CHAPTER 1

Introduction

There are markedly different ways of conceptualizing mental illness in contemporary society, as sociological reviews such as Pilgrim (1997) and Pilgrim and Rogers (1999) indicate. This is reflected in the wide range of terminologies used when referring to psychopathology in academic disciplines and clinical practice. These differing conceptualizations and frameworks for understanding the nature, cause and cure of disturbing experiences are reflected in the various models of psychopathology which we outline in this book.

We begin by overviewing the main models of psychopathology, which can be listed as:

1. The Lay Model;
2. The Legal Model;
3. The Psychiatric Model;
4. Psychological Models: Psychoanalytic, Behavioural, Cognitive, Cognitive-Behavioural, Humanistic, and Socio-cultural; and
5. Sociological Models: Social causation, Social constructivism (labelling theory), and Critical Theory.

Such a wide range of views highlights the controversy surrounding the field of mental illness. As von Bertalanffy writes: ‘All scientific constructs are models representing certain aspects or perspectives of reality. This even applies to theoretical physics: far from being a metaphysical presentation of ultimate reality (as the materialism of the past proclaimed and modern positivism implies) it is but one of those models and, as recent developments show, neither exhaustive nor unique’ (1987: 62).
2 Models of Psychopathology

Normality and abnormality

Psychology is a wide and eclectic discipline mainly concerned with ‘normal’ conduct and experience, although concepts of abnormality are considered. Buss (1966) suggests that psychologists have put forward four conceptions of normality/abnormality:

- The statistical concept;
- the concept of an ideal;
- the concept of specific behaviour; and
- the concept of distorted cognitions.

Neither the different models of psychopathology nor the therapies derived from them fall into clear distinct categories, whereby each can be compared readily with the others. Rather there are points of convergence, divergence, and interweaving. This leads to several ambiguities in trying to categorize and clearly delineate concepts of psychopathology. This interweaving can be seen in the following examples.

A. Some models of psychopathology use diagnostic criteria and descriptions based on the psychiatric model. For example, this influence is very clear in the use of psychiatric nosologies within psychoanalysis, as basically the psychoanalytical model uses the same language as the medical model. Clients are often called ‘patients’ and presenting problems ‘symptoms’, while ‘inner life’ is usually called ‘psychopathology’.

B. Exploratory therapies, such as psychodynamic and humanistic therapies, in some respects have a similarity with the professional style of both psychiatry and the less exploratory versions of the psychological model, such as cognitive therapy. Although these take an interest in what the patient is saying, they essentially consider this as information with which to build up an expert formulation. The psychiatrist relies wholly on symptoms – what the patient says – in order to make a decision about a diagnosis and to prescribe treatment. The cognitive therapist builds up a picture of the patient’s cognitions and a functional understanding of their role in their life. However, when this leads to the person reconstructing some aspect of their life there is clearly a similarity with the therapeutic practices of exploratory psychotherapy. Some have argued (e.g. Bannister 1983) that even a prescriptive behavioural technique such as systematic desensitization is simply one way amongst many in which people come to a subjective reconstruction.
C. Exploratory versions of the psychological model differ from both ordinary conversations and from the prescriptive or structured interviews conducted by many psychiatrists and cognitive-behaviourists. Foucault (1981) discusses the similarities between psychoanalysis and the Catholic confessional. As with the confessional there is disciplinary power – or professional dominance. Although the therapist may control the setting, the patient cannot. The expert retains control of the interpretive framework in the conversation. For example a patient turning up late or not at all is often interpreted as some form of resistance to personal change. The narrative of the client always operates within the therapist’s framework and thus, a power asymmetry remains inevitable (Spence 1982). Hayley (1963) discusses the processes of power in clinical psychoanalysis. However, as we shall see when addressing issues related to power later, this issue does not disappear simply because the orientation is Rogerian or any other humanistic therapy.

The lay model

Throughout history and in every culture there is some idea of psychological difference, although what these differences are varies. Even the terms used to describe difference are not identical. However, no culture is indifferent to those who are sad, frightened or unintelligible in their conduct (Horowitz 1983). For example, in Europe from the seventeenth to the twentieth century, such differences were attributed increasingly to medical ideas and less to religious ideas such as demonic possession. Some writers point out that this was the period that madness became ‘medicalized’ (Scull 1979).

