for 'psychological'. In both cases, then, the terminology already assumes that our perspective upon these phenomena should be a fundamentally

BOX 1.1

What is the DSM?

'The **DSM**' is The Diagnostic and Statistical Manual of the American Psychiatric Association. It contains the diagnostic criteria that American psychiatrists use in their practice. In Europe and the UK, psychiatrists most often favour the slightly different psychiatric diagnostic criteria set out in The International Classification of Diseases (**ICD**), produced by the World Health Organization. However, although they may use these criteria in their practice, for research purposes UK and European psychiatrists also tend to use the DSM.

Both the ICD and the DSM have been subject to frequent revisions. The ICD is currently on version 10, whilst the current DSM is known as DSM-IV-TR: version IV, text revision. As we went to press, both DSM-5 (the APA seem to have changed their numbering system) and ICD 11 were expected shortly.

At least in its current version, the DSM claims to be purely descriptive and

a-theoretical, instead of depending upon concepts derived from theories. This means that it does not use earlier concepts such as **neurosis**: a collective term for forms of distress that involve exaggerations of everyday responses (e.g. excessive worrying) but do not involve distorted perceptions or unusual beliefs. Whereas the concept of neurosis was originally derived from psychoanalytic theory, the DSM purports to be no more than a set of descriptions of the disorders frequently observed by clinicians. These disorders are proposed by panels of experts, and are subject to a consultation process and approval by a central committee before they can be included in the manual.

Despite this, critics argue that the DSM is far from value-free and neutral. They suggest that in practice the DSM furthers the interests, not just of psychiatry, but also of the pharmaceutical and insurance industries (because, under America's insurance-based healthcare system, a diagnosis is needed in order to reclaim the cost of treatments such as medication).

Another concern frequently raised by critics is that the DSM has promoted the **medicalization** of everyday life: in other words, it encourages us to see everyday difficulties and stresses (for example, shyness) as 'symptoms' of 'illness' that then require 'treatment'. Certainly, the number of separate diagnoses within each version of the DSM has tended to increase with each revision, as the table shows. However, advocates of diagnosis argue that the system is simply becoming more accurate and refined over time, and that the changing numbers reflect this process of development.

TITLE	YEAR	DIAGNOSES
DSM	1952	106
DSM-II	1968	182
DSM-III	1980	265
DSM-III-R	1987	292
DSM-IV	1994	297
DSM-IV-TR	2000	297

Chapter 5 contains a lengthy discussion of psychiatric diagnosis and the issues that are frequently associated with it.

PROOF



How we see or represent the world depends on how we choose to frame it, as well as upon what there is in the world for us to see

medical one, and that at its most basic level our concern is with people who are diseased or sick.

We think that this assumption is incorrect. In our view, when people are given diagnoses such as schizophrenia or depression it is neither accurate nor helpful to think of them as being medically ill or diseased. So in this book we will use the terms 'psychopathology' and 'mental illness' very infrequently, and even then only when they are already being used by the people whose work we are drawing upon. In their place, we will use the term **distress**. When we use this term, we use it to refer to just the same kinds of phenomena that textbooks of this kind usually call mental illness or psychopathology. We use distress to mean *all* of the different kinds of difficult or unusual experiences associated with the hundreds of psychiatric diagnoses currently employed. Distress is our term for the core subject matter of this book: the experiences associated with diagnostic categories such as schizophrenia and depression, and with the work of professions such as clinical psychology, psychiatry, social work and nursing.

However, to reduce repetitive language, we will occasionally draw on other phrases like '*mental health problem*'. This terminology is also open to challenge, because by locating these experiences in relation to health it also implies a link to illness. However, it is more ambiguous than '*mental illness*', carries less conceptual baggage, and is easily understood because it is widely used.

Similarly, we will sometimes use the term **madness** to collectively describe experiences associated with the more

severe forms of distress. These include experiences such as hearing voices, which is an example of a **hallucination**: a general term for the perception of a stimulus that is not present. They also include advocating the unusual beliefs that clinicians call **delusions**: beliefs that can be shown to be either impossible or false, but which are sometimes proclaimed strongly by service users. These experiences are primarily associated with psychiatric diagnoses such as schizophrenia and bipolar disorder, and are sometimes collectively referred to as **psychosis**. There has been a recent debate in the UK about terms like psychosis and schizophrenia, and a 'Campaign against the Schizophrenia Label', which has received significant media attention. As with the other terms we favour in this book, we have used *madness* rather than *psychosis* because it mostly avoids the many connotations of illness or disease that accompany the alternatives.

You will probably be familiar with discussions about terminology from other areas of your studies. Because language supplies the concepts that structure our thinking and debating – sometimes very subtly, in ways we don't necessarily realize – it is vital to ensure that we are using appropriate terms. However, it's also important to realize that, in relation to distress, these discussions are often particularly contentious. Because distress touches the lives of so many people, and because the ways we understand it have very real implications for the ways that we respond to it, there are often very strong feelings about the terminology that is used.

For example, there is extensive disagreement about the term we should use to refer to people who experience distress. In recent years, the dominance of the medical perspective associated with psychiatry has meant that the term **patient** is very often used. Over the last 20 or 30 years, however, some of those who experience distress have organized themselves into activist groups and campaigned strongly for a change of terminology. They have argued that the term 'patient' implies a passive position where someone puts themselves in the hands of experts to be fixed. Some also object that the term inappropriately focuses almost exclusively on the medical and biological aspects of care (e.g. medication), rather than adopting a more holistic approach. As a result of these objections, some professionals now refer to those who use their services as **clients**. However, some groups have argued instead that they should be referred to as **consumers** (popular in the USA, Australia and New Zealand) or **service users** (popular in the UK), and many professionals have also taken up this language.

But these terms have also been challenged. Some suggest that they obscure the fact that many people are not always willing consumers of mental health services, unlike the consumers of other goods and services: some, for example, will be receiving compulsory treatment. Such critics have sometimes suggested that the term **recipient** is more accurate. And yet others have argued that, because they have had to cope not only with their distress, but also with psychiatric interventions which they have experienced as negative or unhelpful, the term **psychiatric system survivor** is most appropriate.

In short, then, there is no 'right' term to use and people in distress, like everyone else, have their own preferences and understandings. In this book we will usually use the term '*service user*', since this is one of the terms most widely used in the UK. But we will also sometimes use other terms, where other people have used them or where the context demands it.

Stigma and discrimination

Language and terminology are important because of how they affect our thinking. However, they also matter in relation to service users and their experiences of distress because of the widespread discrimination to which such people are subject. The UK government regularly surveys public attitudes about 'mental illness': a survey (Office for National Statistics, 2010b) of 1,745 people revealed that

- 78% of people agree that 'people with mental illness have for too long been the subject of ridicule'
- 75% agree that 'people with mental health problems should have the same rights to a job as anyone else'
- 87% agree that 'we need to adopt a more tolerant attitude towards people with mental illness' (a fall from 92% in 1994)

At the same time, however, only 26% of people agreed that 'most women who were once patients in a mental hospital can be trusted as babysitters'. Only 34% agreed that 'less emphasis should be placed on protecting the public from people with mental illness', and only 33% agreed that 'mental hospitals are an outdated means of treating people with mental illness'.

This survey suggests that the public have ambivalent feelings about service users and distress. One way of understanding this ambivalence is to see negative attitudes as an example of **stigma**. This approach draws upon sociologist Erving Goffman's (1963) work *Stigma: Notes on the management of spoiled identity*, where he described the process of stigmatization as involving being viewed as socially deviant and linked with negative stereotypes. Since then, a number of researchers have drawn on this paradigm to suggest that experiencing distress or being given a psychiatric diagnosis can lead to one being stigmatized. Drawing on this insight, there has been a considerable amount of research into why mental distress is linked to negative attitudes.

