The origins and expression of psychological distress

Iain Ryrie and Ian Norman

Chapter overview

The origins and expression of psychological distress arise from the broad spectrum of conscious and unconscious mental activity that we might refer to simply as human experience. Psychological distress, to some degree at least, is necessary for people to function. Without it we may find ourselves in situations that threaten our lives, but which we are unable to do anything about because we fail to register the distress that such situations should engender. There is a point, though, at which the experience of psychological distress can become the experience of disorder (or illness) and it is these shades of the spectrum that we explore in this opening chapter. Of course, where the boundary is drawn or which shades of human experience constitute disorder is open to debate. We do not draw conclusions in this respect but encourage the reader to consider an integrated explanation of human experience, and thus, of mental disorders. Different models or ways of understanding psychological distress and disorder are therefore described both as singular explanations but also as building blocks for a more integrated view of these phenomena. Systems that classify disordered experiences are presented, and the prevalence and symptoms of key disorders are described. The chapter also includes service-user perspectives on the systems currently employed to classify their human experience.

In summary this chapter covers:

- models of mental disorder;
- integrating models of mental disorder;
- the classification of mental disorder;
- incidence of mental disorder and key symptoms;
- user perspectives.
Experiencing ‘mental health’ or having a ‘mental illness’ may appear as two distinct, separate states of being. Such dualistic thought may also appear advantageous. The boundary it represents provides a point of exclusion beyond which we can place our fears of the unknown. ‘Madness’ becomes distinct from ‘sanity’, and for the majority, ‘madness’ is not within ‘us’ but belongs to ‘them’. This seems a comforting position to pursue, but is human experience quite so linear?

‘Mental health’ is in fact inseparable from ‘mental illness’. They do not exist independently of one another, in the same way as night can only be understood in relation to day, black to white, up to down, happy to sad, and of course, back to front. These pairs of opposites each describe the same phenomenon of interest but do so from different perspectives, which is the very antithesis of a boundary that distinguishes two separate entities. ‘Mental health’ and ‘mental illness’ are terms of relation, not of reality, and the reality they describe is human experience.

We begin this text with such a cautionary note since the history of mental illness is a history of exclusion, separation, distinction and ‘otherness’ (Tudor 1996). What we present in the following pages are the approaches different schools have taken to explaining the aetiology of mental disorder. We examine also a number of treatment implications for each of the models. However, this should not be viewed as a definitive account of the terrain within which mental health nursing operates. Professional interest should necessarily incorporate mental health or ‘well-being’, and for this reason we recommend this chapter is read in conjunction with Tudor’s chapter on health promotion (Chapter 2).

So, as we describe different models, or ways of understanding mental disorder, it is important to beware of the artificial boundaries such distinctions draw. To identify professionally with only these shades of the spectrum of human experience is to miss something vital about the human condition. If as nurses we focus only on disorder and illness, what chance is there to promote the mental health of those who endeavour to live a fulfilling life in spite of an illness or disorder?

The disease model

Before examining the disease model it is necessary to deal with the general meaning attributed to disease. Kendall (1975) has reviewed disease definitions in psychiatry, which range from the purely subjective (for example, personal suffering) to the purely objective (for example, the presence of an identifiable pathogen). This latter interpretation tends to predominate and is defined by Scadding (1967) as the presence of abnormal phenomena displayed by a group within a species, that sets the group apart from its species in so far as the disease places them at a biological disadvantage. In lay terms, a disease is only present if it harms the
individual or reduces his or her capacity to reproduce (Tyrer and Steinberg 1998).

We may all feel comfortable with the idea of physical disease, such as a cancer, a damaged heart valve, or a pathogen that can be transmitted between people. We can probably also agree that these conditions do, more or less, place individuals at some sort of disadvantage. Disease theorists similarly attribute mental disorders, or psychiatric illnesses, to physiological and chemical changes in the individual, particularly in the brain but also in other parts of the body (Tyrer and Steinberg 1998).

Thus we can understand clearly the basis for disorders of perception and cognition among, say, people with dementia or those who have suffered brain injuries. Observable physiological changes in brain structure have correlates in human behaviour. The disease model extends beyond these organic conditions to explain disorders such as depression, which can be attributed to changes in serotonin levels or to some other chemical fluctuation. Similarly, schizophrenia can be attributed to chemical abnormalities, and more recently to physiological differences such as the size of the temporal lobe in the human brain (Gournay 1996).

The disease model, following traditional medicine, endeavours to identify through scientific objectivity the presence of a stable phenomenon that we call ‘mental illness’. Clinical syndromes become refined into diagnoses, which are essentially codes for heterogeneous, and often unstable collections of symptoms (Craig 2000). Objectivity in psychiatry is at best quite ‘fuzzy’, but remains the gold standard. Such a gold standard affords incredible power to its possessor. Clinical syndromes and diagnoses are codified languages, available only to those who have willingly immersed themselves in that particular paradigm. They can provide an efficient means to communicate complex phenomena, but only to those in the know.

The treatment armoury of the disease theorist is also elitist, being available only to the qualified practitioner. Medicines are prescribed to balance chemical imbalances, electroconvulsive therapy is administered to shunt neural pathways into shape, positron emission tomography may be requested to check those temporal lobes and, in the most extreme of cases, pieces of the brain may be removed.

A consistent criticism of the disease model is the possibility that people with mental disorders can become passive recipients of treatment and the nurse or doctor an authority on the person’s experience. However, this is not a consequence of the disease model per se, but reflects something of the way in which practitioners apply their knowledge. Passive receipt of care can accompany any model if practitioners fail to speak to people as people, but instead believe they are dealing with symptoms, syndromes or a collection of behavioural problems. We see no reason why the disease model cannot take account of the person behind the symptoms or syndrome, and indeed in our experience this has largely been the case, though not always so.

Some commentators have questioned the validity of associations between human physiology, brain chemistry and mental disorder. In fact there are both weak and strong arguments of this type. The ‘strong’ camp
rejects outright any attempt to reduce human experience to physiological and chemical structures, and tends therefore to reject the disease model. In contrast, the ‘weak’ camp acknowledges the contribution of the physical sciences to our understanding of mental disorder but maintains that they are insufficient to explain adequately the phenomenon of interest. For example, some people with schizophrenia do appear to have ventricular enlargement, but others do not (Van Horne and McManus 1992).

The case for and against a physiological ‘disease’ explanation for mental disorders has been rehearsed in the academic literature (cf. Gournay 1996; Dawson 1997, 1998; Provencher et al. 1997; Barker et al. 1998; Keen 1999; Burnard and Hannigan 2000, Wilkin 2001). We refer readers to these to draw their own conclusions.

The psychodynamic model

The psychodynamic model is more accurately described as a style of human interaction and understanding that draws on a broad philosophy, which includes clinical, biological and evolutionary theory as well as religion and the arts (Tyrer and Steinberg 1998). Psychodynamic practice may conjure an image of the psychoanalyst listening to their patient’s stream of consciousness as the patient lies on a couch at their side. This may occur but the psychodynamic model has many branches including some forms of family therapy, group therapies and art therapy (Tyrer and Steinberg 1998).