Experts and non experts in the field of mental abnormality recognize madness when they come across it. We come across people whose conduct we find confusing or distressing or frightening to such a point that we call for expert help. If people act in ways that are unintelligible to others they are often dismissed using derisory terms such as ‘looney’. When we feel sad or anxious ourselves we might come to a point that we decide to go to the doctor for help. Sometimes this is framed as bad nerves or nervousness although these ideas prefigure concepts of neurosis and psychosis that warrant professional help. More recently the term ‘mental distress’ has been adopted by service users. However, this does not recognize the often distressing effect on others.
4 Models of Psychopathology

There is a degree of overlap between lay and psychiatric ideas of mental illness. For example, in categories such as anorexia, where there is uncertainty about the cause and the contribution of cultural factors, lay and psychiatric epistemologies are similar (Lees 1997). However, there are also differences between lay and professional perspectives. This is particularly the case with anti-social behaviour. Examples of this may be seen when lay people faced with unacceptable and abhorrent conduct are asked to evaluate the madness or badness in such behaviour. This is evident in murder trials, such as that of Peter Sutcliffe (the Yorkshire Ripper), whose defence was that he was on a mission from God. Jurors dismissed his excuse of mental illness, despite the view of expert witnesses for both defence and prosecution that he was schizophrenic.

There is a mixed lay view about mental abnormality and anti-social conduct. Rosen (1968) points out that in ancient Rome and Athens madness was defined in pre-psychiatric terms by two main features – aimless wandering and violence. A study carried out by Westermeyer and Kroll (1978) in Laos, which at the time had no mental health professionals, explored villagers’ perceptions of ‘baa’ people. These were people who in Western eyes would generally be termed mentally ill. They found that ‘baa’ people were judged to be violent in 11 per cent of cases before their change of character, but this went up to 54 per cent after ‘baa’ was identified.

The lay view tends to exaggerate the link between violence and schizophrenia. In the US studies indicate that the public has mixed views about the association of mental disorder and violence. A study carried out by the Feld Institute (1984) showed that 61 per cent agreed with a statement indicating that a person diagnosed as schizophrenic was more likely to commit a violent crime than a normal person. However, another survey (DYG Corporation 1990) found that only 24 per cent thought that mentally ill people were more violent, while 45 per cent of the sample thought that mentally ill people were less violent than others. In Britain studies have also pointed to a mixed lay view of a link between violence and mental disorder which is dependent on a complex relationship between personal experience, beliefs and media messages (Philo et al. 1996).

The legal model

The legal framework is relevant to considerations of psychopathology as it defines the terms and conditions under which mental health
professionals can and cannot detain patients and compulsorily treat them.

In the nineteenth century, psychiatry was greatly influenced by eugenics – it was assumed that a variety of deviant conducts could be explained by a tainted gene pool in the lower orders of society. This degeneracy theory, which characterized early biological psychiatry, lumped together the mad, bad and the dim. However, during and after the First World War this framework was challenged. For example, in the forensic field, eugenic ideas of degeneracy, which accounted for criminality in terms of an inherited disposition to bad conduct (Forsythe 1990), were replaced by an increasing interest in environmental or psychological explanations for lawbreaking. Since that time, psychiatric experts have played a major role in identifying and explaining human conduct.

In Britain the law has a definition of mental disorder, which includes four separate conditions: mental illness, mental impairment, severe mental impairment and psychopathic disorder. The first of these is not defined; the second and third refer to those with learning difficulties who are in addition deemed to be dangerous; the fourth refers to anti-social individuals who are ‘abnormally aggressive’ or who manifest ‘serious irresponsible conduct’.

The legal framework leans on psychiatric opinion in two ways. First, because of the absence of precise legal definitions of mental illness, it accepts tautologically that mental illness in a legal sense is the same as psychiatry defines it to be. However, when there is some doubt, the lay view of madness is also taken into consideration by the legal framework. The second way is when certain cases are tried in court, psychiatric opinion is offered as the expert view on the presence or absence of any of the four legal categories. The legal framework accepts that certain forms of badness can be a medical condition. This condition allows offenders the defence of mental disorder and thus absolves them from personal responsibility – although this does not mean that the person will be treated benignly as medically ill. The opposite also holds true – that some are diagnosed as mentally impaired in some way by experts, and legal considerations are given to this view, even if the lay perspective views the person as quite sane and responsible for his/her actions (for example in the case of Ernest Saunders 1990).

