Chapter 1
Introduction

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lecture and discussion, students should be able to:

1. Understand the historical antecedents and treatments of people with mental health problems.
2. Critically consider the strengths and weaknesses of the DSM diagnostic system and alternatives including the dimensional and formulation approaches.
3. Consider the aetiology of mental health problems from a number of perspectives: genetic, biopsychosocial, socio-cultural, and systemic.
4. Consider the pros and cons of psychotherapy and pharmacotherapy.

CHAPTER OUTLINE

The chapter provides a brief introduction and broad overview of many of the issues to be considered later in the book. It therefore serves to highlight some of the key issues in the aetiology and treatment of mental health problems.

1.1 Historical overview
- Somatogenic and psychogenic perspectives
- Care in the community

1.2 Issues of diagnosis
- The medical model
- Alternatives to the medical model
  - Dimensional approaches
  - Psychological formulation

1.3 The aetiology of mental health problems
- Genetic models
- Biological models
- Psychological models
- Socio-cultural models
  - Childhood adversity
  - Socio-economic differences
  - Gender differences
  - Minority status

Systemic models

1.4 Psychotherapy versus pharmacotherapy

QUESTIONS FOR DISCUSSION

These questions are designed to elicit discussion about the causes of mental health problems, and possible interventions to ameliorate them. There is no 'correct' answer, but they may prepare students for the issues within the lecture/chapter and trigger discussion on issues relevant to it.

If you had a *relatively mild* mental health problem, which of the following treatment approaches would you prefer?

i. Talk to friends and family
ii. Use self-help material from books, internet and other sources
iii. Medication
iv. Psychotherapy
v. A combination of medication and psychotherapy

If you had a *severe* mental health problem, which of the following treatment approaches would you prefer?

i. Talk to friends and family
ii. Use self-help material from books, internet and other sources
iii. Medication
iv. Psychotherapy
v. A combination of medication and psychotherapy

How was the main diagnostic system used by psychiatrists (DSM 5) developed?

i. Through scientific exploration and theories of the causes and nature of mental health problems
ii. As a social construct based on the opinions of a committee of expert psychiatrists
iii. Through discussion with experts from a range of disciplines related to mental health including psychiatrists, psychologists, sociologists and neuroscientists
iv. A combination of i and iii

Which of the following is the *most* important in the aetiology of mental health problems?

i. A genetic predisposition
ii. Life circumstances in adulthood
iii. Childhood adversity

iv. None or all of the above

How important are therapist characteristics in the delivery of psychological therapies? For example, when working with a person from a minority population, should the therapist be:

i. Someone of the same gender
ii. Someone of the same cultural heritage
iii. Someone who understands the culture of the individual
iv. It should not matter

LECTURE SUGGESTIONS

The key messages from this chapter are:

i. Diagnoses are a social construct, and a questionable one at that, and have a number of limitations as a consequence. Perhaps the most extreme example of this can be found in the APA's decision to remove homosexuality from their list of disorders based on a ballot of their members! More subtle may be the shift in DSM 5 to include a range of experiences into diagnostic categories at the risk of increasing medicalization and pathologizing normal human experiences. Diagnoses may also be used as a means of control. There is good evidence, for example, that a diagnosis of ADHD may be used to prevent children attending certain US schools or as a reason to prescribe medication to control behaviour which until recently would have been seen as 'naughty' rather than clinically defined.
ii. While of potential clinical value when medication is prescribed and in research papers to ensure comparability of study populations, clinical diagnoses offer little to psychotherapists who are more interested in a clinical formulation: a theoretical model of both long- and short-term contributors to the problems the individual faces. These may be social, economic, internal cognitive or cultural processes. Each may need to be addressed within the formulation and, to the degree that this is possible, in the intervention.
iii. A key issue of the diagnostic system is that it forms a dichotomy. One either has a 'disorder' or does not. It is much more fruitful to think of any mental health issue as being on a continuum, with people at one end of this continuum experiencing what may be 'normal' experiences but to a significantly greater degree than the typical person within the population. This may be measured in terms of frequency or severity. We all feel sad or anxious at times and consider this to be normal. The experiences and underlying cognitive processes of someone with an anxiety or mood disorder, differ only in the severity or frequency with which they are experienced.

iv. Neurological and psychological models of mental health disorders are often set up as opposing explanations: the condition is EITHER neurological OR psychological. It is more useful to consider the approaches as different levels of explanation of the same condition: much like physics describes sub-atomic processes while chemistry may explain the same processes in terms of supra-atomic processes, neurological processes clearly underpin psychological processes, and are in turn influenced by our experiences. Accordingly, rather than competing models, they should be viewed as parallel explanations of the same phenomena.

v. Finally, any disorder is likely to have a range of interacting and, potentially, transactional causes. Childhood trauma may establish a pattern of behaviour which then contributes to behaviours in adulthood that provoke responses from others, prolonging or triggering further problems. Critical to thinking in this context is that, while acknowledging the role of childhood issues in the development of adult disorders, it is important to not simply see them as independently causal. Any understanding of this relationship must consider mediating processes between the two. These will include, as a minimum, cognitive processes involving beliefs about the self and others established as a consequence of childhood experiences and beliefs which may influence our mood and behaviour throughout adulthood. Important also are the responses from the environment that result from these behaviours and may also sustain problematic beliefs. It is also important to consider that, while we are increasingly finding genetic contributors to mental health disorders, these form one risk factor among many. Psychosocial and environmental factors may contribute equally or more to the risk of developing mental health problems. Both genes and environment moderate risk, but do not directly 'cause' mental health disorders.

CLASSROOM ACTIVITIES

Potential discussion topics in small groups

- **Opposing small groups** argue the case for and against pharmacological and psychological treatment of a range of mental health problems; e.g. anxiety, depression and schizophrenia. Each group consider both the pros of their assigned intervention approach and the arguments against the other. So, those assigned to support pharmacological approaches, for example, identify both the benefits of this approach and the disbenefits of psychological approaches. Do the pros and cons vary according to the condition under exploration?

- **Small group discussion** of the various costs and benefits of treating an individual with an acute mental disturbance, and potential suicidal ideation, within the community (i.e. typically, their home). What are the risks and benefits? What are the implications for

families: guilt if there is a poor outcome, the effort of caring? Why *do* we want to stop people being admitted into hospital: cost, prevention of dependence on ‘medical’ support, etc?

- **Small group discussion** of the pros and cons of the formulation approach to the treatment of mental health problems, and who needs to employ it. Although it is *the* approach taken by all psychotherapists, it may not be necessary for those who prescribe medication. It is also prone to error for a range of reasons, including therapist competence, complexity, disclosure by those involved. It may also not be necessary. The standard intervention for many anxiety problems is known as exposure with response prevention – close to the systematic desensitization treatment for phobias which students should already be aware of. To do this, is it really necessary to have a full formulation of the person’s history, childhood, identification of early influences of anxiety, episodes of phobic response in the past and more? Can a simple ‘formulation-free’ approach be sufficient? If so, under what circumstances may a formulation become more relevant?