Common to all psychodynamic approaches, which delineates them from other psychotherapeutic perspectives (for example, behaviour therapy), is their primary focus on the ideas and feelings behind the words and actions that constitute human behaviour. Psychiatric disorders are not viewed as illnesses with disease-based aetiologies but as conflicts between different levels of mental functioning. Of critical importance here are the conscious and unconscious levels. Substantial amounts of mental activity that occur beyond our awareness are believed to determine much of our behaviour.

Human development is important in this respect since a person’s early experiences can produce a particular gestalt or view of the person and their world, which they will take with them into adult life. This gestalt will include mental tricks and mechanisms to protect the person’s sense of self. Problems may arise if our gestalt, that we necessarily cling to, is at odds with the real circumstances we find ourselves in as adults.

Let us take the simple example of a man whose childhood was coloured by restraint, control, uncertainty and occasional pleasure. Then as an adult he works hard to please others, to demonstrate control and restraint in the expectation that doing for others will bring occasional pleasure. If this man was a priest then we may feel his gestalt fits his real circumstances. But suppose this man spent his life struggling to forge a career in marketing or merchant banking, or in the stock market to please his father? Though a simplistic example you may agree that conflict is likely to dominate this man’s experience. Conflict between his personal aspirations and the expectations of others. Conflict between his working alliances and the impossibility
of any harmony in such a work environment. Conflict between his relative failings as a merchant banker and his father’s exacting standards. He may not be conscious of these specific conflicts but will nevertheless be affected by them as unconscious mental activity tries to reconcile the irreconcilable. Quite literally, the psychodynamic therapist views psychological distress as the upshoots of unconscious thought (Tyrer and Steinberg 1998). This simple principle is central to most if not all psychodynamic therapies.

Different theories have been put forward within the psychodynamic tradition to explain different human experiences, but the founding father of the psychodynamic school was Sigmund Freud (1856–1939). Freud was a biological thinker interested primarily in an organism’s attraction to pleasure and repulsion from pain. Application of the pain/pleasure continuum to the human mind and its development led Freud to divide mental life into the id, ego and superego. The id represents our basic primitive instincts, present at birth, which tend toward the pursuit of pleasure or gratification. As we pursue gratification we become aware also of an external reality separate from ourselves and this realization necessitates the formulation of a self or ego. Others in our world have helped shape the external reality in terms of laws, rules and social expectations. This realization leads to the development of the superego, which is more easily understood as our conscience.

So we have needs (id), wishes (ego) and a conscience (superego) and, perhaps not surprisingly, psychological distress arises from the struggles that take place between them. Many of these struggles take place in the unconscious and Freudian analysts are concerned with healing the radical split between the conscious and unconscious, thereby creating a strong and healthy ego that is an accurate and acceptable self-image.

Freud’s contemporaries and his followers have built subsequently upon his work to elaborate the psychodynamic school. Carl Jung (1875–1961) studied under Freud, who designated Jung his successor and crown prince. However, after less than ten years of collaboration they fell out over theoretical disagreements and never spoke to each other again! While Freud had dedicated his work to the ego level of personal functioning, Jung was more inclined to examine transpersonal levels of human awareness. For Jung there were aspects of a person that appeared to transcend or go beyond the person, and this premise was incomprehensible to Freud, whose work had been confined to the realms of the ego or self.

Jung had studied the great mythologies of the world, particularly their totems, ancient symbols, images and mythological motifs. What he discovered was that these images appeared with some regularity in the dreams and fantasies of modern Europeans, the majority of whom had never been exposed to these myths. His basic premise was that these primordial images, or archetypes as he called them, are common to all people. They do not belong to single individuals but are in fact transindividual or transcendent of the self.

Jung called this deep layer of the psyche, in which the archetypes reside, the ‘collective unconscious’. Notice this is not individual consciousness
but is something that resides deep within us all. According to Jung these archetypes live on, whether we are aware of them or not, and continue to move us deeply in creative but also destructive ways. As an example, Jungian therapists are interested in people’s key dreams and understanding the symbolism within them with recourse to ancient mythology. Knowing what mythological images have meant over time to the human race as a whole enables people to understand what the images may mean in their experience of the *collective unconscious*. It follows that through such conscious integration people are no longer forcibly moved by unconscious archetypes. Therefore, though related to Freud’s ideas, Jung extended them beyond the organism to the cultural context within which the organism lives and used this context (or collective unconscious) to understand the psychic distress encountered by people.

Melanie Klein (1882–1960) is another key psychodynamic theorist whose work focused on the first two to three months of a child’s life at a time when she believed the ego struggles to differentiate between itself and external reality. Unable to comprehend that good and bad can be present in the same object the infant assumes the *paranoid position* in which all things are either good or bad but never both. When able to comprehend that these qualities do exist in a single object (for example both the mother’s love and her chastisement) the infant experiences this new discovery and moves to the *depressive position*. Therefore in Kleinian terms the experience and acceptance of depression is considered a maturational step necessary for personal growth (Tyrer and Steinberg 1998).

The influence of these early works on more contemporary psychodynamic therapies such as ‘humanistic therapy’, ‘drama therapy’, ‘art therapy’ and some forms of counselling is without doubt (Tyrer and Steinberg 1998). Equally, the psychodynamic tradition has influenced mental health nursing, particularly through the works of Hildegard Peplau and Annie Altschul (cf. Chapter 3; see also annotated bibliography).

**The behavioural model**

The behavioural model has a scientific basis in Learning Theory. Symptoms are considered to be learned habits arising from the interaction between external events or stressors and an individual’s personality. Persistent, distressing symptoms are considered maladaptive responses rather than being markers for some underlying disease or illness. For the behaviour therapist the symptoms and their associated behaviours *are* the disorder (Tyrer and Steinberg 1998).

Learning theory posits that two forms of conditioning are responsible for the formation of symptoms; *classical* and *operant*. Classical conditioning refers to a neutral stimulus that becomes associated with an unrelated but established stimulus response sequence. Seminal experimental work in this area was conducted by the Russian physiologist Pavlov (1927) who conditioned dogs to salivate in response to a bell rather than to the established stimulus of food. Initially food was provided to the animals when a bell
sounded. After several such trials the animals would salivate at the sound of the bell even when unaccompanied by food.

Operant conditioning results from behaviour rather than as the consequence of a stimulus. Skinner (1972) conducted seminal work in this field with a box in which one or more levers could be pressed. Rats would be placed in the box and through natural curiosity they would eventually press one or all of the levers. When the appropriate lever was pressed food would be deposited in the box. Gradually the rats would learn to continually press the appropriate lever until their appetites were satisfied. Thus it is not a neutral stimulus or the manipulation of an experimenter that conditioned the rats, but their own behaviour.

But how do these theories relate to the development of human behavioural problems? Take a simple example involving a phobia or fear of spiders in a parent of a family with children. When the parent encounters a spider their response may be at odds with the threat that a spider poses. They may appear to panic, perhaps scream and will certainly try to avoid the spider. It is possible that the children in this family will also develop a similar response since they have been subject to the classical conditioning of the parent. Thus they may learn to fear and avoid spiders, which can become self-perpetuating as their fear confirms the danger spiders pose, and their avoidance obviates any opportunity to realize that spiders pose no threat.