Research suggests that the development of negative attitudes begins early in life. Rose, Thornicroft, Pinfold and Kassam (2007) asked 472 14-year-old school students 'What sorts of words or phrases might you use to describe someone who experiences mental health problems?' They reported that around 250 words were mentioned by the young people, including terms such as nuts, psycho, loony, weird, freak, spastic and demented. In their interview study of 1,737 adults, Crisp, Gelder, Rix, Meltzer and Rowlands (2000) reported that their respondents commonly perceived people who had been given a diagnosis of schizophrenia as unpredictable and dangerous, even though about half of them knew someone with a mental health problem. Unfortunately, research also shows that such prejudiced views are even reported amongst doctors (Mukherjee, Fialho, Wijetunge, Checkinski & Surgenor, 2002) and may be made worse by some nurse training (Sadow, Ryder & Webster, 2002).

Despite a huge amount of money spent on 'anti-stigma' campaigns the effects on public attitudes have been modest, leading some to suggest that attitudes about mental health may be different from other attitudes (Crisp et al., 2000). However, in a recent review, Read, Haslam, Sayce and Davies (2006) suggest that it may be the underlying assumptions of the anti-stigma paradigm which are the reason for the lack of change. These approaches are typically based on two assumptions, the first of which is that the public need to be taught to adopt a **biomedical model** of distress – to assume that distress is caused by diseases or illnesses of the brain or mind, and that

these illnesses are what psychiatric diagnoses describe. The second assumption is that this will result in less discrimination, because people will be more tolerant if they think that an unusual behaviour is caused by a medical illness or disease; otherwise, they might hold the person morally responsible. Another problem noted by some critics of these campaigns is that stigma is seen as caused by problematic attitudes located inside individuals, rather than as a product of, or reaction to, discrimination at a societal level – in a similar manner to sexism and racism (Sayce, 1998).

If only it were this simple. The fact is, millions of people will suffer from some form of mental health problem during their lives. We can't promise a quick fix, but we can offer support and sound, practical advice for a better life. Talk to us.

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This poster was part of an advertising campaign by a UK mental health charity. What does it make you think? Does it stigmatize people with mental health problems, or does it challenge their stigmatization? What does it suggest to you about the causes of distress?

A number of studies have reported that, whilst the public may use medical terminology, they place a 'greater emphasis on psychosocial than biogenetic explanations of schizophrenia' (Read et al., 2006, p. 311). Moreover, contrary to the assumptions of the anti-stigma paradigm, biomedical explanations are associated with more negative attitudes and behaviour than **psychosocial models**, in which mental health problems are seen as psychological in nature and caused by adverse life events and circumstances (Lam, Salkovskis & Warwick, 2005; Mehta & Farina, 1997; Read & Harré, 2001; Read et al., 2006). Why might this be? One possibility is that, if unusual experiences or behaviours are seen as biomedical in origin, they become more mystifying and unpredictable. Conversely, if they are seen as the result of someone's life experiences, they are perhaps more understandable. So public education programmes focusing on psychosocial explanations may well fare better than those that endorse biomedical approaches (see Figure 1.1).

PROOF

Biomedical approach	Psychosocial approach
Sees the person's mental health problems as the main problem	Sees barriers in society as the main problem
Sees problems as a symptom of an underlying disease process and illness	Sees problems as an understandable response to adverse life events
Sees societal reactions as due to the stigma attached to having a mental health problem	Sees societal reactions as due to discrimination against a marginalised group (like racism, sexism etc)
Aim of public education is to remove perceived blame attached to the individual by 'blaming' the illness rather than the person	Rejects the relevance of notions of 'blame' and aims to promote diversity, reduce fear and increase empathy and understanding
Key public education slogan 'Mental illness is an illness like any other'	Key public education slogans: 'I'm crazy: so what?' 'It's normal to be different'

Figure 1.1 Contrasting biomedical and psychosocial approaches to public education about mental health

Discrimination

Although many people experience mental health problems, there is now substantial evidence that mental health service users experience significant discrimination across all areas of their lives (Sayce, 2000). For example, only 24% of people with long-term mental health problems were in work in England in 2003 – the lowest employment rate of any of the main groups of people with disabilities (Social Exclusion Unit, 2004). Almost half (47%) of Read and Baker's (1996) respondents said that they had been abused or harassed in public. Berzins, Petch and Atkinson (2003) reported that people with mental health problems suffered much higher rates of verbal abuse and physical harassment than the general public, with much of it committed by teenagers and neighbours.

Sadly, discrimination intrudes into even the most intimate relationships and can lead to many people with mental health problems feeling isolated (Mind, 2004) and being wary about telling other people about their own or another's distress (Mental Health Foundation, 2000). There has also been an increase in community opposition to nearby mental health facilities. Research suggests that residents' fears are fuelled by media reporting, and are associated – on occasion – with both vandalism and assaults (Repper, Sayce, Strong, Willmot and Haines, 1997).

Another domain within which mental health service users experience discrimination is the media. Headlines such as 'Schizophrenic Given Life for Murder' (*Daily Express*, 24 March 2009), and terms such as 'Psycho Cabbie' (*The Sun*, 4 June 2010), serve to associate mental health service users with violence and fear and help to spread negative attitudes. Indeed, many commentators see disproportionate media reporting as an important maintaining factor in more widespread discrimination. In one study of a range of print and broadcast media, stories about homicides and crimes accounted for 27% of all coverage of mental health (Care Services Improvement Partnership/Shift, 2006). Messages about the risks of violence posed by people with mental health problems were present in 15% of stories, most of which implied the risk was high.

News and entertainment media focus primarily on violence against others when addressing issues relating to mental illness, with these items receiving 'headline' treatment (Philo, 1994). These findings are robust (e.g. CSIP/Shift, 2006; Philo, 1996; Pinfold & Thornicroft, 2006) and influence the public's fear of unpredictability and violence (Philo, 1996). Levey and Howells noted (1995) that perceived dangerousness was not as important as the perceived difference and unpredictability of people with a diagnosis of schizophrenia. Moreover, they

reported that reliance on fictional television was associated with higher ratings of unpredictability.

Rose (1998) compared UK TV news coverage in the summer and winter of 1986 with TV news and other programmes between May and July 1992. Although she found variety in TV genres like soap operas and comedies, the category of danger was very frequent. For example, a third of all camera shots in her collection of TV news relevant to mental health dealt either visually or verbally with danger, violence and crime. Moreover, on the news, nearly two thirds of all stories involving those with psychiatric diagnoses fell into the category of crime news, although crime news accounts for only 10% of news coverage. As well as increasing the general public's fear, negative media representations have an impact on people with mental health problems themselves. Half the respondents of a UK mental health charity's survey of mental health service users said that their mental health had been negatively affected and a third said others had reacted negatively towards them as a result of such reports (Mind, 2000).