As mental illness is not legally defined, judges have sometimes used the lay perspective. For example, in 1974, Judge Lawton commented that the term ‘mental illness’ involves ‘ordinary words of the English language. They have no particular medical significance.’ Judge
Lawton referred to the words of Lord Reid in a case when the defendant’s mental state was being considered. He commented: ‘I ask myself what would the ordinary sensible person have said about the patient’s condition in this case if he had been informed of his behaviour? In my judgment such a person would have said “Well the fellow is obviously mentally ill”’ (cited in Jones 1991: 15). This lay conception of legal insanity has been called ‘the-man-must-be-mad’ test (Hoggett 1990).

Thus in one way the legal framework accepts a psychiatric model, but when this model is found lacking in some respect then the definitions of ordinary lay language are included in the legal framework. This raises issues such as whether madness is for legal and lay purposes a matter of incomprehensible conduct. ‘Normal’ bad, anti-social or criminal acts are goal directed whereas ‘mentally disordered’ criminal acts are not directed towards a clear material gain.

In practice, there are two major ambiguities about such a simple legal distinction. First, sex offenders may end up either in prison or in secure psychiatric units, illustrating the confusion in how the legal system judges the motive of sexual gratification. Second, as we have already pointed out, some murderers (for example, Sutcliffe and Neilson) are judged within the lay language of common sense, to be sane, despite the opposite view of expert witnesses. If the legal framework relies on a lay perspective through the jury system to decide the presence or absence of mental abnormality, then the ambivalence we have discussed is likely to be seen in their decisions. Lay people may view on the one hand that a person must be ‘sick’ or ‘mad’ to commit dreadful deeds and yet view that such actions deserve the severest of punishments.

Despite the lack of a definition of mental illness in the legal framework, it nevertheless accepts the concept of ‘mental disorder’. However, these categories are still open to debate and dispute regarding their basis for diagnosis in specific cases. Also the legal framework delegates the power of identification of mental abnormality to psychiatry, implying acceptance of the psychiatric model. However, the dominant medical considerations at the beginning of the legal process then diminish. For instance, when an abnormal offender is considered for release or ‘discharge’ from an institution, non-medical people then take part in the decision – lay people and lawyers are members of Mental Health Review Tribunals and take part in the judgements made.
Psychological models

In an overview Buss (1966) outlines three main psychological concepts of normality-abnormality. These are:

1. The statistical concept – for example objective and empirical models, the cognitive-behavioural model;
2. The concept of an ideal – for example the humanistic model;
3. The specific behaviour concept – for example the behavioural model.

The statistical concept

The statistical view holds that frequently occurring behaviours in a population are normal, and thus infrequently occurring behaviours are not normal. This is similar to ‘norms’ in sociology. For example if we observe the speed at which a person walks – a certain pace would be considered normal. Above this speed, a person might be considered to be anxious, while below it the person might be considered depressed. Most people walk at a rate between the upper and lower limits of this frequency distribution.

However, questions arise, such as who decides on the cut-off points at each end of the distribution and how are such decisions made? Thus frequency of a behaviour in itself does not inform us when a certain behaviour is to be judged abnormal, as value judgements have to be made as to where the cut-off points should be between normality and abnormality. Further, a statistical model may not be valid across cultures – even within the same country. For example, walking slowly may be the norm in a country village, while walking quickly is the norm in a busy city.

In themselves statistical concepts do not inform us why some deviations from the norm are only noted when they are apparent in one direction rather than bi-directional. The example of walking refers to a bi-directional judgement: fast or slow. However, regarding other concepts such as intelligence, negative judgements are only made when outside the norm in one direction. While being ‘bright’ is valued and will not, without other considerations, lead to being put into the patient role, being ‘dim’ may well do so.

The statistical approach within the field of abnormal psychology remains influential. Psychologists are taught the parameters of normality and abnormality through the statistical approach, which
stresses that characteristics in any population follow a normal distribution. The acceptance of a normal distribution implies that there are underlying assumptions in psychological models of a continuous relationship between the normal and abnormal. However the idea of continuity in one variable does not mean that ipso facto there is continuity between other variables. For example, in Eysenck’s personality theory (Eysenck 1955), although both neurosis and psychosis follow a normal distribution curve, they are considered to be separate from each other.