The behaviour therapist is interested in replacing maladaptive responses with adaptive behaviour patterns. This is usually done by gradually removing the fear response through such techniques as graded exposure and systematic desensitization. So the parent in our example may first be encouraged to imagine spiders, then view pictures of them in a book, followed by seeing them in a jar across the room, then holding the jar and finally holding the spider. Each of these stages will invoke a fear response but these will gradually subside if the person is encouraged to remain with the present situation through which they learn that spiders are actually quite harmless.

An important principle of behaviour therapy is a collaborative working partnership between client and therapist. A person’s behaviour is part of their own responsibility and not something that can be handed over to a doctor to sort out (Tyrer and Steinberg 1998). The therapist does not view the person as being abnormal or ill, but regards them as an equal partner in an unlearning, or new learning process. Furthermore, behaviour therapists see this partnership as critical if the individual is to maintain and develop their new adaptive behaviours once therapy has finished.

This approach to managing human behaviour has had a major influence on mental health nursing, for example, through the work of Isaac Marks (Marks et al. 1978; Marks 1987) who, though not a nurse, has championed nurse behaviour therapists. Their contribution to health care has been evaluated by Gournay et al. (2000) and is described by Rogers et al. in Chapter 15.
The cognitive model

Put simply, the cognitive model posits that people interpret their thoughts, which in turn are the main determinants of behaviour (Tyrer and Steinberg 1998). This stands in sharp contrast to the behavioural or disease models, which do not accommodate the cognitive mechanisms involved in behaviour and illness. For the cognitive therapist primacy is given to errors or biases in thinking and it is these dysfunctional thought patterns that create mental disorders.

An important framework used by many cognitive therapists is the ABC model first described by Ellis (1962). A stands for ‘activating event’, B stands for ‘beliefs’ about the ‘activating event’, and C stands for the emotional or behavioural ‘consequence’ that follows B, given A. Thus, a person who comes across a spider (activating event) may think it harmless or dangerous (beliefs) and will either continue their usual activity or be unable to do so (consequence).

While the behavioural model focuses on the fear response, or consequence in the above example, the crux of the problem according to the cognitive model rests in the beliefs that people hold. Repetitive thoughts (ruminations) can lead to persistent actions (rituals), which can prevent normal functioning. Significant change in a person’s mental health necessarily involves significant change in their cognitions (Tyrer and Steinberg 1998).

Though the reverse of the behavioural model, the two are rarely in major conflict. Open, collaborative working partnerships are established by respective therapists, and in the case of cognitive therapy, the client is encouraged to explore their thinking patterns and consider more appropriate and adaptive thoughts that fit the evidence. Furthermore, a growing discipline of cognitive behavioural therapy has emerged in recent decades (Trower et al. 1988; Hawton et al. 1989; Curwen et al. 2000). This trend is evident also in the practice of mental health nursing (cf. Chapters 10 and 25).

The cognitive model is the youngest of those described and it remains to be seen how it may develop and to what ends. Of contemporary interest, however, is the use of this model to manage distressing delusions, hallucinations and feelings of paranoia that people may experience in the course of a mental disorder (Kingdon and Turkington 1993; Chadwick et al. 1996).

The social model

The social model is concerned with the influence of social forces as the causes or precipitants of mental disorder. While the psychodynamic model is principally concerned with the individual and their personal relations, the social model focuses on the person in the context of their society as a whole (Tyrer and Steinberg 1998).

Evidence that social forces are central to the aetiology of mental disorder can be traced to the work of Emile Durkheim (1897) who
demonstrated that social factors, particularly isolation and the loss of social bonds, were predictive of suicide. We may be more familiar with associations between poor living circumstances in deprived geographical areas and the incidence of physical health problems (Whitehead 1992). However, this relationship holds also for mental disorders, perhaps because the associated deprivation is usually accompanied by unemployment, loss of social role and a subsequent sense of alienation from mainstream society (Hirsch 1988; Thornicroft 1991).

At the heart of this model is the premise that we are all prone to mental disturbance when unpleasant events strike us without warning. This fact led Holmes and Rahe (1967) to develop the Social Readjustment Rating Scale, which attributes a severity score to 42 life events according to the degree of change or adaptation they produce in people. Perhaps not surprisingly, bereavement, divorce and starting a new job are high on the list.

There is an intuitive appeal to the social model since we are all likely to have experienced major upheavals in our lives that may have caused us to feel psychological distress. Anxiety and low mood, for example, may be experienced in the run up to a series of exams or in response to the frustrations associated typically with moving house. The social model provides also a rationale for the origin of other types of psychological distress in which delusions, hallucinations and an apparent loss of contact with reality occur. For example, it is known that unexpected life events are associated with the onset of schizophrenia (Brown and Birley 1968). Furthermore, the levels of critical ‘expressed emotion’ experienced by a person with schizophrenia from family members is predictive of the severity of the person’s condition and, in particular, the likelihood of relapse (Falloon 1995).

Proponents of the social model do not have fixed ideas about what constitutes a psychiatric illness. Indeed, the model is concerned that labelling people with a psychiatric illness may create a disorder itself (Tyrer and Steinberg 1998). All symptoms and behaviour have to be understood in the context of the society from which they emanate. There are no independent, objective criteria for mental disorder according to the social model, only a boundary line between normal and abnormal that has been set by society.

Supporters of the social model aim to help people take up an acceptable role in society once more, rather than to correct a chemical imbalance or recondition specific behaviours (Tyrer and Steinberg 1998). This may involve social skills training (Liberman et al. 1993), some systemic family therapies (Barker 1981) and more general family interventions involving education on the influence of critical ‘expressed emotion’ (Brooker and Butterworth 1991; Lam et al. 1993; Falloon 1995). Gournay (1995) has reviewed the use of these interventions by mental health nurses.

The social model has experienced something of a renaissance in recent years with its basic premise reflected in Standard One of the NSF for Mental Health (DH 1999), which acknowledges that mental health problems can arise from the adverse effects of social exclusion. Subsequent work has been conducted through the Department of Health (2001) and the Sainsbury
Centre for Mental Health’s Citizenship and Community Programme (Bates 2002) to tackle these adverse effects. The former outlines a process that will enable groups and agencies to contribute to the promotion of public mental health. The latter is focused more specifically on strategies to make social inclusion a reality for people with severe mental health problems. The mental health charity MIND has also reprinted their 1999 inquiry into social exclusion and mental health problems (MIND 1999). Additionally, there have been recent discussion papers on the modernization of the social model in mental health (Duggan et al. 2002), and critiques of the role of the media in perpetuating a perception of the mentally ill as violent and dangerous (Paterson and Stark 2001).

**Gender and ethnicity**

We have chosen to introduce gender and ethnicity at this point since their relationship to mental disorder may be best understood from the perspective of the social model of mental disorders. This is not to say that hormonal differences do not exist between the genders, and these may contribute to differential experiences of mental disorder, but more important perhaps is the observation that differential treatment of women in our society has been a consistent feature of its history.