The media bias against mental health service users is especially unhelpful because it largely ignores the available evidence. A UK study found that murders by mental health service users are infrequent and occur less than once a week (Large, Smith, Swinson, Shaw & Nielssen, 2008). Whilst this might sound alarming at first, it should be seen in the context of other statistics. First, only 10% of people convicted of murder in the UK are thought to have any mental health difficulties at the time of their crime (Department of Health, 2001), and 95% of all murders are committed by people who have never been given a psychiatric diagnosis (Institute of Psychiatry, 2006). Second, the number of people experiencing mental health difficulties at any one time is large – typically around one in six of the population, or – in the UK – roughly 7 million people. These figures show that the vast majority of murders are committed by people without mental health problems, and that the proportion of people with mental health problems who commit murder is extremely small. Other violent attacks by mental health service users (i.e. those not causing death) are similarly much less frequent than media reporting suggests, and when they do occur they are frequently also associated with the use of alcohol or other drugs (Fazel, Langstrom, Hjern, Grann & Lichtenstein, 2009).

In fact, contrary to public fears, people with mental health problems are far more likely to be victims of violence than perpetrators; for example, they are six times more likely than the general population to die by homicide (Hiroeh, Appleby, Mortensen & Dunn, 2001). A US study of people experiencing

psychosis found that they were 14 times more likely to be the victims of violent crime than to be arrested for committing violence themselves (Walsh et al., 2003). They are also far more likely to be a danger to themselves than to other people; for example, one influential study found that 90% of UK suicides involve people with mental health problems (Barraclough, Bunch, Nelson & Sainsbury, 1974).

How might we change stigmatizing attitudes and discriminatory behaviour? As we have seen, promoting psychosocial rather than biomedical explanations may help. In addition, activists like Sayce (1998, 2000) have argued that lessons can be learned from broader disability campaigns. Here, campaigners argued that it was not a person's disability which was the problem (as might be expected from an individualistic biomedical approach), rather it was the way in which society unintentionally created barriers by organizing the environment in a way which was convenient only for people without a disability. In the same way, rather than focusing on individual experiences of stigma, we might see public attitudes to service users – fuelled by inaccurate media reporting – as socially-created barriers to their acceptance by others.

What is distress?

Throughout this book, then, we use 'distress' as a generic term to refer to all the phenomena and experiences that are sometimes called 'psychopathology' or 'mental illness'. But, as we have suggested, this is not just about a preference for a different way of describing these experiences: it also signals a different way of conceptualizing them. We will now describe in more detail how we conceptualize distress, and how – as a concept – it differs from concepts of mental illness or psychopathology.

When we talk about distress, we are talking about a highly variable and heterogeneous set of experiences. These experiences can include

- strong or overwhelming emotional states, of various kinds, that disrupt everyday life and prevent people from functioning
- habitual and repetitive patterns of acting – for example, in relation to personal hygiene, or to do with safety and security – that create anxiety if they are not carried out
- experiences of seeing and hearing things that other people do not see or hear, or of holding beliefs that are considered by others to be unusual and extreme.

In this book, we take these kinds of experiences as problems in their own right. This contrasts with the approach frequently taken in psychiatry, where service users' talk of these kinds of experiences can very quickly get re-interpreted as nothing more than symptoms of an illness. In psychiatric settings, doctors are frequently listening out for particular patterns of difficulty in order to match the person's experience with a pre-defined diagnostic category. However, this might mean that they miss some of the complexity and fluidity of people's actual experiences of distress: in attentively looking for patterns of symptoms, they may fail to notice the ways in which people's distress is linked to the circumstances of their situations. As a consequence, rich accounts of distress that engage with its meaning and detail in a person's life may be difficult to achieve from within a psychiatric framework.

From our perspective, however, experiences of distress are part and parcel of the other experiences of everyday life. They do not form a separate, unitary category of symptoms that can be understood separately from everything else. Experiences associated with distress – just like every other experience – are bound up with social and material conditions, personal biographies, life events and relationships. And, just like every other experience, they are influenced by our biological capacities, by the many, variable potentials produced by our nature as living, organic beings.

But if distress is not separate from other aspects of experience, and does not form a unitary category all to itself, how can we know where it starts and ends? How can we reliably and validly draw an objective line between distress – the province of services such as clinical psychology and psychiatry – and more everyday experiences of being unhappy, worried and so on?

Simply put, our answer is that we cannot draw such a line. We do not believe that it is possible to produce a set of criteria or definitions that transcend history, place and culture and that can be used objectively to discriminate between those who are clinically distressed and those who are not. In the DSM, the existence of a distinct line between normal and abnormal is taken for granted – even though it is recognized that only appropriately trained expert psychiatrists might be able to determine exactly where it lies. By contrast, we believe that there is no value-free distinction between behaviours and experiences that are considered normal and those that are considered abnormal. Neither is there any universal standard against which people's emotions, thoughts and actions can be judged, and by reference to which they can be categorized as deviant. On the contrary, the identification of distress as distress will always be entwined with prevailing cultural norms of emotionality, behaviour and morality.

However, this does not mean that cultural norms are the sole criteria against which distress might be identified. Sometimes a person's ways of acting or experiencing can make it difficult for them to live their lives as they would like, or can have a bad effect upon their physical health. When this happens, their behaviour is never somehow floating free of cultural norms: what we want to do in our lives, for example, is continuously influenced by the precepts, norms and values of our time and culture.

Nevertheless, there are patterns of activity and experience which would be unhelpful or damaging in most circumstances. Gradually starving yourself – perhaps because you have come to believe that only by doing so can you begin to meet all of the many expectations placed upon you – will damage your physical health, no matter where or when you live. Similarly, being so profoundly miserable that you are unable even to get out of bed is likely to prevent you from achieving your goals, whatever those goals are. In the same way, experiencing angry and abusive voices that no-one else can hear is likely to make you frightened, confused and distracted, and this will probably occur to some extent even in cultures where voice-hearing is not as thoroughly stigmatized as it is in the West. So, whilst these dysfunctional or damaging consequences are definitely not separate from wider cultural norms and values, they do not arise solely because of them: they are also a product of specific patterns of experience and activity.

To some extent, distress can also be identified with respect to the extent to which a person's actions and experiences

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are unusual and inexplicable. Again, cultural norms play an important role here, and in two ways. First, almost by definition, norms refer to the ways of acting and experiencing displayed by the majority. However, there are difficult issues involved in trying to agree the threshold at which an experience becomes seen as clinically significant (see Box 1.2 for a discussion). Second, norms are relevant because we are far more ready to ascribe distress to people when their ways of being in the world do not make sense to us. When what people say or how they act is not only unusual but also seems to lack any obvious explanation, we are more likely to conclude that they are experiencing distress of some kind. In other words, it is not just the frequency or rarity of someone's acts and experiences that counts – it is also the sense or the *meaning* that we are able to give to them.

Another issue is that there are significant numbers of people who receive treatment from psychiatric or clinical psychological services but who do not want these interventions. Some might be experiencing the transient states of extreme euphoria and intense energy that psychiatrists call mania; others might be hearing voices that are friendly and supportive, rather than angry or abusive; yet others might be very unhappy, worried or confused, but have nevertheless come to believe that the treatments are not working, or that they produce as many difficulties as they solve. Some such people might end up receiving services, not because they themselves are distressed, but because their behaviours and experiences are distressing to others around them. Others may end up receiving services because their behaviour leads them to fall foul of the law. Again, cultural norms are highly relevant here: but in cases

like these those norms are either mediated by other people's experiences, or codified in legal or other requirements. These examples show how the identification of distress can be a compassionate move, perhaps by attempting to keep safe someone who might otherwise be a danger to themselves. But they also show how distress is always bound up with the wider structures of power that organize our lives, and by which interventions might be imposed against our will.