The ‘ideal’ concept of normality

Concepts regarding an ideal for human development are implicit in humanistic and psychoanalytical models. In psychoanalysis, normality is defined when the individual’s conscious characteristics dominate over unconscious characteristics (Kubie 1954). In the humanistic model, the ideal person is one who fulfils their human potential or ‘self actualizes’. Jahoda (1958) outlines six criteria for positive mental health:

1. Balance of psychic forces;
2. Self-actualization;
3. Resistance to stress;
4. Autonomy;
5. Competence;

Each of these criteria is problematic. The first two only have meaning within frames of reference that concur with the humanistic and psychoanalytical models. The third, resistance to stress, does not address issues such as its appropriateness. There are some situations where anxiety is normal and adaptive. Further, lack of anxiety under high stress conditions has been one of the defining characteristics of ‘primary psychopathy’ in the psychiatric model. Similarly, people who tend to avoid human contact, or who are extremely autonomous, may be classified as ‘schizoid’ or suffering from ‘simple schizophrenia’. Competence is a highly variable characteristic, its norms differing according to time and place. Perception of reality has the same problem of inconsistency in definition. For example, in some cultures the ability to see visions and hear voices is esteemed, whereas in other cultures such phenomena would be appraised negatively,
and taken as evidence that the person does not share accepted reality.

Specific behaviours

The development of psychology as a scientific academic discipline has been associated with its focus on specific, objective aspects of conduct and on characteristics that are readily amenable to empirical measurement. Academic psychology separated from philosophy, of which it originally formed a part, on the basis of these objective considerations. The theory of behaviourism tried to restrict the area of concern of psychology to behaviour, and so dismiss subjective experience as unsuitable for scientific enquiry. Although this view no longer dominates psychology, it remains influential. Thus psychologists have tried to operationalize in behavioural terms what is meant by abnormality. Terms such as ‘maladaptive’, ‘unwanted’, ‘unacceptable’ behaviour are used generally within most psychological models. The advantage of this perspective is that it is explicit in defining abnormality. However, its weakness is that values and norms are left implicit and rarely questioned. The concept of specific behaviour still does not answer questions about who decides what is wanted or acceptable, and what happens when some people find certain behaviours desirable and acceptable and others do not. As we discuss later when considering the socio-cultural model, many theorists point out that it is those holding more influence or power in society who define what is acceptable reality. Hence, what is deemed unwanted or maladaptive behaviour does not have the status of objective fact but rather is socially negotiated. Conceptualizations of psychopathology are relative, reflecting the value system and power relationships of a particular culture at a particular time.

Scientific perspectives

The different models of psychopathology also reflect assumptions regarding the nature of scientific enquiry. D’Andrade (1986) distinguishes three forms of science: physical, natural and semiotic (systems of meaning). These distinctions are reflected in different academic disciplines:

1. Physical science: for example physics, chemistry, astronomy and related engineering sciences;
2. Natural science: for example biology, geology, oceanography, meteorology, economics, psychology, anthropology and sociology;
3. Semiotic science: for example anthropology, linguistics, psychology and sociology.

Some disciplines such as psychology and sociology occur in both the second and third categories, since there are divergent views about what constitutes legitimate knowledge, and which methods are considered valid to produce such knowledge.

There is an underlying assumption in the first group, physical science, that legitimate knowledge results from studying the lawful relationships that exist in the world. This view of science is characterized by description, explanation and prediction. It also assumes a consensus of empirical description, carried out by independent observers, which is potentially repeatable and falsifiable and so contributes to the production of objective knowledge. Reality is considered to exist independently of its observers. It is also assumed that the findings of scientific knowledge are generalizable from one situation to another.

Most of these assumptions are also found in natural science. However there are two major differences. First, prediction is recognized to be more elusive; nevertheless it is attempted. This is because naturally occurring phenomena such as the life of organisms are open, not closed systems. The second major difference concerns generalizability. Natural events are assumed to be limited to time and place, that is, they are context-specific. However, this group of disciplines still treats the focus of their enquiry as being like a machine that is to be understood. This mechanistic view of the world entails the assumption of determinism, as it attempts to understand causal relationships, and the methodology of this group is concerned with testing hypotheses, and with quantifying or measuring differences between experimental groups or naturally occurring phenomena.