**Gender**

The literature consistently reports fewer women to be in receipt of specialist mental health services than men (for example, Repper and Perkins 1995; Owen and Milburn 2001). Though this may reflect a lower prevalence of mental disorder among women, evidence suggests that the phenomenon is a marker for the diagnostic practices and expectations of practitioners, which are different for men than for women (Ussher 1991). For example, Perkins and Rowland (1991) identified a tendency for male patients to be encouraged to find employment, while women were more likely to be expected to improve their self-care and domestic skills. Further, it is known that most women are reluctant to share facilities with male patients, whom they often experience as threatening (Repper and Perkins 1995). Whether or not these reasons are sufficient to explain the under-representation of women in specialist mental health services, it remains that women are a minority group whose needs are often overlooked. Owen and colleagues consider these issues in depth and propose strategies to improve mental health services for women (Owen et al. 1998, Owen and Milburn 2001).

A key experience that predominantly affects women and which contributes to mental health problems is domestic violence. Not only does this bring anguish to the women involved, but there is now evidence of lifelong effects on children who witness such violence (Hall and Lynch 1998). Furthermore, abused women may not approach relevant services for help, partly through the fear of retribution from their partners but also because to do so would threaten their social roles, for example as mother, housekeeper, wife, etc.
Ramsay et al. (2002) have recently completed a systematic review of domestic violence with particular emphasis on the role of health care workers in screening for this form of abuse. From this it is far from clear that screening per se is advantageous and further evidence is needed to elicit the benefits of specific interventions.

**Ethnicity**

The flow of people across continents, which is an increasingly common feature of modern life, provides a clear example of how social forces can affect a person’s mental health. Many of these people will have fled unimaginable psychological and physical pain in an attempt to find respite and asylum. This group is particularly vulnerable to mental health problems. Post-traumatic stress disorder is commonly reported and the risk of suicide is also raised in this group (DH 1999).

Within established UK communities there is evidence also of interactions between ethnicity and mental health. For example, young Asian women have a relatively high rate of suicide which, though poorly understood, has been attributed to conflicts between parental expectations and the aspirations of children who develop in a Western culture (NHS Centre for Reviews and Dissemination 1996). However, of all the ethnic groups that make up modern Britain, the Black African-Caribbean population’s experience provides a salutary lesson on the effect of social forces on mental health.

A consistent finding in the literature has been the differential experiences of African-Caribbeans in mental health services compared with others in our communities. Their care pathways are problematic and are more often characterized by compulsory admissions to hospital, police involvement prior to admission, the administration of medications by force, and contentious staff–user interactions (Goater et al. 1999, Thornicroft et al. 1999). They are also more likely to receive a diagnosis of schizophrenia and less likely than other social groups to receive diagnoses of depression or other affective disorders (Harrison et al. 1989; Lloyd and Moodley 1992).

What social forces might account for these differentials? African-Caribbeans are afforded poorer housing, experience higher levels of unemployment and draw a lower average income per household than their white counterparts (Modood et al. 1998). Further, approximately one third of young black men between the ages of 20 and 24 are unemployed, and for the African-Caribbean population at large, unemployment is approximately three times greater than it is among white communities (Sainsbury Centre for Mental Health (SCMH) 2002).

The social model posits that the experiences of African-Caribbean communities in the UK are sufficient to engender mental health problems. However, these differentials are not just a feature of everyday life but extend into the arena of mental health care itself. For example, psychiatrists have been found to more frequently view black people as violent (Lewis et al. 1990), and racial stereotyping of this kind (not only by psychiatrists but by
mental health nurses and other staff, too), significantly influences patient management (Spector 2001). Thus, there are community features associated with deprivation that African-Caribbean people experience, which we know affect their mental health, and there are the attitudes of some health care professionals, which compound the experience of mental ill-health. The Sainsbury Centre for Mental Health (SCMH) has recently completed a major qualitative inquiry into this phenomenon, which they have termed ‘circles of fear’ (SCMH 2002). A wide-ranging programme is needed to break these circles of fear, the main aims of which should be to:

- ensure that Black service users are treated with respect and that their voices are heard;
- deliver early intervention and early access to services to prevent escalation of crises;
- ensure that services are accessible, welcoming, relevant and well-integrated with the community;
- increase understanding and effective communication on both sides including creating a culture that allows people to discuss race and mental health issues; and
- deliver greater support and funding to services led by the Black community.

### Integrating models of mental illness

There are key features that appear to differentiate each of the models we have described. For example, the disease model is concerned with physical, biological and chemical markers of mental illness. These markers can be observed and measured, and are, therefore, representative of an objective orientation. In contrast, the cognitive model deals with internal thought processes unique to individuals. This orientation is therefore primarily subjective.

There is a further difference to note. The behavioural model is concerned with a person’s behaviour. Attention to this alone will suffice for the behaviour therapist. This model is clearly orientated to the self. In contrast, the social model is concerned not with self but with forces beyond a person’s control in the society in which they live. This orientation we have called community.

These two dimensions, subjective–objective and self–community, are used to formulate a four-quadrant schema (Figure 1.1). We have positioned each of the models in their respective quadrants. Thus, the disease model, which is concerned with a person’s biophysiological profile is upper right (objective–self). Similarly, the behavioural model, which deals with a person’s observable behaviours is also upper right. The cognitive model however, is upper left (subjective–self) since its primary focus is on the internal thought processes of the individual.
Freudian psychodynamics are certainly upper left (subjective–self) dealing as they do with our inner world and specifically our sense of self. However, as we have seen, Jungian psychodynamics are premised on a transcendent self, borne of intersubjective culture and mythology (community). For this reason we feel inclined to position Jung in the lower left quadrant (subjective–community). Finally, the social model is certainly community oriented but straddles both lower quadrants. Unemployment and poverty are quantifiable attributes, and each is associated with mental disorder. This interpretation of the social model reflects the lower right quadrant.
(objective–community). On the other hand, intersubjective experiences such as kinship and expressed emotion are also associated with mental disorder. This interpretation reflects the lower left quadrant (subjective–community).

Figure 1.1 illustrates the general orientation of different schools of thought in explaining the aetiology of mental disorder and points of comparison and contrast. But things are more complex than appear here, and there is certainly blurring across the quadrants. Cognitive behavioural therapy is a good example, since cognitive therapists might argue that although they deal initially with unique internal thought processes, they endeavour to alter these with recourse to external, observable evidence (objective–self). Nevertheless, it remains true that they are primarily concerned with, and rooted in, a person’s subjective experience. And, anyway, we would wish to encourage integration (blurring) in the minds of our readers. All models have something to contribute to our contemporary understanding of mental disorders precisely because human experience is made up of a subjective and objective sense of self, and a subjective and objective sense of community.

We suggest, therefore, that the models of mental disorder considered here have many more points in common than difference because they each tap into a limited but, nevertheless, vital aspect of human experience. This stands in contrast to the literature that often reflects an egocentric discourse in which opposing camps endeavour to discredit each other. Beware the academic or practitioner who works hard to undermine any one of these models. They will probably have reason to suggest an alternative (complementary) model, but are likely to be in error regarding the model(s) they try to deny. Human experience arises from all four quadrants and mental health nurses need to draw upon all of them in their practice rather than discount some but not others on grounds of preference or prejudice. We return to this basic schema (Figure 1.1) when describing the assessment of mental health and illness in Chapter 7.

**The stress vulnerability model**

An integrated, second-order model has been developed by Zubin and Spring (1977) to specifically explain the aetiology of schizophrenia. Incorporating all other models, it has as its common denominator the relationship between stress and vulnerability. Stress is the variable that influences the manifestation of symptoms and a person’s vulnerability represents their predisposition to such manifestations.