To summarize: distress is always conceptualized with respect to cultural norms, but these norms are not the sole criteria against which distress is understood. One consideration is that distress always has a subjective component, regardless of its location within culture. Another is that, intersecting with cultural norms, we also have

- Judgements about the extent to which a person's actions and experiences are harmful or dysfunctional
- Judgements about the extent to which they are unusual
- Judgements about the meaning of actions and experiences
- The influence of power relations

None of these judgements is simply objective, just as the operation of hierarchical power relations cannot simply be seen as 'objectively' correct. But whilst these judgements and influences do not escape the influence of cultural norms, they are not identical to them, either. Instead, they point to numerous ways in which the contexts, consequences and meanings of experience are part of its conceptualization as distress. They make it clear that distress is always socially and culturally positioned, that it will vary according to the specifics of time

BOX 1.2

The problem of thresholds

We have seen that one criterion for identifying experiences as mental health problems is how unusual they are. But what is the threshold beyond which an experience is considered so unusual that it is significant? This question is important, because research shows that some phenomena associated with distress are far more common than is usually supposed.

Of a random sample of 7,076 Dutch people, Van Os, Hannsen, Bijl and Ravelli (2000) reported that, whilst 3.3% had 'true' delusions (i.e. meeting all diagnostic criteria) an additional 8.7% an additional 8.7% had delusions that were 'not clinically relevant' – that is, they were 'not bothered by it and not seeking help for it' (van Os et al., 2000, p. 13). Similar findings have been reported in relation to hearing voices (see Chapter 11).

Stein, Walker and Forde (1994) conducted a telephone survey in Canada to ask about experiences of social

anxiety, finding that 61% of respondents reported being much or somewhat more anxious than others in at least one of the seven social situations surveyed. However, if the threshold at which a person's distress was considered clinically significant was moved, the prevalence of 'social anxiety syndrome' varied from 1.9% to 18.7%. Many diagnostic criteria are formulated without any empirical investigation of base rates in the general population. This may explain why there is a frequent disparity between numbers of people seen by mental health services and numbers of people in community surveys who meet diagnostic criteria.

Moffit et al. (2010) have suggested that many estimates of prevalence in community surveys undercount because they rely on retrospective accounts. Their prospective study, which followed participants between the ages of 18 and 32 and interviewed them four times during this period, found prevalence rates for DSM diagnoses that were twice those of other national surveys. They conclude by suggesting that 'researchers might begin to ask why so many people

experience a DSM-defined disorder at least once during their life-times, and what this prevalence means for etiological theory, the construct validity of the DSM approach to defining disorder, service delivery policy, the economic burden of disease, and public perceptions of the stigma of mental disorder' (p. 907).

Because there are cultural norms about what might be regarded as grounds for distress, where the threshold for distress is set will have a considerable impact. One US study has suggested that 'about half of Americans will meet the criteria for a DSM-IV disorder sometime in their life' (Kessler et al., 2005, p. 593). If half of the population experiences something, is it unusual? To some extent, this depends on one's worldview. For example, Sigmund Freud, one of the founders of psychoanalysis, did not see it as his job to make people happy: instead he simply argued that 'you will see for yourself that much has been gained if we succeed in turning your hysterical misery into common unhappiness' (Freud & Breuer, 1895/2004, p. 306).

and place, and will be patterned according to broader socio-logical variables such as socio-economic status, gender and ethnicity. Conceptualized in this way, distress is quite different from mental illness or psychopathology, both of which imply objective disease states that can be identified in ways that are distinct from cultural norms.

Why not abnormal psychology?

Our claim that there are no objective criteria by which distress can be distinguished from other kinds of experience is a challenge to the idea that some kinds of experience – and perhaps even some kinds of person – are simply abnormal. But this is such a taken-for-granted idea that it even lends its name to the most commonly used title for textbooks like this one, which are typically described as books on abnormal psychology. This term is very widely used, perhaps because classifying some kinds of experience as abnormal makes it reasonable to describe them as expressions of psychopathology or mental illness. Since abnormal psychology is such a common term, we should explain why we do not use it in this book.

Whilst the notion that trained professionals can use objective criteria to distinguish between normality and abnormality is perhaps comforting, it is nevertheless mistaken. Speaking very generally, formal definitions of abnormality can be classed as medical, as statistical, or as social – but whichever kind of definition we use, we encounter contradictions and problems. Each kind of definition excludes some phenomena we might intuitively want to define as psychologically abnormal, includes some we would not want to define as abnormal, or smuggles elements of subjective opinion into what are ostensibly objective judgements.

For example, if we use a **medical definition of normality**, we will tend to class as normal those activities which contribute to health and wellbeing, and class as abnormal those that endanger life or wellbeing or which cause harm to bodily organs or tissues. But this means that many highly prevalent everyday activities – such as smoking, drinking alcohol, dieting, extreme sports, body-piercing and tattooing – would be classed as abnormal, because they all involve actual or potential damage to the body.

If we use a **statistical definition of normality**, we will class as abnormal those activities, behaviours and characteristics that are, numerically, relatively unusual in a given population. Statistical definitions of normality derived from psychology sometimes use psychometric instruments, normal distributions and similar procedures by which to distinguish those who are abnormal from those who are not. But without also drawing on cultural values and norms (for example, in deciding which experiences to include in psychometric scales) statistical definitions will always generate contradictions, because some highly valued attributes – being a member of the royal family, perhaps, or excelling at sport – are statistically highly abnormal.

If instead we use a **social definition of abnormality**, this will reflect the specific kinds of activities and experiences approved or disapproved of in that time and place, so will inevitably be subject to marked variation. This variation operates within as well as between cultures: groups and subcultures have their own norms of behaviour and conduct that sometimes differ significantly from those of the dominant or mainstream

culture (Hebdige, 1979). Social definitions recognize the culturally normative dimension of distress that we described above, but when we try to formalize them it becomes apparent that we also have to invoke other (typically unspecified) criteria to decide *which* social norms, when, and where, to use as the basis of our decisions.

So concepts of normality and abnormality do not provide an objective basis for the identification of mental illness or psychopathology, and this in part explains why we have not relied upon these concepts in this book. But the term 'abnormal psychology' is nevertheless widely used, and seems acceptable to the majority of psychology lecturers and students. Despite this, there are other reasons why we choose not to describe this as a book about abnormal psychology.

Abnormal psychology is confusing and unclear

One reason we haven't used the term 'abnormal psychology' is that it is ambiguous: is it the psychology itself that is abnormal, or does the term refer to the psychology of abnormality? Common sense would suggest that it is the second of these options that most people have in mind; if so, this only leads to a second, thornier set of confusions.

As we have already discussed, there is no straightforward, objective way to distinguish abnormal behaviours and experiences from normal ones. Even more fundamentally, though, it is impossible to easily identify a body of psychological theory and practice that is both exclusive to abnormality and unconnected with other topics. Psychological explanations in abnormal psychology tend to draw upon just the same kinds of paradigms and theories as other psychological explanations – biological, cognitive, behavioural, social, developmental and so on. It does not seem necessary to assume that the psychological processes that occur in distress are fundamentally different or abnormal in comparison to those that occur in other, supposedly normal, experiences. There are many successful psychological models of distress that draw upon established psychological theories and concepts such as learning theory, attribution theory, schema and so on.

Abnormal psychology is not consistently psychological

A further way in which abnormal psychology is confusing is that it is not consistently psychological. Frequently, abnormal psychology entirely abandons psychology and turns instead to psychiatry. This is clearly demonstrated in the overall structure of most textbooks, which typically follow, more or less faithfully, the diagnostic categories associated with one of the major psychiatric diagnostic systems such as the DSM or ICD. But this necessarily means that the inconsistency also runs deeper: even where psychological explanations are offered, they are directed at problems already defined in psychiatric terms. So in abnormal psychology there is an unresolved tension between psychiatry and psychology, and frequent shifts from one to the other. Moreover, when this happens, abnormal psychology typically offers no rationale for this shift from a psychological mode of explanation and description to a medical, psychiatric one.