There is a major difference between the underlying assumptions of the above two groups and those underlying semiotic science. In these disciplines, claims to knowledge still involve descriptions, but explanations are considered to be tentative and predictions are almost abandoned. Whereas disciplines in the physical and natural sciences view objectivity as their goal, in semiotic science there is recognition that any understanding of human life entails the understanding of meanings that are imposed or negotiated intersubjectively. Consequently science and its focus of enquiry – that is human life – entails the exploration of meaning. This involves the production and justification of
interpretations, but if generalizations are made at all they are made tentatively. Whereas the disciplines in the first two sciences explore causes, in semiotic science the nature of enquiry explores understanding. Its enquiry is not based on hypotheses testing but upon interpretation, that is it is an inductive rather than a deductive approach.

This conceptual separation of natural from semiotic science was made in the late nineteenth century by Dilthey (1976) who highlighted the differing assumptions underlying the natural and social or cultural sciences. The phenomena to be investigated in cultural sciences require a different methodology from that used in the natural sciences. This idea of understanding in interpretive social science was also highlighted by Max Weber in sociology, and within psychiatry by Karl Jaspers.

In practice, disciplines studying society and human conduct do not neatly fall into semiotic science. For example, psychology uses forms of enquiry that range from physiology to sociology. Thus, as Smart points out, the human sciences cannot be located as belonging in any neat categorization or epistemological arrangement:

The indeterminate character of the epistemological form of the human sciences leaves a number of methodological and analytical questions and options open. It effectively leaves the human sciences free, or relatively so, to pursue a range of methodological and analytical possibilities, but in addition it means that from the beginning these sciences are in difficulty, are necessarily precarious and uncertain as sciences. (1990: 401)

Smart emphasizes the ‘range of methodological and analytical possibilities’ for human sciences. In practice such a range has tended to encourage a search for the security of simple answers instead of consideration of the complexities. The search for simple answers can result in reductionism, seen for example in the theory and practice of behaviourism and behaviour therapy.

Social science, such as anthropology, psychology and sociology, spreads across the boundaries of the natural and semiotic sciences. Within each discipline there are differing assumptions about what constitutes science. Thus within social psychology there is both experimental social psychology which is natural science activity, and discourse analysis which is semiotic science activity. Understanding and insights from either of these views of psychology may inform the work of clinicians.

The difference between an approach to science based on
explanation and understanding or interpretation is relevant to the differing views of psychopathology. In this book we refer to these underlying scientific assumptions as they apply to the main models of psychopathology. Our aim is not to reach any firm conclusions about such issues but rather to outline the differing perspectives and conceptualizations of the main models of psychopathology. The whole field of psychopathology is highly debated and there are no absolute criteria that experts can agree on regarding how we view, define and deal with psychopathology. Terms such as mental disorder, mental illness, maladaptive or unacceptable behaviour, or just crazy do not simply have a singly discrete entity to which they all refer.

Although when exploring the various models, there are differences in terminology, there are also fundamental conceptual differences between the models. Each reflects one perception of reality and ignores other aspects. In this way they might be viewed as a fragmented set of perspectives, divided internally and between each other, although at times partly overlapping, with any attempt at integration reflecting yet another model. However, all the models and perspectives on psychopathology that we consider in this book share one characteristic. None of them has been able to conceptualize psychopathology in a way that is universally constant and invariable.

**Developmental aspects**

During the process of socialization the child learns how to become an accepted member of society. Part of this process involves learning social norms and acquiring the appropriate ways of controlling and expressing emotion. Both these factors are relevant because the field of mental health implicates distressed experiences and distressing conduct on the one hand and deviance from norms on the other.

Freudianism has influenced a variety of social theories. Psychoanalysis offers a theory that links the individual’s inner life to the external social context. It provides an account of the emotional life of individuals while at the same time offering an explanation of how mental ill health is determined by society (Jacoby 1975; Holland 1978; Craib 1989).