Two types of stress are at play here. The first is known as ambient stress and reflects the general concerns and pressures that we all face in our everyday lives. Although such stressors are necessary for us to function and perform some people experience more ambient stress than others; we have referred to this previously in our discussion of family interventions and levels of critical expressed emotion. The second type of stress arises from life events and again we are familiar with these, following an earlier reference to Holmes and Rahe’s (1967) Social Readjustment Rating Scale.
Similarly, there are two types of vulnerability. The first is inborn and will likely include genetic loading and the neurophysiology of the person. The second is acquired and will be specific to an individual’s life experiences but may include perinatal complications, maladaptive learned behaviours or thought patterns, and adolescent peer interactions (Zubin and Spring 1977). Notice that these descriptions include features from the single models previously described and can, therefore, be mapped according to the four quadrants in Figure 1.1: for example, vulnerability can be upper left (thought patterns) or upper right (genetic loading) but also lower left (adolescent peer interactions).

Zubin and Spring’s (1977) central hypothesis is that the interface between an individual’s vulnerability and the stress they experience in the course of their lives is the basis for the development or otherwise of schizophrenic symptomatology. There will, of course, be a range of vulnerabilities in any population, with some people being extremely prone to illness even when experiencing relatively mild levels of stress, to those whose vulnerability is so low that they are able to tolerate high levels of stress for significant periods without any trace of psychiatric symptoms.

Since its publication in 1977 this model has had considerable impact in the field of mental health care. It offers hope to those who experience mental disorders because it suggests that coping mechanisms can be acquired to counter the effects of stress and thus reduce the risk of continued illness or relapse. The model is also of considerable value to mental health staff, since it provides a rationale for the use of psychosocial as well as medicinal interventions, and nursing has significantly developed its psychosocial skills base as a result (Gournay 1995).

A contemporary perspective

Our recommendation that mental health nurses familiarize themselves with these models of mental disorder and employ an integrated perspective in practice is supported by the NSF for Mental Health (DH 1999). Each of the single models described above is reflected to varying degrees within this national policy document. We make some of these connections explicit.

Standard 1: mental health promotion

The rationale for this standard is that ‘mental health problems can result from the range of adverse effects associated with social exclusion . . .’ (p. 4). Here we see evidence of a social explanation for mental health problems and the recommended interventions are directed towards populations and communities as well as individuals.

Standards 2 and 3: primary care and access to services

Recommendations are made regarding the use of medication, electroconvulsive therapy, cognitive therapy, cognitive behavioural therapy and
focused psychoanalytic therapy for individuals who present with depression. Cognitive behavioural therapy is recommended also for anxiety disorders. The disease, psychoanalytical, behavioural and cognitive models are evident in these recommendations.

Standards 4 and 5: effective services for people with severe mental illness

Though concerned primarily with care processes, interventions are recommended that variously reflect all the models of mental disorder previously described; these interventions include anti-psychotic medication, cognitive therapy, family interventions and vocational services.

Standard 6: caring about carers

This standard is concerned with assessing the needs of carers and ensuring services are provided to meet those needs. Implicit is the recognition that the stress of caring can affect the carer’s own physical and mental health. These associations are supported by the social model of mental disorder.

Standard 7: preventing suicide

Suicide prevention is, in part, achieved by the recommendations made under standards 1–6 and therefore involves interventions that stem from each of the models.

The classification of mental disorder

Systems for classifying mental disorder or ‘illness’ stem from the medical model, which as Tyrer and Steinberg (1998) point out is not an aetiological model itself but an approach to diagnosing individual disorder. In a general sense all models apply this process, with exception perhaps of the social model, although the systems that are used for classification purposes vary between models. For example, when discussing the cognitive model we described Ellis’s (1962) ABC framework for defining specific cognitive problems that arise between an activating event and the behavioural or cognitive consequence. Problem-oriented statements can be constructed from such an analysis, which represent one approach to classification. For example, ‘When I make eye contact with strangers in public (Activating event), I believe they immediately think bad of me (Belief), and therefore I avoid social interaction (Consequence).’ This statement classifies a cognitive or behavioural problem depending on your perspective.

Medical diagnosis is another classification system, which represents the dominant frame of reference for most mental health workers internationally. These diagnoses are described in two classification systems; the *International Classification of Disease* (ICD-10 World Health Organization (WHO) 1992);
and the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV American Psychiatric Association (APA) 1994). In the UK our primary frame of reference is ICD-10, which is described below. DSM-IV is described in more detail in Chapter 2. But first we draw out some differences between the two systems.

Ideally each diagnosis should be mutually exclusive and stand independently of other symptoms associated with other diagnoses. Rarely in practice is this achieved. More often than not a range of symptoms may indicate the relevance of two or more diagnoses. This point is particularly pertinent to the ICD-10 classification system, which uses a single axis upon which to select diagnoses for an individual’s disorder. If more than one is selected they may appear to contradict each other (Tyrer and Steinberg 1998). However, psychiatric diagnoses are based on a hierarchical system so that each disorder can manifest symptoms present in disorders lower down the hierarchy, but not above it (Sturt 1981). For example, an individual who experiences persistent low mood may receive a diagnosis of depression. However, if the low mood is accompanied by delusional thought patterns, a diagnosis of schizoaffective disorder will take precedence over a diagnosis of depression.

In contrast to the single-axis approach of ICD-10 there is an increasing tendency to use multi-axial approaches in which clinical diagnosis is only one part. Thus, in DSM-IV the clinical diagnosis is axis 1, personality status is described in axis 2, and developmental delay, intellectual status, physical health, social functioning and reactions to stress are all separate axes. This approach allows several descriptors to be attributed to an individual’s symptoms and their general condition.

Before examining ICD-10 diagnostic categories it is important to stress that any classification system classifies syndromes and conditions, but not individuals. We may all suffer from one or more disorders of either a mental or physical nature at different times in our lives. It is meaningless, therefore, as well as stigmatizing, to use such labels to describe people. A person should never be equated with a disorder, physical or mental (WHO 2001).

### ICD-10 diagnostic categories

Table 1.1 presents the main diagnostic groupings in ICD-10 together with their key features. The table presents an overview and we refer readers to subsequent chapters for more detailed accounts of many of these conditions. Equally, we would recommend an examination of the WHO (1992) classification manual, particularly Chapter 5, which provides detailed information on all 100 categories of classification (though a proportion of these remain unused at present).