In this textbook, we try to avoid these confusions by presenting consistently psychological accounts of distress. This does not mean, of course, that we entirely ignore psychiatry: this

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would be impossible, given that so much of the evidence we have about distress is associated with it. Nor does it mean that we ignore any of the multiple facets of distress, such as its biological, cognitive or developmental aspects.

However, it does mean that we treat psychological explanations of distress as sufficient in their own right. Rather than subordinating them to psychiatry by applying them only to problems defined in the first instance as medical and psychiatric, we also use psychology to define the nature and character of people's distress.

Abnormal psychology is unhelpful

A third reason we haven't used the term 'abnormal psychology' is that it is likely to be particularly unhelpful for many of the people who will be expected to study it. As we note throughout this book, distress is very common and it is likely that most readers will know someone who has experienced it (see Box 1.3).

In this context, teaching that is framed from the outset as being about something abnormal will already import a range of assumptions that, for many readers, are likely to be difficult or unhelpful. It is hard to engage constructively with teaching that labels you, or the people you love and care for, as abnormal.

Even more seriously, this unhelpful aspect of abnormal psychology is not confined to its likely effects upon the learning and teaching of psychology. Although the majority of people who study psychology do not go on to have careers in the profession, they will nevertheless draw upon what they have learned at other points in their lives. This means that they

will tend to possess a limited and restrictive set of conceptual frameworks when they themselves, or people in their lives, encounter mental health problems. These limitations, and the assumptions of abnormality which they reproduce, may act as barriers to people's ability to understand difficulties and respond to them appropriately.

Of course, *all* teaching and learning starts from a set of assumptions about what we imagine to be the nature of the topic and what students need to learn about it. We do not imagine that by avoiding the term 'abnormal psychology' we have somehow written a textbook that is free from any assumptions – far from it. We simply hope that the assumptions we started from will prove more helpful and appropriate for psychologists and many others who wish to engage with this topic.

Isn't this just anti-psychiatry?

Some readers might consider that our arguments so far are 'just **anti-psychiatry**'. By this, people mean the work of psychiatrists and others in the 1960s, like Ronald Laing in the UK and Thomas Szasz in the USA, both of whom were critical of the legitimacy of psychiatric claims. As we will see in Chapter 2, the so-called anti-psychiatrists were not a homogenous group, and there were important differences between the key figures. Moreover, both Laing and Szasz were unhappy with the term 'anti-psychiatry', and they were clearly not against all ideas and practices in this area, since they both continued to practise psychotherapy.

Many modern abnormal psychology and psychiatry textbooks give the impression that the challenges raised by the

BOX 1.3

I know someone who has a mental health problem

Many readers of this book will either know someone who has had a mental health problem, will have experienced a problem themselves, or may do so in the future. UK mental health campaigners suggest that about one in four people will, at some point in the course of their lives, experience clinical levels of distress. Elsewhere in this book, we ask whether such figures challenge common definitions of mental illness based upon notions of organic disease and dysfunction. For now, all we need to recognize is that such experiences are very common, so if you have experienced distress – or know someone who has – you are not alone.

In a survey of students attending an abnormal psychology class in the US, Patricia Connor-Greene (2001) found that almost every student reported knowing someone with a mental health problem, that quite often students knew several

such people, and that the people they knew were most often family members. She observed that taking part in such a class is not 'simply an abstract academic exercise; it is a potential source of knowledge and skills that could have a significant impact on students, families and friends' (Connor-Greene, 2001, p. 211).

We take this point seriously. Throughout the book we have sought to portray people in distress in a respectful manner, and to avoid an 'us and them' attitude. We have tried to investigate and present the evidence behind, for example, claims about particular mental health interventions, so that readers of the book can act as informed citizens when helping a family member to weigh up the pros and cons of different intervention options.

When reading about mental health, one can easily start to recognize oneself in the descriptions of certain kinds of problem. As we will see in later chapters, studies of the normal population suggest that many mental health problems are normally distributed, such that a lot of us experience them at a low level (i.e.

in a manner which does not get in the way of our lives or cause significant difficulties for us or those close to us). Thus, if you feel that you are a little obsessive because you like things to be neat and tidy, it does not mean you have a disease called obsessive compulsive disorder. This self-recognition problem is very common. If you asked the other students in the class if they have started to question whether they have a mental health problem, we think it is likely they will say that they have too!

If, however, you do have a problem that is long-lasting, and that is causing difficulties that get in the way of your life and causing you further distress, then you should consider seeking help. Most universities and colleges have mental health or counselling services, and these can be an appropriate place to start. For those who are not students, local voluntary services in your area can usually be identified by searching the internet. You could also try discussing your difficulties with your GP, who – if it is appropriate – will be able to refer you to more specialist services.

anti-psychiatry movement were addressed with a new edition of the DSM in the 1980s. However, this new manual did not solve the more fundamental conceptual problems noted by these critics – for example, that value judgements are necessarily involved in definitions of mental illness, and that there is no clearly evidenced biological basis for mental illness, and thus no physical tests for (say) schizophrenia in the way that there are for infections or viruses. Moreover, there has been a considerable body of empirical research over the last fifty years which has cast new light on some of the debates which began in the 1960s. Throughout the book we will draw on this research to demonstrate that there are continuing problems with the validity and reliability of diagnostic constructs. Likewise, we will draw on this research to show that a focus on the experience of forms of distress can yield results that are valuable to service users, researchers and clinicians.

It may help here to consider some of the debates in other areas of psychology, for example between different approaches to social psychology or between paradigms like learning theory and psychoanalysis. Here, too, there are debates about assumptive frameworks, key concepts, terminology and methodology. In these areas, too, we have had to accept that research is always, to some degree, a reflection of its time, affected by cultural norms and so on. Our contention is that this is also true in mental health, so throughout the book you will see debates analogous to those found in other areas of psychology.

In short, there are some similarities between aspects of our approach and the ideas of the anti-psychiatrists, but there are also significant differences. This book reflects the findings of the nearly fifty years of research and discussion that has taken

place since the 1960s. The term 'anti-psychiatry' seems to exclude all of this more recent work, is simplistic, and carries far too much historical and conceptual baggage; for these reasons we would not use this label to characterize our approach.

From disorder to experience

Most mental health textbooks, then, focus on psychiatric disorders; Box 1.4 shows how disorder is typically defined within psychiatry, and discusses some problems associated with such definitions. By contrast, in this book we focus on experience. By this we mean that we will describe and try to explain experiences of distress without presuming that they are always caused by an underlying disorder of some kind. We will treat the difficulties themselves as something to be explained, rather than attributing them to an underlying disorder that in fact may not even exist.

In the last few years there has been a growing tendency for psychology to engage directly with the particularities of experience itself, rather than, for example, engaging with general biological or cognitive capacities. There have been three recent books on the psychology of experience, each one taking a slightly different focus. Ben Bradley (2005) emphasizes that experience is always relational and shaped by the simultaneous experiences of other people. He also discusses ways of thinking about the significance of time in relation to experience. Dave Middleton and Steve Brown (2005) show how our experience is made in part from our memories, exploring how they help give meaning to everything we see, hear and feel. Niamh Stephenson and Dimitris Papadopoulos (2007)

BOX 1.4

DSM-IV definition of mental disorder

In DSM-IV each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in or more areas of functioning). This syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual. Neither deviant behaviour nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of dysfunction in the individual.