For Freud, civilization puts limits on the free expression and experience of emotions, especially the instincts of sexual desire and murderous aggression. These limits lead to the need in the child to repress anti-social feeling and behaviour in exchange for family and societal acceptance. The battle between emotions and social conformity leads
to the development of neurosis. However, Freudianism provides a partial social theory, since Freud’s emphasis is on civilization (Freud 1930) leading to repression and neurosis. Accordingly, we are all to some extent neurotic for more or less the same reasons, balancing our instinctual needs with the constraints of reality. Differences between social groups are thus not addressed systematically by Freud’s theory, although later analytically-oriented writers have explored women’s issues (Mitchell 1974; Eichenbaum and Orbach 1982).

Freud offers an explanation for neurotic behaviour arising from anxiety. Later psychoanalysts have also tried to address other issues such as depression (Bowlby 1969/1982, 1973, 1980) and psychosis (Winnicott 1958, 1965; and Laing 1960, 1966, 1967), by looking at the impact of poor care and separation on the infant (from birth to two years). However, as an example of the divergent views within psychoanalysis, the influential work of Melanie Klein (1932) is distinctive because it focuses more on the pathogenic impact of the infant’s inborn aggression rather than the quality of nurturing. Whereas Klein attributes mental ill health as due to instinctual tendencies, Bowlby, Winnicott and Laing are environmentally oriented, emphasizing parental influences, especially that of the mother or primary care giver.

Thus various psychoanalytical accounts consider a general social context (‘civilization’) to emotional development, and the nuclear family then becomes its main frame of sociological reference. Mainstream psychoanalysis tends to play down or ignore variables other than the family, such as the particular stresses associated with class, race and gender. It also ignores the potentially powerful role of extrafamilial social institutions, such as the school, in shaping the child’s identity and emotional life. The psychoanalysts who have looked into these wider areas of theorizing have tended to leave or be rejected by their own professional culture (Reich 1942; Laing 1967; Masson 1990). Psychoanalysis also assumes family relationships that are triangular, or oedipal, that is based on a set of tensions which engender anxiety, created by children relating to a mother and a father. However, in many modern complex societies, children grow up in different family constellations, for example with single or homosexual parents (Miller and Rose 1988).

There is a consensus across many theoretical positions in both sociology and psychology that childhood is a special part of the lifespan. Through the process of socialization, children learn to behave in socially appropriate ways and acquire a confident sense of identity. It is a time when most of the rules and mores associated with the specific socio-cultural context of a child are learned. It is also a time when
gender specific conduct is acquired. The child learns what is expected of him/her both at their current age and in the future, through their exposure to adult models of conduct. They learn gradually to control their body and their emotions in order to perform competently and efficiently in the presence of others. The strong emotional expressions tolerated in childhood become less and less acceptable as the person matures into adulthood. Consequently if an adult becomes more exuberant or sad than is deemed appropriate for the context by others, they may acquire the label of ‘manic-depressive’ (Dreitzel 1973). Children learn the importance of a shared view of reality with their fellows in gaining security and in meriting credibility. All these learned capacities and adherence to societal norms and rules are also bound up with an increasingly elaborate and defined sense of identity. By young adulthood those acting incompetently, immorally or irrationally will be designated by others to be either bad or sick or mad.

Generally, mental illness can be understood as a particular form of difference or ‘deviancy’ that is not characterized by malice aforethought or motivated by personal gain or gratification, as is the case in criminal behaviour. Part of our expectation of normality is that people will be competent in their social role and their actions intelligible to others. Thus if a person is so fearful or sad that their competence breaks down or acts in ways that we do not understand, such as talking to voices that no one else can hear, we may account for this in terms of mental ill health. Thus mental illness might be understood from a social perspective as failed or incomplete socialization. This perspective is reinforced by the emphasis given by different psychological models on the effect of childhood experience on later life. Most psychologists and psychiatrists assume that problems in childhood make the person susceptible to later mental health problems. Likewise, sociological models of depression in adulthood emphasize developmental vulnerability factors as well as current stressors (Brown and Harris 1978).

These are important issues that need to be considered in all the different psychological models of psychopathology. We begin by describing the psychiatric and biological models. We then consider different psychoanalytical models, before outlining the behavioural and cognitive behavioural models, where psychopathology assumes an equally important place, even if explanations of mental health and illness are different. From there we move to that set of models known as humanistic, where it may appear that psychopathology is eschewed as not fitting the view of the person as self-actualizing. Finally we describe sociological and socio-cultural viewpoints, that psychopathology is as much about society’s views as it is about any fine scientific distinctions.