### Psychoses and neuroses

The terms ‘psychoses’ and ‘neuroses’ are second-order classifications that group several of the conditions in Table 1.1. The psychoses are disorders in
**Table 1.1 ICD-10 classification of mental and behavioural disorders**

<table>
<thead>
<tr>
<th>Diagnostic groupings</th>
<th>Key features</th>
</tr>
</thead>
</table>
| F00–F09 | Organic mental disorders including dementias and delirium  
Brain dysfunction resulting in disturbances of cognition, mood, perception and/or behaviour |
| F10–F19 | Psychoactive substance use including intoxication, abuse, dependence and withdrawal states  
Typically present when substance use interferes with a person’s physical, mental or social functioning to the detriment of their well-being |
| F20–F29 | Schizophrenia, schizotypal, delusional and schizoaffective disorders  
Mental states characterized by distortions of thinking, perception and mood, but not due to an organic condition |
| F30–F39 | Mood (affective) disorders including depression, manic disorder and bipolar disorders  
The key symptom is a disturbance in mood though other features will also be present associated with this mood change for example social isolation accompanying depression |
| F40–F48 | Neurotic, stress-related and somatoform disorders including phobias, obsessive compulsive disorder and stress reactions  
A range of symptoms may be present including tension, anxiety, problems with concentration and ritualistic behaviours |
| F50–F59 | Behavioural syndromes including eating disorders, sleep disorders and post-partum mental disorders  
Symptoms vary according to the condition, for example weight loss with certain eating disorders. However, physiological and hormonal factors appear to play a part in these conditions |
| F60–F69 | Disorders of adult personality and behaviour including personality disorders, gender identity disorders and impulse disorders  
Disorders in which clinically significant behaviour patterns are persistent and reflect the person’s lifestyle and way of interacting with others |
| F70–F79 | Mental retardation of varying degrees from mild to profound  
Usually manifest by the impairment of skills associated with intelligence |
| F80–F89 | Disorders of psychological development including autism, speech disorders, disorders in scholastic skills and developmental disorders of motor functions  
Originating in infancy or childhood these disorders delay the development of functions related to maturation of the central nervous system |
| F90–F98 | Behavioural and emotional disorders of childhood including conduct disorders and hyperkinetic disorders  
Only common features are an onset early in life and a fluctuating or unpredictable course |

(Adapted from WHO 1992; and Tyrer and Steinberg 1998)
which ‘... people’s capacity to recognize reality, their thinking processes, judgements and communications are seriously impaired, together with the presence of delusions and hallucinations’ (Craig 2000: 54). In turn, these are divided into ‘organic’ and ‘functional’ psychoses. The former are represented by the group F00–F09 in Table 1.1 in which pathological processes affecting the brain result in psychotic symptoms. The functional psychoses are group F20–F29 and include schizophrenia and delusional disorders but also affective psychoses in which a primary disturbance of mood is accompanied by psychotic symptoms. In keeping with the hierarchical nature of diagnosis, any disorder in the F30–F39 group that incorporates psychotic symptoms will be elevated to a diagnosis within the F20–F29 group.

Individuals who experience neuroses are different from the general population only in the degree of the symptoms they experience. Thus, anxiety and low mood are common to our experience of life. Indeed we would hope that anxiety is present to some degree before, say, an important exam, in order to enhance our performance. However, if this anxiety becomes so great that it debilitates us, so that we cannot even attend the exam, then this may indicate a neurotic mental disorder. Therefore, in contrast to the psychoses, in which a person’s grasp of reality is uncertain, the neuroses are characterized by the heightening of normal human experiences but to levels that interfere with our ability to function. The neuroses are represented by groups F30–F39 and F40–F48 in Table 1.1.

A group that falls outside of the psychoses/neuroses divide are the personality disorders represented by F60–F69. Personality is a familiar concept and one that we may all use to describe friends and colleagues. We may, for example, say that someone is always cheerful or shy. However, the personality disorders contained in F60–F69 are indicative of people who appear to habitually behave in ways that lead them into conflict with society. These deeply ingrained maladaptive behavioural patterns have been classified into different types of personality disorder including obsessive, avoidant, schizoid, paranoid, borderline, antisocial, dependent, schizotypal, histrionic and narcissistic (WHO 1992).

There has been, and is currently, considerable debate regarding how best to provide services for individuals with these conditions, or whether indeed they are treatable at all. It is perhaps true from a disease perspective that such deeply ingrained behavioural patterns, which appear to stand independently of other psychiatric symptoms, may not be amenable to change following a course of medication. However, there is evidence of benefit in the literature of therapies designed specifically for this group, for example, cognitive-behavioural treatment (Linehan et al. 1991) and therapeutic communities (Lees et al. 1999).

A diagnosis of personality disorder has resulted often in the neglect of the individual by psychiatric services. This is unacceptable although we acknowledge that the individual may be untreatable in the traditional sense of the word. Collaborative, open and honest assessment of the trials of life, triggers for problematic behaviours risk situations, can often provide a good starting point for working with these individuals, upon which alternative
strategies can be formulated and advice offered. Clinical experience suggests that an individual with a diagnosis of personality disorder, who consents to such a collaborative enterprise, can derive benefit.

**Serious mental illness and common mental health problems**

A further distinction between different types of mental disorder is made with reference to ‘serious mental illness’ (SMI) and ‘common mental health problems’. Current mental health policy and practice is influenced significantly by the concept of SMI, the origins of which are many, but we draw attention to two predominant influences from the last decade.

In 1990, White published the third quinquennial national survey of community psychiatric nursing. A key finding was that 80 per cent of people with schizophrenia in England had never been on the caseload of a mental health nurse working in the community. Community psychiatric nurses (CPNs) had tended instead towards providing primary care based liaison services through which they were more likely to encounter patients with neurotic rather than psychotic symptoms.

Alongside this increasing awareness of CPN activity the British media reported a number of high-profile homicides committed by people with a mental illness, which they argued demonstrated the failure of community care. Further, it followed that communities were now at risk from those with serious mental illness (Barker *et al.* 1998). The public concern that such reports generated was allayed by the Department of Health who began to target services towards people with SMI. Thus, the *Health of the Nation: Key Area Handbook* (DH 1994a) identified those with SMI to be the priority target group for services, although it acknowledged that defining this group was problematic. Similarly, the Mental Health Nursing Review Team (DH 1994b) recommended that ‘. . . the essential focus for the work of mental health nurses lies in working with people with serious or enduring mental illness in secondary and tertiary care . . .’ (p. 16).

Early attempts to differentiate SMI from common mental health problems relied heavily on the presence of a psychotic diagnosis as a marker for SMI, for example, McLean and Leibowitz (1989) and Patmore and Weaver (1990). This position has essentially remained the same so that SMI is now synonymous with ‘psychoses’ and common mental health problems with ‘neuroses’.

We make two brief observations regarding these new labels that have entered psychiatric parlance in the last decade. First, they are borne of social fears often fuelled by an ill-informed media. Second, were you (or us) to experience depression to the extent that suicide became a convincing option for you, but you had no psychotic symptomatology, your condition, following McLean and Leibowitz (1989) and Patmore and Weaver (1990), would be considered a common mental health problem rather than a serious one.

While we might understand the basis for these labels their utility in practice is questionable. A nursing profession that sides entirely with the concept of serious mental illness, and its association with psychosis, is
narrowing its professional repertoire. Perhaps more importantly, it is overlooking other subgroups within the adult population that will be marginalized by such a narrow definition of SMI (Barker et al. 1998).

**Prevalence and symptomatology of mental disorders**

Prevalence, expressed as a percentage, refers to the number of people with a particular disorder within a given population. Incidence, on the other hand, also expressed as a percentage, refers to the number of new cases that arise within a given population in a given time period. Actual estimates of prevalence and incidence of mental disorders vary from one epidemiological study to the next. Different samples will have been studied and there may be real differences between populations. Also different instruments might have been used, and the results from these might have been interpreted in different ways to define a ‘case’.