Reproduced in Stein et al. (2010, p. 1760)

This definition raises many issues that recur throughout this book: whether or not distress should be seen as a medical or biological problem, the relationships between individuals and their culture, the kinds of reactions we should expect people to show to unpleasant but common experiences such as bereavement, and so on. Notably, however, the definition also displays a continual concern with notions of **dysfunction**, and this raises some complex issues.

For example, Wakefield (1992) distinguishes between disorder and dysfunction. He argues that a disorder is a harmful dysfunction, and that what is considered harmful will be judged according to prevailing social norms. By contrast, a dysfunction – for example, of a cognitive mechanism designed to conduct a specific function – might be identified objectively, so is not subject to the same kinds of influences or biases. This suggestion is insightful: it avoids many of the difficulties associated with definitions of normality and abnormality whilst also recognizing that the notion

of disorder is inescapably social in character.

However, as Kirk and Kutchins (1999) observe, we can only reliably identify a dysfunction if we can say with confidence what the *function* of a system or organ is meant to be. But in relation to human minds and brains, our knowledge of these functions is still remarkably limited. For example, we know that many neural systems frequently serve more than one function, that most basic abilities are enabled by multiple neural systems working in parallel, and that there are frequently many different neural pathways by which the same (or a similar) behavioural or cognitive goal can be reached. They argue further that many forms of distress are probably not dysfunctional in any simple sense: for example, that it may well be 'natural' and a sign that your neural systems are working as they should if you end up feeling deeply miserable because you have lost your job and have no immediate prospect of getting another.

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focus mainly on the ways in which experience is shaped by the wider power relations of society, relations which regulate our experience and – at the same time – create contradictions that can put us somewhat at odds with their requirements.

These different perspectives on experience begin to show how it always spreads in two directions: 'outside' ourselves, into the social and material circumstances that give experience its character and content, and 'inside' ourselves, by way of the many thoughts, feelings and memories it consists of. In this book we will try to explore experience from both of these directions, in the hope that by doing so we can make even superficially baffling experiences more open to explanation. The alternative – attributing what we cannot readily understand to the effects of an underlying disorder – tends to produce unsatisfying, circular explanations: we know that Jenny has schizophrenia because she hears voices, and the reason she hears voices is because she has schizophrenia.

Whilst the kinds of experiences we will consider are quite varied, they are all of the kinds that mental health professionals might encounter in the course of their work. At the start of this chapter we presented Bess's story and suggested that her experiences are fairly typical of those that clinicians encounter. Here are some more examples:

Dave is a 45 year old man who is frustrated with his career. Although he has a well paid, highly respected job and a comfortable home, he is dissatisfied with other aspects of his life and his negative feelings have recently started to become overwhelming. At work, Dave feels that his talents are not being recognized, and that his manager is a bully who does not take his suggestions seriously. In recent months, this situation has begun to preoccupy Dave's thoughts. He has frequent trouble sleeping, and has started experiencing pains in his neck and back. His GP can find no physical cause for these pains, but since Dave recently began experiencing panic attacks he has referred him to a counsellor attached to the practice. Together with the counsellor, Dave has begun exploring how his responses to his manager are shaped by other experiences in his life.

Ellie is a 19 year old woman who got pregnant when she was just 15, although she has not seen her son's father since then. She has tried to provide her son with a stable home, but despairs that she is only surrounding him with the same kinds of instability and confusion that she experienced herself when she was growing up. For a long time now Ellie has felt very miserable, but she has come to believe that if only she had cosmetic surgery to make her body look 'younger', more attractive to men, she would feel much better. When her doctor would not refer her for cosmetic surgery of this kind, Ellie attempted suicide. Since then she has been taking anti-depressant medication and receiving cognitive-behavioural therapy.

Mark is a 25 year old unemployed man who lives with his mother and stepfather in a poor suburb. He never knew his own father, who left home when he was small. His mother remarried and had a daughter with her new partner, and Mark grew up feeling that he always took second place to his sister. Following a long and angry argument with his stepfather, Mark has been lonely and miserable and has started locking himself into his room. Alone at night, he has begun to hear angry male voices criticizing him. Mark is terrified by these experiences, but has not told anyone about them because he fears that people will laugh.

Like all of the other examples in this book, these are fictional – they are not descriptions of real people. Nevertheless, they are fictions closely informed both by clinical practice and by the research literature describing mental health difficulties. This means that we can use them to draw out important issues that are relevant to our understandings of distress – for example, how people are socially positioned. Dave is a middle-class professional, whereas Ellie and Mark are less wealthy and have fewer resources. Studies show that the incidence of psychiatric diagnoses varies with wider economic and social conditions and is patterned according to sociological variables such as class or socio-economic status, gender and ethnicity. Similarly, there is much evidence that women are more likely to be given some psychiatric diagnoses than men, and that overall they are more likely to experience distress. Nevertheless, as our examples illustrate, at the individual level these influences appear complex and uneven.

Ultimately, each of our examples is an attempt to reduce the messy complexity of a lived experience, in all its uncertainty and ambiguity, to a single narrative told from a specific point of view. Inevitably, doing this raises issues. For example, there are always other stories that could have been told: even though we have tried to illustrate something of the great diversity of distressing experiences, it is impossible to encapsulate the variety of experiences being lived out around us all the time. So we could have told many other stories; but we could also have told the stories we did tell in different ways. Mark's stepfather, for example, might have told a story that emphasized Mark's unreasonable behaviour, and described how he frequently becomes aggressive without any apparent justification.



Both psychiatry and psychology are imbued with interests – for example, those of commerce and professional status. Although the problems associated with these interests may be more acute in respect of psychiatry, psychology does not provide a neutral ground from which to approach distress

This suggests that there will often be tensions between what people say about distress according to how they have experienced it, how they have been exposed to it, and how they have been encouraged to understand it. Moreover, these tensions will often have moral, ethical or political dimensions to them. This is only to be expected: partly because distress often first becomes a matter for intervention when people flagrantly breach everyday moral codes and expectations, partly because distress is associated with inequality, disadvantage, discrimination and prejudice, and partly because the stigma associated with it can be used to discredit or denounce the actions and pronouncements of individuals. Stories about distress (like all stories, in fact) are never neutral: they are always told from a point of view, and that point of view always reflects a set of interests.

We have no definitive solution to these problems. We certainly cannot claim that the account we give in this book is somehow neutral, or that it fails to reflect our interests as academic and clinical psychologists. Instead, we have adopted two strategies to take account of these problems. First, we will continually emphasize the importance of *all* kinds of evidence when considering, weighing and assessing the claims made for different explanations of distress. And second, we have included in this book some of the views and perspectives of people who actually experience distress, so that our professional perspectives can be balanced by perspectives from those who have actually received mental health services.

All in the mind?

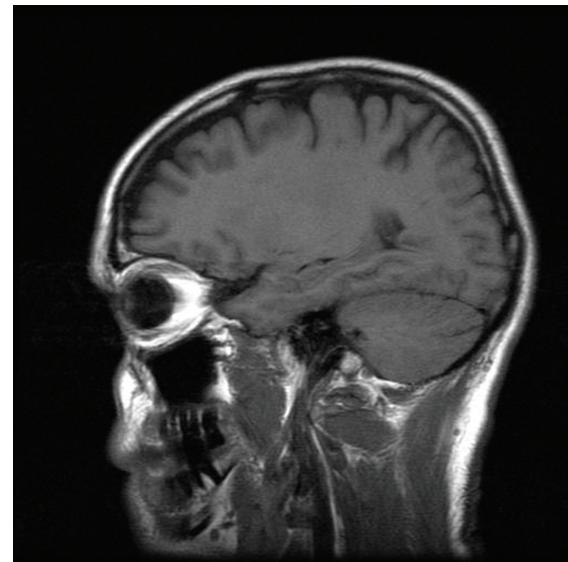
By rejecting psychiatric disease categories we might appear to be denying the reality of people's distress: if the categories aren't real, are we saying that the distress isn't real, either?

This is not the case. We have not based this book upon psychiatric diagnoses because of the extensive evidence regarding their lack of validity, poor reliability, dubious empirical grounding and much-discussed conceptual difficulties (we discuss this evidence in much more detail throughout the book, especially in Chapters 4 and 5).

In place of psychiatric diagnoses, we advocate consistently psychological explanations, but from a psychological perspective, people's distress is just as 'real' as it is from a psychiatric one. The pejorative term 'it's all in her mind' is sometimes used to imply that psychological distress should be something we can simply overcome by an effort of will. It is a moral judgement which ultimately implies that only those of weak character fall prey to psychological disorders. In this book we need to avoid such unjustified moralizing, whilst holding on to the idea that distress is fundamentally psychological. We can do so in a number of ways.

First, we should recall that nothing is simply 'all in the mind'. Mind, body and brain are intimately joined together, and anything that is 'in the mind' is simultaneously a state of the body-brain system. The denigration of psychological distress as being 'all in the mind', in other words, relies for its force upon the cultural commonplace of **mind-body dualism**. Mind-body dualism – also sometimes called **Cartesian dualism** – refers to a tendency, common in Western cultures and associated historically with the philosophy of René Descartes, to treat mind and body as distinct, separate substances with no necessary links between them.

Second, we should recall that pain, such as that from a broken leg, is just as much 'in the mind' as distress, but we



Anything that is 'in the mind' is also a state of the brain and body

don't understand it in these dismissive terms because there is a clear and visible explanation for its severity. Those who experience chronic back pain, by contrast, may also fall prey to such discrimination: having a visible cause for pain – or for distress – helps.

Third, the experiences of distress that are categorized by psychiatric diagnoses are, in any case, overwhelmingly psychological in character. There are no reliable biological markers for different diagnoses, no blood tests or scans that can be used to make diagnoses of depression or schizophrenia. Instead, there are reports – usually verbal – of various kinds of experience: unusual beliefs, profound unhappiness, extreme agitation, hearing voices and so on. These experiences may well also have aspects that are visible in the person's bearing and manner: people who are deeply unhappy, for example, often talk more slowly than other people, and sometimes more quietly. They may have difficulty thinking of words or concentrating on the flow of conversation, and may find it hard to motivate themselves. But the existence of these bodily elements does not necessarily mean that there is a physical disease called depression, although it does demonstrate, again, that psychological states are simultaneously states of the body and brain.

Fourth, we should always keep in mind that even when people's own actions seem to be unhelpful and self-defeating, this does not mean that they are simply responsible for their own distress. Putting this another way, just because how we respond to our distress can make a difference to the outcome, this doesn't mean that individuals should be held personally responsible for failing to respond in what, from an outsider's perspective, is the 'correct' manner. In actuality, most people's room to manoeuvre is far more limited than it might at first appear, and many simply do not have the resources to deal with their situation in ways that are markedly different. Moreover, just like everyone else, when people experiencing distress make choices, they always do so with limited knowledge of their consequences: we can know what we do, but cannot so readily know all of the effects of what we do.

Far from denying the reality of people's distress, then, psychological explanations begin with this reality and attempt to understand how it has been constituted. In our view,

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only the existence of a cultural prejudice against psychological explanations for distress prevents this from being more obvious.

Models of distress

In science, models are often used as an aid to thinking about and researching problems. Formal scientific models are derived from theories and bear a systematic relationship to them. There are also more 'informal' models that are most accurately located within a paradigm rather than a theory, and these are the kind of models typically used in relation to distress. We have already mentioned biopsychosocial, biomedical and psychosocial models of distress, but in the literature many more are described. Figure 1.2 shows some of the most commonly-cited models of distress, together with their most frequently used synonyms.

Whilst for convenience we have named these models as though they were separate and distinct entities, you need to be aware that in actual practice things are far more confusing. For example, it is possible to conceive of the diathesis-stress model as a variant of the biopsychosocial model, because it attempts to unite biology, in the form of an organic vulnerability or **diathesis**, with the psychological and social influences that cause stress.

However, it is equally possible to conceive of the diathesis-stress model as a variant of the medical or psychiatric model, because it posits that clinical distress only arises in people who are medically (biologically) vulnerable. Likewise, some family systems models are also psychoanalytic; and many psychological models are cognitive as well as behavioural. Similarly, many people would see the biological model as being the same as the medical or psychiatric one, whereas some would differentiate these.

Using models to understand distress can yield a number of advantages. Models simplify complex issues, making it easier to think about them and to generate ways of researching them empirically. They do this largely by selecting some aspects of distress as most relevant to enquiry, and others as less relevant: this assists with both theory and empirical research. Using a biological model of distress, for example, the primary

focus of study will be what occurs inside the brain and body of someone experiencing distress; other influences will only be important to the extent that they make a difference to the body and brain.

Models also supply a mode of representation – an analogy or set of metaphors that is useful for communication and conceptualization. In the cognitive model, for example, the analogy is that the mind works like a computer, so we conceive of distress as caused by faulty information processing. In this way, models also organize events and phenomena into (possible) causal chains. If distress is cognitive and arises because of faulty information processing, the causal chains will implicate psychological mechanisms and strategies (attributions, perceptions etc.); if distress is biological, the causal chains will depend on biological phenomena such as features of the brain.

However, these benefits can also become limitations. Because models are analogies or metaphors for distress, rather than *actual* distress, they can easily be over-extended. Once we begin to think of distress in terms of (for example) a cognitive model, we might be tempted to keep on thinking of it this way even when we encounter aspects that might be better explained in other ways. For example, although some aspects of being extremely sad can be conceptualized cognitively (in terms of a set of negative cognitive biases), other aspects are probably better explained by reference to biological or social processes. This might seem to imply that a biopsychosocial model is what is needed, and whilst in a superficial sense this is obviously true, in practice most biopsychosocial accounts are inadequate (we discuss this issue in Chapter 4, especially in Box 4.5).

Another possible disadvantage of using models is that, in simplifying distress by focusing on what is most relevant from a given perspective, they might actually leave out what is most important, but we will never know this unless we start from the actual phenomena (the experience of being distressed, in all of its complexity and confusions) rather than from within the bounds of a model to which we have already made an intellectual or professional commitment.

A final disadvantage is that models of distress can be misleading with respect to causality because they might imply sets of relations that, in actuality, do not exist. For example, a biological model of distress that emphasizes the role of hormones might give the impression that these hormones only interact with each other, and lose sight of the fact that levels of hormones also fluctuate according to external influences such as social and relationship status.

There are also deeper conceptual issues with most commonly used models of distress because for the most part they accept boundaries that we might wish to question. For example, biological and social influences tend to be either kept apart or – when they are brought together – mediated by psychology. Whilst there is some sense in this, it then makes it very difficult to consider situations where biological and social influences might interact directly, without necessarily being psychologically mediated, such as in the development of an embryo in the womb, or in the very early days of a human infant's life.