The NSF for Mental Health (DH 1999) used a variety of sources to present prevalence data including World Health Organization figures, which generate European and other world region estimates, rather than country specific data (though the most recent report (WHO 2001) does provide estimates for Manchester as a marker for UK data). The NSF (DH 1999) also relied on a survey of psychiatric morbidity for adults conducted in the UK in 1994 (Meltzer et al. 1995). More recently this survey was repeated (Singleton et al. 2001) and it is these data that we have chosen that most accurately represent the prevalence of mental disorders in the UK.

Singleton et al. (2001) sampled more than 15,000 private households in England, Wales and Scotland, of which 8,886 took part in the survey, and in each of these households one member completed a battery of instruments. All subjects were between the ages of 16 and 74. The survey gathered symptom data, which were used to describe both the incidence of symptoms among those who did not meet diagnostic criteria, and the prevalence of specific diagnoses where the level of symptoms indicated their presence. ICD-10 diagnoses as presented in Table 1.1 were used for this purpose.

The report provides data for common mental health problems in terms of the weekly prevalence per 1000 adults (Table 1.2). The report also provides data for more severe forms of disorder and substance use in terms of the annual prevalence per 1000 adults (Table 1.3). Notice that Table 1.3 refers to ‘probable psychosis’ since its confirmation through research interviews can be difficult to accurately discern. ‘Probable psychosis’ refers to schizophrenia, schizotypal and delusional disorders (F20–29 in Table 1.1).

The mental disorders contained in Tables 1.1, 1.2 and 1.3 can affect a person’s mood, thought processes, perceptions and behaviours. Common symptoms associated with these disorders are described below. They are examined in more detail in the chapters to follow, which deal with specific mental disorders.
Mood

Anxiety

Anxiety is distinguished from general tension by its accompanying physical sensations (autonomic nervous system arousal), including palpitations, sweating and tremor. Anxiety may occur in response to phobic situations or specific thoughts but can also occur independently of any such trigger (free-floating anxiety), or be linked to a sense that something dreadful is about to occur (anxious foreboding) (Craig 2000). Anxiety may also occur abruptly for short periods during which the person experiences marked fearfulness and may feel they are losing control (panic attacks).

Depression

'Sad', 'gloomy' and 'low spirits' are synonymous with depressed mood. More severe forms of this experience encompass additional features including a reduced emotional response to the ups and downs of life (flattened or blunted affect). The individual may also experience disturbed sleep patterns, loss of appetite and a lack of interest in and engagement with life. More extreme forms of this experience can be accompanied by feelings of hopelessness, possibly leading to suicidal thoughts. Other terms associated with this experience include self-deprecation (loss of confidence in self and a

<table>
<thead>
<tr>
<th>Table 1.2</th>
<th>Weekly prevalence of common mental disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Weekly prevalence per 1000 adults aged 16–74</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Mixed anxiety and depression</td>
<td>88</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>44</td>
</tr>
<tr>
<td>Depression</td>
<td>26</td>
</tr>
<tr>
<td>All phobias</td>
<td>18</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>11</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>7</td>
</tr>
</tbody>
</table>

(Adapted from Singleton et al. 2001)

<table>
<thead>
<tr>
<th>Table 1.3</th>
<th>Annual prevalence of severe mental disorders and substance dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Annual prevalence per 1000 adults aged 16–74</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Probable psychosis</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>74</td>
</tr>
<tr>
<td>Any drug dependence</td>
<td>37</td>
</tr>
</tbody>
</table>

(Adapted from Singleton et al. 2001)
developing sense of worthlessness) and pathological guilt (feeling responsible for actions that may be inconsequential to others).

*Elation*

Individuals who experience elation in the course of a mental health problem may feel euphoric and excited but also irritable and impatient (Craig 2000). Typically, concentration is impaired, there is over-talkativeness, a reduced need for sleep and reckless acts are not uncommon, for example excessive spending sprees. Common to these symptoms is an underlying self-esteem that is exaggerated, and grandiose beliefs, such as having special intelligence, are not uncommon.

*Thought processes*

*Obsessational thoughts and compulsions*

A person’s thoughts are considered obsessional when they become intrusive, unwanted and no longer amenable to self-control (obsessional ruminations). *Obsessional incompleteness* refers to an overriding desire to ensure every aspect of a task has been correctly executed before the individual can consider it complete. Intrusive thoughts of this type may be accompanied by repetitive, ritualistic behaviour. An important feature that distinguishes these types of thought is the person’s awareness that they are their own.

*Delusions*

A delusion is a false impression or belief that we can all be subject to from time to time. In the mental health field additional qualities associated with delusional thought distinguish it as a symptom of mental disorder. The belief is usually held with absolute and compelling conviction, is typically idiosyncratic and resistant to modification through experience or discussion (Craig 2000). Different types of delusion have been classified including delusions of persecution and delusions of reference. The latter often involves people feeling that news items on the TV, radio or in newspapers have a double meaning and make reference specifically to them.

*Thought possession*

Some people with mental health problems encounter the sensation that the innermost workings of their mind are amenable to outsiders (Craig 2000). Different sorts of experience have been described including thought broadcasting (a person believes that their thoughts are heard aloud by those around them), and thought insertion (a loss in the ownership of a person’s own thoughts, usually accompanied by a delusional explanation for how thoughts are placed in their mind).
Perceptions

Perception among people who experience mental health problems can become diminished, heightened or distorted (Craig 2000). Hallucinations are a key symptom in this respect, which are defined as false perceptions insofar as there is no adequate external stimulus for the experience. Each of the five human senses can be affected by hallucinations. Thus, hallucinations are typically referred to as auditory, visual, olfactory, tactile and gustatory.

Behaviour

The behaviour and appearance of people with mental disorders may appear strange or unusual. A lack of self-care and accompanying self-neglect are not uncommon, but neither are they necessarily an indication of mental disorder. The specific patterns and qualities of a person’s speech are more useful indicators of a mental disorder. Symptoms may include pressure of speech (a rush of words that is difficult to stop), flight of ideas (skipping from topic to topic with no logical association), and poverty of speech (speaking freely but in such a vague manner that no meaningful information is communicated).

The symptoms associated with the functional psychoses are sometimes also referred to as ‘positive’ and ‘negative’. Brennan explores these terms in detail in Chapter 13.

User perspectives on mental disorders

Thus far, we have proposed a four-quadrant schema for understanding human experience and have described disordered human experience in terms of classification systems, incidence data and symptomatology. Note that these latter terms refer to the upper right quadrant (objective–self) of Figure 1.1. They objectify human experience into codified systems of description, including numbers. So, having proposed a four-quadrant integration we have subsequently planted our feet firmly in only one!

Well, this says something of the dominant perspective in contemporary psychiatry. It is not in itself wrong, since human experience is made up of a subjective and objective sense of self and a subjective and objective sense of community. But it is only part of the story, or more precisely, one-quarter. In this final section we begin to redress the balance with reference to the personal accounts of mental health service users and the research they have conducted.

When people who have experienced mental disorders describe the connections that are important to them in the expression of their distress, their needs, and thus the imbalances that have led to their condition, there are striking similarities across individuals and groups. Users value common
things such as respect, choice, self-help and advocacy. Their expressed needs include intimacy and privacy, satisfying social and sexual lives, happiness and meaningful activity (Repper 2000). These all stem from left quadrant territory, both *self* and *community*, and we should be grateful for the reminder.