Throughout this book we will sometimes have to make reference to models of distress, and you can use the table in this section to orient yourself toward them. However, whilst they can be useful, you should always bear in mind that they can also be misleading.

Biomedical (biological)
Medical (psychiatric, illness)
Diathesis-stress (stress-diathesis, stress-vulnerability)
Behavioural
Cognitive
Humanistic (existential)
Psychodynamic (psychoanalytic)
Family systems
Psychosocial (sociocultural)
Biopsychosocial

Figure 1.2 Models of distress

Overview of this book

This book is in two parts. The first part provides a foundation for the second by systematically setting out key concepts, debates and evidence. The aim of the first part is to supply a detailed account of distress that describes its character, identifies causal influences, and discusses responses to it. In the second part, we apply this account of distress to a subset of the most common kinds of mental health problems encountered by professionals in clinical psychology, psychiatry, social work and related disciplines.

Part 1

This part contains eight chapters which, read together, provide a consistently psychological account of distress. Although we frequently discuss psychiatric diagnoses in this part, we do not use them as explanations. Instead, we offer explanations that draw upon psychological theories and concepts, supplemented where appropriate with evidence and ideas from disciplines including neuroscience, anthropology, sociology, epidemiology and other relevant disciplines. In this way we provide an account of distress that avoids 'jumping ship' and uncritically importing wholesale a set of concepts and theories from psychiatry. Part 1 has eight chapters:

- Introduction (this chapter)
- History
- Culture
- Biology
- Diagnosis and Formulation
- Causal Influences
- Service Users and Survivors
- Interventions

History: To understand why we have the ideas we do today it is vital to look at how those ideas were developed, so in this chapter we provide a survey of the different ways that distress has been understood and treated over the centuries. Our history shows how there have always been competing strands of explanation and treatment for distress, some primarily implicating the body and its organs and some primarily implicating experiences, meanings, thoughts and feelings.

Culture: This chapter describes how distress differs between cultures. It discusses some of the great variability in the forms of distress, the variability in the ways that it gets linked to other aspects of experience, and the variability in the outcomes associated with it. As we have already suggested, distress is thoroughly bound up with culture, and this chapter illustrates the extent and consequences of this.

Biology: Our approach to biology treats it as an inescapable part of distress, but does not make the unfounded psychiatric assumption that it is always the ultimate cause of people's difficulties. In this chapter we explain why there are problems with biopsychosocial accounts of distress, and in their place offer an alternative view of the role of biology. We summarize evidence that supports our approach, drawing upon studies of attachment as well as upon recent work in psychology and neuroscience.

Diagnosis and Formulation: Textbooks of 'abnormal psychology' are usually organized around systems of psychiatric diagnosis, such as one of the versions of the DSM. This chapter presents some of the evidence that psychiatric

diagnosis is not valid and reliable enough to provide a firm scientific basis for understanding distress. It then sketches an alternative, consistently psychological approach to classifying distress.

Causal Influences: In some instances, the causes of a person's distress might seem quite obvious; in others, they may seem mysterious or obscure. This chapter provides a detailed discussion of the notion of causality in relation to distress, showing how it is often more difficult to ascertain and understand than we imagine. We describe and evaluate the research methods used to establish causality in distress, and then review evidence showing that – regardless of the specific form that distress takes – it is associated time and again with a common set of causal influences.

Service Users and Survivors: Mental health service users sometimes describe themselves as *experts by experience*. This chapter draws upon some of that expertise and describes how the service user movement in the UK has mounted a series of challenges to the treatments offered by services. A discussion of the work of the 'Hearing Voices Network' shows how service users are continuing to challenge conventional services by organizing themselves to provide viable alternatives to conventional therapies.

Interventions: Here we describe the kinds of interventions for distress typically offered by Western mental health services. We describe psychiatric medication, psychotherapy, and community psychology interventions, using these to show how each offers different potential sources of help to people experiencing distress. A number of different mental health professionals are involved in offering interventions to people in distress – in the appendix to the book we describe some of the key professional groups and the kinds of settings within which they work.

Part 2

Part two of the book contains five chapters. In each one we discuss in detail one of the major kinds of distress that contemporary Western mental health services encounter.

We had to make some difficult choices about how we should present this material. On the one hand, we did not want to organize the material around psychiatric diagnoses. On the other hand, we knew that many mental health modules are structured in this way. This meant that we needed to present our material in a way that was useful to as many people as possible.

We have done this by structuring these chapters around broad forms of distress where there is some commonality in the underlying **phenomenology** of an experience. In psychology, phenomenology refers to exactly what an experience is like – what kinds of characteristics, features and subjective qualities it has. Reflecting some of its links with philosophy (phenomenology is also an important branch of philosophy), this usually means that efforts are made to include the bodily or **embodied** aspects of experience, as well as those usually described as mental or cognitive.

What does this look like in practice? Well, for example, it means that Chapter 9, 'Sadness and Worry', deliberately treats together aspects of experience that are usually treated separately in books organized according to the DSM classification. In other books, these experiences are likely to be addressed in two separate chapters, one focused upon 'Depression' and

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the other focused upon 'Anxiety Disorders'. Similarly, Chapter 11 on 'Madness' includes experiences that, in other textbooks, would be addressed separately in relation to psychiatric diagnoses such as schizophrenia and bipolar disorder.

Although the number of different kinds of distress we discuss in this way is fairly small, they will account for the vast majority of the referrals received by UK mental health services. The chapters are

- Sadness and Worry
- Sexuality and Gender
- Madness
- Distressed Bodies and Eating
- Disordered Personalities

Each of these five chapters is structured in a similar way, and each one builds upon the concepts and evidence laid out in Part 1 of the book. Within each of these chapters there are sections on history and culture, a summary of the psychiatric diagnoses typically given to people experiencing this form of distress, a review of the evidence regarding causality, and a description of the kinds of treatments and interventions available for this kind of distress.

How to use this book

Sequence

Because most 'abnormal psychology' textbooks are structured around the diagnostic categories of the DSM, they often do not make a sequential, structured argument. This means that it is usually quite easy to dip into them, regardless of the order of the chapters, in order to read about specific diagnoses.

This book is a little different. In Part 1, especially, all of the chapters are linked so that together they provide a systematic argument that explains our approach to distress. The chapters in Part 2 are more like the chapters in other textbooks, in that it does not especially matter in which order you look at them. However, whilst these chapters can be read in isolation, you

will get a lot more out of reading all of them if you first read the chapters in Part 1.

Questions

Each of the chapters has a set of questions associated with it. You can use these questions to check your own learning and make sure that you understand the material in the book in the way that we intend. There are guiding questions at the start of each chapter that will alert you to recurrent themes to keep in mind as you read. There are also summary or revision questions at the end, which you can use to check that your learning is proceeding adequately.

Boxes

All through the book we use boxes to introduce additional material alongside the main text. Some of the boxes simply contain material that, although linked to the main text, is easier to explain separately. Other boxes contain discussions of key theories, concepts or issues which will recur throughout the book.

Key terms and concepts

You have probably already noticed that whenever we use any specialist terms or language for the first time, the term is printed in **bold** and a definition or explanation appears very close by – mostly immediately afterwards, occasionally just beforehand.

Stories and experiences

Almost all of the chapters in this book start with a story about someone's experience. As we have already explained, these stories are all fictional but, at the same time, they are informed by clinical practice and by close readings of the mental health literature. You can read them as a very quick and accessible way of orienting yourself to the concerns and issues that each chapter raises.