But service users also draw attention to the lower right quadrant where *objective–community* forces can threaten their well-being. Income, housing, benefits and employment are typical examples (Duggan et al. 1997). So, what of upper right? Well, mental health service users are actually much more connected to human experience than the professional literature might have us believe. Upper right does not need developing anywhere near as much as the other quadrants, since the objective sciences have that base covered, at least for the time being. And service users readily acknowledge that they have benefited from these *objective–self* sciences. A survey of more than 500 service users, conducted by a research team of service users, concluded that ‘while many users suffered from the side effects of psychotropic drugs, most also appreciated the benefits and lessening of symptoms’ (Rose 2001: 6). This seems a balanced view.

The evidence points to an integrated understanding of the origins of human experience and a corresponding focus on those areas where care and attention is required (*self* and *community* in both subjective and objective terms). This point is made clearly in the service user research introduced above (Rose 2001). Through rigorous methodological procedures, out of respect for the scientific method (upper right), this service user research team designed an interview schedule that could be administered by service users (trained in interview techniques) to describe the perspectives of current mental health service users on community and hospital care. The instrument, which it is hoped will contribute to the formulation of a set of user-defined standards to compliment those already in the NSF (DH 1999), covers all four quadrants.

Personal experiences of *self*, such as the ability to make choices based on sufficient information (*subjective–self*) are key items in relation to various health care practices, including medication (*objective–self*). Rose’s interview method taps social forces that may be experienced as oppressive or liberating, such as the police or user groups (*objective–community*), and also incorporates *subjective–community* interests such as relations with professional staff. A psychotherapist once declared a client’s criticism of her service to be a symptom of their psychopathology (Rose 2001). This is a crude analysis in which all experience must be reduced to upper right and stands in sharp contrast to the integrated, four-quadrant, holistic orientation of many service users.

From the evidence to date it would appear that mental health service users do not distinguish one mental health nursing approach or set of skills (model and its treatment implications) as being the correct one or the only one, but recognize the potential value of all, providing no one approach is applied oppressively and providing all are delivered with respect for the person and their choices.
We end this chapter with an insightful piece of literature written by a ‘psychiatric-nurse therapist’ who experienced a mental disorder during the course of his nursing career (Olson 2002). Tom, his Christian name, takes the reader through the emergence of his distress and the battles that ensued over diagnoses and treatment approaches. Following four separate diagnoses made by four independent practitioners Tom comments that it ‘. . . was like the story of the blind men who, touching separate parts of an elephant, each reached a different conclusion about what was before them’ (p. 437). Tom did not feel as though he was being treated as a person but as bits of a person. Regarding his treatment experience he could conclude only that it ‘. . . reveal(s) professional ego as an important barrier to coordination of care’ (p. 443). All were fighting their own corners, edifying their separate positions, cutting off others, and ultimately, therefore, failing miserably to treat the whole person. The real irony is that they all had something to contribute to Tom’s care if only they had contributed unconditionally instead of forcefully pursuing their own agendas.

Conclusion

Nurses are the professional group in closest contact with mental health service users over lengthy periods of illness and wellness, which provides them opportunity to become involved in many areas of a person’s life during different stages of health (Repper 2000). We have described various models of mental disorder, each of which taps into different aspects of human experience. These points emphasize the importance of mental health nurses embracing an integrated understanding of human experience, through which all models have something to contribute. This is not to say that we should avoid specializing in interventions derived clearly from one model than the others, for example, behavioural therapy, psychodynamic counseling. Rather, we should acknowledge the necessary but insufficient basis of such specialist knowledge to describe the experience of being human. From this position we will be better placed to provide holistic, integrated care by either broadening our own perspective, or by enjoining with others who possess complimentary specialist knowledge. As we have seen, an important source of complimentary specialist knowledge is the service user, from whom nurses have much to learn if we are to purposefully assist people through their experience of mental disorder, and aid their recovery.

We began this chapter by suggesting that mental illness and mental health are terms of relation that describe the reality of human experience. We have, therefore, given an account of one side of human experience (or at least some shades of its spectrum). To fully appreciate the contribution nurses can make to the well-being of people, we need to understand the concept of mental health, to understand its meaning and the implications this might have for our role. To conclude, we summarize the main points of this chapter below:
Mental disorders represent shades in the spectrum of human experience, which comprise a subjective and objective sense of self and a subjective and objective sense of community.

Models of mental disorder describe aetiology and treatment implications in relation to different levels of human functioning: biophysical organism (disease); the unconscious (psychodynamic); thought processes (cognitive); actions (behavioural); and self in context (social).

The models can be mapped against a four-quadrant schema of human experience (Figure 1.1), demonstrating their partial, though necessary, contribution to the treatment and care of people who experience mental disorders.

Mental health nurses need to develop an integrated understanding of mental disorders, to be demonstrated in collaborative partnerships with service users and professional colleagues.

This chapter represents only part of the story, describing as it does disorder – we must consider the antithesis of this position to fully comprehend human experience, and to realize the full extent of nursing’s contribution to mental health care work. To this end we would encourage you to read this chapter in combination with Chapter 2, which considers the concept of health.

Questions for reflection and discussion

1. Reflect on each of the following and consider how much you feel they contribute to your sense of self: genetic endowment; early childhood experiences; learned behaviour or ways of thinking from parents and peers; and social factors.

2. Reflect on a time in your life when you felt distressed (for example losing a loved-one, your job, your self-esteem, or experiencing prolonged periods of stress). Spend a little while familiarizing yourself with the events of that time, what your life looked like and how it felt, and then ask yourself: ‘Would others have experienced those events in the same way?’ And: ‘If not, why not?’

3. Put yourself in the position of a person you have known or nursed who has been diagnosed with a mental disorder. What do you remember or think was their preferred perspective on the nature of their problems and the interventions that they considered most appropriate? Did these differ from the reality of the care they received and, if so, why?

4. Use the schema presented in Figure 1.1 to identify the orientation of the chapters that follow. Are they concerned primarily with the objective or the subjective indicators of health and/or illness at the individual or community level?
5 Before embarking on Chapter 2 think about your own ideas of what mental health is, using the basic schema in Figure 1.1 to explore its likely dimensions.

**Annotated bibliography**

- Tyrer, P. and Steinberg, D. (1998) *Models for Mental Disorder: Conceptual Models in Psychiatry.* Chichester: John Wiley and Sons. Now in its third edition, this text provides a detailed yet accessible explanation of the main models of mental disorder in contemporary practice. We have adopted Tyrer and Steinberg’s five basic model structure in this chapter but have pursued a different path to integration. However, we recommend also Tyrer and Steinberg’s approach, which is predicated on levels of functioning rather than, as ours, the components of human experience.


- *Journal of Psychiatric and Mental Health Nursing* Volumes 5: 3 and 6: 4. These volumes are dedicated to the contributions of Hildegard Peplau and Annie Altschul to mental health nursing. These pioneers draw upon interpersonal theories of human experience and psychodynamic principles in their work. Papers in these volumes demonstrate the application of Peplau’s and Altschul’s ideas to contemporary health care practice.

**References**


